THE LIVED EXPERIENCE OF NURSING STUDENTS IN CARING FOR SUFFERING INDIVIDUALS: A PHENOMENOLOGICAL ANALYSIS

by

Susan Sweat Gunby

A DISSERTATION

Presented in Partial Fulfillment of Requirements for
the Degree of Doctor of Philosophy in Nursing in the School
of Nursing in the College of Health Sciences
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Acceptance

This dissertation, THE LIVED EXPERIENCE OF NURSING STUDENTS IN CARING FOR SUFFERING INDIVIDUALS: A PHENOMENOLOGICAL ANALYSIS by SUSAN SWEAT GUNBY, was prepared under the direction of the candidate's dissertation committee. It is accepted by the committee members in partial fulfillment of the requirements for the degree of Doctor of Philosophy in Nursing in the School of Nursing in the College of Health Sciences, Georgia State University.

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ABSTRACT

THE LIVED EXPERIENCE OF NURSING STUDENTS

IN CARING FOR SUFFERING INDIVIDUALS:

A PHENOMENOLOGICAL ANALYSIS

by

SUSAN SWEAT GUNBY

The purpose of this study was to illuminate the lived experience of nursing students in caring for individuals who were suffering. A phenomenological approach was utilized consisting of four iterative steps: purposive sampling, intensive interviewing, inductive data analysis using Giorgi's (1985) method, and uncovering the essential structure of the phenomenon. Using purposive sampling, 12 generic undergraduate nursing students were recruited from a large university located in the southeastern United States. Participants were interviewed and asked to describe their experiences related to caring for a suffering individual. Interviews were audiotaped and then transcribed. The transcriptions of the interviews constituted the data for analysis. Data were analyzed utilizing the four-step process delineated by Giorgi (1985). Methodological rigor of the study was established through adherence to the four trustworthiness criteria established by Guba and Lincoln (1989). These include credibility, transferability, dependability, and confirmability. Five themes emerged from the data:

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remembering/knowing, listening/voicing, attending, standing inside/standing outside, and being with. Remembering/knowing was constituted by the subthemes of remembering the experience, making a difference, and knowing the experience. Subthemes for listening/voicing were caring, becoming educated, emulating role models, describing the lack of role models, and discovering self. Seven subthemes emerged for attending: maintaining human dignity, showing compassion, respecting, caring/nurturing, managing pain, individualizing, and connecting/putting oneself in the suffering person's shoes. Standing inside/standing outside described a paradoxical coalescing of being with and caring for an individual who is suffering while also needing or wanting to distance oneself to protect one's vulnerability. Being with the family recognized the preeminent position of the family; the subthemes were listening/communicating, caring/showing compassion, and connecting/putting oneself in the family's shoes. Further abstraction from the data yielded the major conclusion of this study: Insight into nursing students' experiences in caring for suffering individuals is gained through their narratives of the lived experience. This research is significant to nursing education because it illuminates the ways nursing students learn to care for suffering individuals.

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I hope this dissertation will serve as a tribute to the nursing students who willingly shared their experiences. They represent the art of nursing.

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This dissertation is dedicated to my husband, Tom W. Gunby. Accomplishment of this goal would not have been possible without his love, encouragement, belief in me, and enthusiastic assistance. Thank you, Tom.

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CHAPTER I

INTRODUCTION

A void exists in nursing literature relative to the lived experience of nursing students in caring for individuals who are suffering. Commonly in their first nursing course, nursing students are introduced to the American Nurses' Association Code for Nurses (1985) which has in its preamble the statement that "nursing encompasses the promotion and restoration of health, the prevention of illness, and the alleviation of suffering" (p. 1). As a nurse educator, I have observed that most nursing school curricula address the pathologic nature of illness, the nursing care of clients who are ill, the prevention of illness, and the promotion of health. However, overall there seems to be minimal discussion, both in nursing textbooks and in curricula, of the alleviation of suffering.

In a classic article written in 1974, Copp asked the question "Why do we understand so little about suffering, one of the oldest human reactions?" (p. 491). Nurses may lack understanding about personal feelings concerning suffering; thus, they may not be cognizant of the experiences of others who are suffering. Curricula in many nursing schools focus on the alleviation of physical pain and include no discussion of suffering. In 1974 Copp stated "no one has markedly enriched our awareness of the phenomenon of suffering...the course is almost uncharted" (p. 491). This statement remains true today.

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Graffam (1990) surveyed 390 baccalaureate nursing programs relative to the teaching of pain management and found that 81% of the 305 usable questionnaires indicated these schools included some formal class content on the concept of pain. Fifty seven programs had no formal class content on pain, while 23 programs reported a separate course on pain. A noteworthy finding made by Graffam (1990) revealed that in all 305 programs the total amount of time spent on this topic throughout the entire curricula ranged from less that 2 hours to more than 15 hours with the mode being 4.

Ferrell, McGuire, and Donovan (1993) conducted a survey of faculty from 14 baccalaureate nursing programs in the United States on their knowledge and beliefs about pain. The impetus for their study was a perception that nurses and other health care professionals are inadequately prepared to care for patients in pain. Reasons identified for this lack of preparation include inadequacies in nursing and medical education, absence of curriculum content related to pain management, and faculty attitudes and beliefs related to pain.

In describing their research, Ferrell, McGuire, and Donovan (1993) did not mention the concept of suffering; however, their research parallels many of my perceptions regarding the lack of preparation of health care professionals for caring for suffering individuals. Ferrell, McGuire, and Donovan (1993) stated nurse educators have a tremendous opportunity to have a long-lasting effect on the individual nurse's pain management practices. Findings from their study suggest that in baccalaureate schools of nursing, faculty knowledge and beliefs about pain, as well as curriculum content related to it, may be less than optimal.

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They found faculty had difficulty with some very basic knowledge related to the concept of pain, such as not understanding the subjective versus objective nature of pain.

Ferrell, McGuire, and Donovan (1993) suggested that in order to correct the academic deficits in pain education, nurse educators need to know there may be problems with their own knowledge and beliefs. Furthermore, faculty need to acknowledge there may be problems with the nursing school curricula related to pain management. Ferrell, McGuire, and Donovan (1993) summarized their stance by stating "only through adequate undergraduate education on pain will students become clinicians equipped to contribute significantly to the worldwide goal of pain relief for those who suffer" (p. 87).

The idea for this dissertation research was derived from my 20 years of teaching nursing students about the concept of pain and from extensive research in this particular area. Based on this experience, I believe students are inadequately prepared to care for individuals who are in pain and for individuals who are suffering. Owing to the facts that the major complaint of most clients for whom nursing students care is that of pain and that many of the clients and families nursing students care for are suffering, it would seem evident students need more extensive preparation (while in school) to prepare them for these experiences. Young-Mason (1988) substantiated the significance of this claim when she stated:

> The desire to alleviate suffering has always been embodied within the discipline of nursing, but in certain instances nurses have been impotent in their ability to respond to suffering, and, at times, unaware of the ways in

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> which they themselves might actually perpetuate it. It has not always been clear just exactly what compassion is, or whether or not it can be taught. However, one thing is certain: Patients, families, administrators, and the community at large cling to an expected trust that nurses have a deep understanding and knowledge of both the suffering and the compassion possible in the human condition. (p. 299)

Furthermore, Young-Mason (1988) explained that "compassion is not transferring one's imagining of one's own suffering onto another, but entering the point of view of the sufferer while also retaining one's own sense of rational needs and practical benefits for the sufferer" (p. 301). Emphasizing the critical importance of educating nursing students in the care of suffering individuals, Young-Mason (1988) adduced:

> compassion is no mere sentimental emotion, nor is it an attempt to merely pity another. The compassionate act, thus defined, becomes the living basis for assisting those who are suffering. The complimentary acts of compassion and advocacy may well be the most powerful, rewarding, and necessary acts of the nursing profession. (p. 301)

Steeves, Kahn, and Benoliel (1990) conducted a study of registered nurses' interpretations of the suffering of their patients and started their discourse with this statement: "The nurse's encounter with suffering is a central aspect of nursing practice" (p. 715). These authors also concluded that there has been very little descriptive research conducted on how nurses experience and react to a patient's suffering.

Nursing education has only recently begun to utilize qualitative research methods to address the phenomena encountered by faculty and students. According to Ray (1987), "The movement toward advancing nursing as a human science, as the science and art of caring, demands a new scientific approach--one

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which addresses the study of human experience as it is lived" (p. 167). There is a paucity of nursing education research that has utilized the phenomenological method to describe the lived experience of nursing students. Nelms (1988) argued that nursing educators:

> must begin systematically to illuminate the internalized personal meaning or "lived experience" of the nursing student as they experience the planned curriculum and the learning environment in order to make nursing education more personally relevant for nursing students and faculty and ultimately to make the nursing profession more sensitive and personally relevant to the public it serves. (pp. 4-5)

This study will focus on the lived experience of nursing students in caring for individuals who are suffering.

Background

I reviewed over 20 of the most widely used textbooks in introductory nursing courses and in medical-surgical nursing courses in order to determine the content included on suffering. The majority of textbooks reviewed have chapters or sections on the topic of "pain" but do not include a discussion on "suffering." An additional interesting finding is even though almost all textbooks indicate pain is the major reason clients are seen by health care providers and are admitted to hospitals, the content included in most textbooks on pain and suffering is placed toward the end of the book. I question whether this influences nursing educators in their selection of critical course content to teach nursing students and whether nursing students believe this content is not as important to learn as the subjects that precede it in the textbooks.

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In my review of textbooks, Narrow and Buschele (1987) were the only authors to speak about both of the concepts of pain and suffering; however, they included the statements exclusively in a brief introduction to the chapter on management of pain. According to Narrow and Buschle (1987):

> The relief of pain and suffering is one of the most significant of all nursing functions. Other activities such as the prevention of illness, the promotion of health, and contributions to the therapeutic regimen are all important, but both patient and family often value above all else the nurse's ability to relieve pain and suffering. (p. 726)

Narrow and Buschle (1987) addressed the point that nurses provide the most continuous care for clients as compared to other health care professionals and stated the following:

> Nurses are with the patient more frequently and for longer periods than any other health care workers and therefore have a unique opportunity either to relieve his pain or to help him learn to live with it. The care of a person in pain can be extremely difficult for the nurse as well as the patient, especially if the pain is intractable . . . . It is not easy to stand by the patient, to "hang in there" when nothing seems to be fully effective, and the nurse requires a special attribute known as staying power in order to do. This characteristic makes it possible for a nurse to provide whatever physical and psychological comfort is possible by her presence, skill, and caring. (p. 736)

In the remainder of the chapter on pain there was no further mention of suffering, nor did the authors elaborate as to how the nurse can learn to cope with caring for individuals who are in pain or suffering. They did not describe how the nurse can acquire the attribute of staying power.

Phipps, Long, and Woods (1987) addressed suffering by equating it with pain in one sentence in a chapter on the concept of pain by indicating that the "care of patients suffering pain demands skill in both the science and art of

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nursing" (p. 301). These authors discussed the significance of the nurses' reaction to pain but not to suffering.

Thompson, McFarland, Hirsch, Tucker, and Bower (1989) wrote a section in a chapter entitled "Cognitive Perceptual" relative to the concept of pain without a single mention of suffering. They defined pain as "the state in which an individual experiences and reports the presence of severe discomfort or an uncomfortable sensation" (p. 1719).

The authors, Brunner and Suddarth (1988), without recognizing the significance of suffering, composed a very thorough discussion of pain that encompasses nursing assessment, acute versus chronic pain, phases of pain experience, behavioral responses, assessing harmful effects of pain, nursing interventions, noninvasive pain relief measures, medications to decrease or relieve pain, patient education, and pain centers. They noted that algology, the study of pain, is a new science.

In a very brief portion of a chapter on several different concepts, Ames and Kneisl (1988) wrote about understanding and caring for the patient in pain but did not refer to suffering in any direct manner. According to Sundberg (1989), "pain is a common human experience" (p. 623); however, while she compiled an extensive chapter on pain in a textbook, there was no coverage of the concept of suffering. Kemp, Pillitteri, and Brown (1989) did not introduce the topic of suffering in their discussion of pain.

Potter and Perry (1991) devoted an entire chapter in their basic nursing textbook to the subject of pain. The word "suffering" is not listed in the index

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and is only mentioned a couple of times in the chapter on pain. The few references to suffering equate it with the concept of pain.

Hood and Dincher (1992) wrote a chapter on the subject of pain without mentioning suffering. The index in their book on adult health nursing does not include the subject of suffering.

Considerable research and numerous publications have focused on the perception, assessment, measurement, and treatment of pain (Camp & O'Sullivan, 1987; Camp, 1988; Copp, 1985; Cupples, 1992; Gaston-Johansson & Asklund-Gustafsson, 1985; Gildea & Quirk, 1977; Giuffre, Keane, Hatfield, & Korevaar, 1988; Greipp, 1992; Guck, Meilman, & Skultety, 1987; Holm, Cohen, Dudas, Medema, & Allen, 1989; Jacox, 1978; Jensen, Karoly, & Braver, 1986; Ketavouri, 1987; Max, 1992; McCaffery, 1979; McCaffery & Beebe, 1989; McCaffery, 1992; McGuire, 1988; McGuire, 1992; Melzack, 1975; Nolan, 1990; Oberle, Wry, Paul, & Grace, 1990; Price, 1992; Puntillo, 1988; Reading, 1983; Taenzer, Melzack, & Jeans, 1986; Taylor, Skelton, & Butcher, 1984; Tittle, Long, & McMillan, 1992). The majority of these studies focused on the cues nurses used when they assessed the pain a patient was experiencing and how the nurse measured the patient's pain. The cues most frequently utilized by nurses were the verbalizations by the patient that described their pain and their subsequent request for medication, the assessment by the nurse of the context of the patient, and nursing observations of the patient.

McCaffery (1979) was the only author from those listed above who acknowledged, albeit a very cursory and ambiguous notation, that pain and

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suffering are two different but inextricably related concepts. There are two major categories of pain relief according to McCaffery (1979) "those that alter some dimension of the sensation of pain and those that change the extent to which the patient suffers from the pain" (p. 35). McCaffery (1979) asserted that "alterations in suffering and sensation often overlap" (p. 35) and that "goals for pain relief measures often involve changing both the suffering and the sensation aspects of pain" (p. 35).

In a textbook by Flynn and Heffron (1988) that purports to "represent selected topics that are fundamental to professional nursing practice" (p. ix), the concept of pain was explored very comprehensively without acknowledging the concept of suffering.

Barbara Stevens wrote the foreword to the Davitz and Davitz (1981) book which focused on the inferences of nurses regarding patients' pain and psychological distress. Stevens noted suffering and the cure for suffering are central to any concept of nursing which perceives the nurse as caregiver, sustainer, and one who supports the patient through an illness. She emphasized that any research which reflects upon suffering, its interpretation, and its management is crucial to the nursing profession.

Davitz and Davitz (1981) believed nursing educators and theorists have recognized the significance of understanding the suffering of patients, but they noted there have been relatively few systematic investigations focused upon nurses' perceptions and reactions to suffering. I contend they are incorrect because a review of the literature reveals more research on nurses' inferences of

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suffering and little, if any, research on the experience of nurses in learning to care for those who are suffering or the lived experience of nurses who have cared for those who are suffering. Davitz and Davitz (1981) enumerated a critical premise upon which this dissertation research is based which is, by failing to study suffering and its effects upon nurses, nursing research has bypassed an essential part of the discipline.

Studies conducted by Davitz and Pendleton (1969), Davitz, Sameshima, and Davitz (1976), and Davitz and Davitz (1981) focused on the relationship between inferences to suffering and variables such as the ethnic background of the nurse, clinical specialties, selected patient characteristics, diagnosis of patient, level of nursing education, and professional identity of the nurse.

Davitz and Davitz (1981) concluded that every person who suffers, experiences unique distress and that no one can directly perceive the suffering of another person. They believed this is true because suffering is a subjective experience; thus, any evaluation of the nature and degree of another's suffering necessarily depends upon inference.

Relative to the belief system of the nurse, Davitz and Davitz (1981) spoke of an "implicit theory of suffering" (p. 9) everyone possesses. These beliefs affect the judgments health care providers make about the suffering of patients or clients. Critical to this premise is the degree to which one tends to maximize or minimize reactions to the suffering of others. Owing to the fact that a large portion of nursing care involves responding to the suffering of patients, this is of great significance to nursing (Davitz & Davitz, 1981).

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Morse, Bottorff, Anderson, O'Brien, and Solberg (1992) described an alternative model for nursing which focused on how the nurse communicates an expanded expression of caring for those who are suffering. The model delineated by these authors is very relevant to this dissertation research and therefore, will be discussed in detail. Their paradigm is based on two broad characteristics: (a) whether the nurse is focused on the patient's response (i.e., engaged and, therefore, embodying the sufferer's experience) or focused on the self, protecting one's self from experiencing the suffering of the patient, and (b) whether the response is reflexive and spontaneous or learned and, therefore, controlled.

Morse et al. (1992) identified rich descriptions from both the caregiver and the patient which related to how they responded to the suffering experience. These descriptions are of particular value in understanding human responses to suffering in the clinical setting. These researchers suggested a communication model that places emphasis on the actual process of emotive engagement or embodiment of the nurse with the patient who is suffering instead of placing the greatest value on the outcome of enabling the sufferer to gain insight. The value of this method may be seen in this description by Morse et al. (1992):

> Removed from the experience of suffering, the caregiver is not usually consciously aware of his or her own body. However, observing a patient suffering causes distress in the nurse, and, consequently, awareness of his/her own body. Thus, the nurse is engaged with the patient's suffering, and the patient's suffering is embodied by the nurse, and suffering becomes a shared experience. (p. 811)

In cases where the nurse is powerless to alleviate the suffering of patients, the patient is forced to endure the agony, and the nurse is forced to witness and,

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therefore, to share the experience (Morse et al., 1992). The nurse senses the patient's suffering and this evokes an empathetic insight that, in turn, evokes reflexive and spontaneous expressions of verbal comfort, such as sympathy, pity, compassion, commiseration, and reflexive reassurance. Constant exposure to patient suffering can emotionally drain the nurse. Consequently, the experience of shared suffering must be controlled by the nurse in order that the nurse may leave the suffering patient and care for other patients, limit personal involvement in the patient's suffering, and avoid becoming emotionally drained and exhausted (Morse et al., 1992).

Methods health care professionals may use in controlling engagement with a patient who is suffering include the learned replacement of a first-level reflexive response with the use of reflected, first level responses such as labeling and distancing. Another method is a professional, second-level response such as the use of therapeutic empathy. A third method is the use of detached, second-level responses such as false reassurance or use of rote behaviors (Morse et al., 1992).

Morse et al. (1992) revealed critical insight into the education of nurses about caring for the suffering. They noted human responses which are first-level, sufferer-focused responses are triggered by the emotional insight of the nurse. These responses are not learned; they appear to be culturally conditioned, almost reflexive or automatic in nature, and they are comforting to the sufferer. The authors revealed these responses are not valued in nursing, and nurses are taught to react to patients in a more professional manner. The illuminating observation they made is that despite the fact these responses are not a part of

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formal nursing education, they are used by nurses in their daily care of patients.

Acknowledging there is a limit to how much shared suffering the caregiver can tolerate, Morse et al. (1992) asserted "because nurses are exposed to so much suffering, constantly bombarded with emotional stresses, and frequently required to inflict pain (i.e., to cause additional suffering), they learn to redirect, alter, or squelch the spontaneous arousal of first-level emotive responses" (p. 812).

Discussing the concept of pity, Morse et al. (1992) suggested that "quality pity" is especially useful to the patient during periods of extreme suffering. When a caregiver expresses this pity, it has the effect of endorsing the sufferer's experience and, if the sufferer is in a state of shock or disbelief, it has the effect of confirming reality, thereby enabling and enhancing the sufferer's ability to accept reality.

Sympathy is another emotion that, when given appropriately, legitimizes and justifies feelings of suffering experienced by the patient. Morse et al. (1992) disagreed with authors who suggest sympathy interferes with the nurse's ability to accurately perceive the patient's experience and to offer assistance because the caregiver is dominated by her or his own sorrow for the sufferer.

Compassion is a strong emotion which may be stimulated by the presence of suffering. According to Morse et al., compassion:

> . . . demonstrates acceptance of the sufferer's plight. The compassionate caregiver echoes the sufferer's sentiment and shares in the suffering. In sharing the other's suffering, the caregiver expresses compassion that strengthens and comforts the sufferer. (p. 814)

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Feelings of compassion can lead caregivers to withdraw from the suffering patient and shield themselves in order to avoid further pain or emotional involvement.

Commiseration is approached by Morse et al. (1992) in an interesting manner. Commiseration involves reflecting on a mutual response to a common experience and therefore, may be initiated by either the caregiver or the sufferer. "While commiserating, the caregiver and the sufferer share a feeling of identity, enabling the caregiver to listen and communicate sincere expressions of agreement and understanding" (p. 815). An important point made by Morse et al. (1992) is that nurses and patients who are suffering do not have to have undergone identical experiences in order to be able to commiserate.

Discussing patient-focused, second-level responses, Morse et al. (1992) stated when nurses attempt to reduce their own emotional responses to the sufferer, thereby decreasing their personal investment in the suffering, they initiate learned professional reactions such as therapeutic empathy, humor, distraction, and confronting. These types of responses result in pseudoengagement. The caregiver is able to remain somewhat detached, objective, and therapeutically "at arm's length" from the person who is suffering. These learned responses are often acquired in basic nursing education programs from experience and from the modeling of faculty and other nurses.

Three responses found in the self-focused, first-level responses are shielding, withdrawing, and guarding. They all serve to protect the caregiver by reducing the caregiver's sensitivity to the suffering experience, which keeps the caregiver emotionally separated from the sufferer. Four other responses in this

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level include labeling, dehumanizing, distancing, and denying; these protect the caregiver by changing the caregiver's perception of the sufferer. All of these strategies reduce vulnerability of the caregiver and enable the caregiver to have the stamina necessary to continue to administer care.

Morse et al. (1992) argued that the essence of the nurse-patient relationship is engagement and, the engagement of a nurse caring for a patient who is suffering, leads to the empathetic insight or the reflexive emotional response in the nurse that extends to identifying with the patient's experience.

Reich (1987) reviewed models of pain and suffering as he attempted to establish the foundations for an ethic of compassion. He stated the need for compassion is created not so much by pain as by suffering. Acknowledging that pain is often equated with suffering, Reich (1987) said when they are both combined in human experiences, the subject experiences a threat both "from outside" and "from inside" (p. 117).

Reich (1987) noted:

> I would maintain that there must be an empirical moral assessment of what it means to suffer before one can even know the moral requirements of compassion. In this perspective, an ethic of medicine does not simply apply some strong, a priori theory of suffering and compassion to the medical situations of people who suffer; rather, it insists that we must learn in the situation the requirements of compassion by first learning from the sufferer what it means to suffer. (p. 118)

The central premise undergirding Reich's (1987) writing is that caregivers cannot know the requirements of compassion unless they know something of the experience of suffering. He identified three stages of suffering: mute suffering, expressive suffering, and regained autonomy. It is possible to experience the

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suffering of others by entering into their world through their metaphors, through the language by which they express their suffering and the movement beyond it (Reich, 1987).

Writing about the anthropological challenge of pain and suffering, Bockle (1987) stated that "pain and suffering, like disease and death, are among the most mysterious phenomena of human existence" (p. 194).

Suffering is a phenomenon which has been grappled with over time and the body of literature it has generated is oriented mainly in philosophy and religion. Hinds (1992) agreed with several other authors that the efforts by health care professionals to explore suffering have not been substantial.

The purpose of Hinds' paper was to illustrate the phenomenon of suffering as it related to the experience of family caregivers of patients with the diagnosis of cancer. She defined suffering in this context as the "family caregiver's subjective responses and evaluation of their reactions to patient's diagnosis and current status" (p. 920). Hinds did not explain the following points even though she claimed paying attention to them could ameliorate the family caregivers' suffering:

(1) legitimize nurses' professional roles as carers;

(2) be willing to listen/observe for cues that indicate suffering;

(3) assist families to understand and deal constructively with immobilizing emotions that contribute to suffering; and

(4) assist families to acquire needed information and correct suffering-induced misconceptions. (p. 924)

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It would be interesting to know what Hinds meant by the first point.

Wilson, Blazer, and Nashold (1976) agreed that pain is very often considered synonymous with suffering. However, they believed the clinical picture, as well as the lay concept of suffering, implies something more comprehensive. Another point upon which they agreed with other authors is that suffering is ultimately a subjective phenomenon. Suffering is based on the affective response of the sufferer and the caregiver who shares the suffering empathetically (Wilson et al., 1976).

Kreidler (1984) broached the topic of the embedded meaning of suffering in an article that discussed the dual suffering of clients and nurses when facing situations which appear to have no meaning. She questioned whether nurses respond to the needs of those who are suffering or, without realizing it, respond only to those needs with which they feel they can cope.

Even though the relief of suffering is regarded as a critical and essential goal of nursing by both clients and practitioners, nurses can become overwhelmed by suffering to which they cannot relate or which causes them to feel helpless, inadequate, or guilty. These feelings may lead the nurse to maintain a distance from the suffering individual and the situation (Kreidler, 1984).

Kreidler (1984) wrote:

> Nurses need assurance that groping for meaning in suffering is not a sign of deep-seated neurosis, but rather a sign of strength. For some nurses, just as for their patients, this search is for God and personal religion; for others a search for belonging within the family of man, and for others a search for the unique contribution that each can make to life. (p. 174)

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She concluded her article by listing parts of a philosophy for the nurse seeking meaning in suffering.

Farran and Keane-Hagerty (1991) utilized the noted German theologian Dorothee Soelle's interactive phases of suffering in hypothesizing that caregivers encounter them throughout the process of rendering care. Soelle (1973/1975) proposed these phases: (1) acknowledging present loss/powerlessness/isolation/muteness; (2) lamenting plight/accepting powerlessness/conquering existing situation; and (3) gaining solidarity in a changed structure.

Statement of Purpose

The above described interest in pain and suffering provided the impetus for the study's purpose, which focused on the lived experience of nursing students in caring for individuals who are suffering. Through the use of the phenomenological method, common meanings embedded in the experiences of these students were revealed. These meanings offer new possibilities for curriculum and instruction which could enhance learning.

Significance to Nursing

This study should yield a deeper understanding of the lived experience of nursing students in caring for suffering individuals. No other research of this type has been found in nursing or nursing education; and, therefore, this should add to the body of knowledge concerning the concepts of pain and suffering and the theoretical aspects of teaching students to care for individuals who are

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suffering. The knowledge obtained should be of benefit to other disciplines, particularly those related to the health care professions.

The lived experience of nursing students should be of great value to nursing education particularly considering some of the current curriculum revolution changes taking place. This study could lead to an increased level of knowledge related to the ways nursing students learn to care for suffering individuals. Findings from this study could increase awareness of the need for further research on teaching students to care for individuals who are suffering, as well as increasing the awareness of the extant lack of knowledge on caring for those who are suffering.

Owing to the fact that caring for individuals who are experiencing pain and suffering is a part of most nurses' daily activities, nurses need to be more knowledgeable about these concepts. An improvement in patient/client care should result from the research conducted.

The nursing students who participated in this study could experience an enhancement of their self-knowledge through the process of self-reflection experienced as a part of this research.

Summary

Suffering has been studied in philosophy and religion but little in the health care professions. Nursing's perspective of suffering interweaves notions from several other disciplines. These perspectives will be delineated in the review of the literature related to suffering.

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It is my assumption that nurses, on a daily basis, are confronted with many facets and forms of suffering and are challenged constantly to understand it and to relieve it. Nurses should be aware of the lack of knowledge and should understand the conflicting views evident in the existing knowledge relative to caring for those who are suffering in order to render compassionate care to each individual.

Words coupled with the concept of suffering when a review of the literature is conducted include: "monetary compensation," "suicide," "evil," "vicarious," "guilt," "hope," "joy," "masochism," "mental disorders," "literature," "racial," "animal," "pain," "retribution," "God," "martyrdom," and "women as victims."

Suffering has been viewed from the standpoints of being instructive/educational, a punishment, a mystery, a challenge, a nuisance, a means of prioritizing values, a redemptive measure, and as being integral to the healing process. Several of these viewpoints are further delineated in the review of the literature in the next chapter.

Awareness by educators of the experience of nursing students as they care for individuals who are suffering should increase understanding of the phenomenon of suffering. Identification of educational methods (such as role modeling, use of case studies, etc.), which are instructive in teaching students how to care for those who are suffering, should be a result of this research.

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CHAPTER II

CONTEXT OF THE STUDY

Suffering is a multifaceted phenomenon. Philosophers, theologians, psychologists, and many others have advanced explanations and justifications of suffering. Copp (1974) questioned whether the "spectrum of suffering" was a "phenomenon we recognize only when we are in its throes" (p. 491). O'Conner (Copp, 1974) wrote the "sick in their suffering are closer to what is real since they see the things that really matter" (p. 491).

In an attempt to portray the "spectrum" that comprises suffering, it is helpful to review the disparate views of several writers. Upon completion of this review of the literature, I observed that many of the individuals who have conducted scholarly inquiry related to suffering have attempted to quantify the concept. I assert that the need to quantify is part of the mechanistic view of humans which places excessive emphasis on medical technology, scientific experimentation, and reductionism to explain complex phenomena. This adherence to scientific rationale may allow individuals to avoid philosophical and existential issues which arise when analyzing realities such as human suffering. There is a dearth of material on suffering in the nursing and medical literature even though suffering is as old as humankind. Suffering is regarded as the most common, most persistent, and most puzzling problem affecting all people.

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Discussions by nurses on the theoretical and empirical bases of suffering started less than 30 years ago (Duffy, 1992). The majority of the material on the concept of suffering is found in theological and philosophical literature. Nursing and medicine have tended to categorize the concept of suffering with the concept of pain and thus, equate the two terms.

Kahn and Steeves (1986) noted that the Cumulative Index to Nursing and Allied Health Literature eliminated the indexing category of suffering in 1982 due to the lack of materials. From 1982 until 1990, the Cumulative Index to Nursing and Allied Health Literature, categorized references on suffering under "pain/psychosocial factors" or "psychosocial aspects of illness." In 1991, the Cumulative Index to Nursing and Allied Health Literature defined suffering as "a negative affective state resulting from an event or situation that is perceived to be physically painful, uncomfortable, or psychologically distressing" (p. 928).

Hauerwas (1986) stated suffering is not something you can eliminate, but rather it is something with which you must learn to live. From the root of the word "suffering," comes the idea of submitting or being forced to submit to and endure some particular set of circumstances (Hauerwas, 1986). Dougherty (1979) defined "suffering" in its reflective dimension as:

> . . . the quasi-perceptive experience of the world, inasmuch as it is an indivisible power of destruction which permanently burdens our puny individuality, so as to remind us by way of concomitant awareness of its permanent frailty as well. (p. 60)

In an attempt to write a conceptual description and content analysis of suffering, Battenfield (1984) found that a search of the literature revealed:

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> . . . a neither comprehensive or final definition of suffering and its fractional subcomponents nor a tool for evaluating responses to suffering. This is perhaps because conceptual notions including suffering are never inert and easily defy structure. (p. 36)

According to van Eys (1992), "the word suffering is rich in meanings and heavily value-laden" and "the meaning can range widely: allowing or tolerating, enduring or undergoing, sustaining an injury and finally, undergoing or feeling pain and distress" (p. 117).

Suffering is viewed by Breton (1979) as "the idea of an evil or a disorder" (p. 63) and the person who is suffering feels as though he or she has been invaded by a foreign power set up inside them permanently.

No one simply suffers; one always suffers from something (Hauerwas, 1986). Suffering always takes place in an interpretative context. Hauerwas (1986) offered a profoundly different interpretation of suffering when he observed that suffering is not morally significant only because things happen to a person that cannot be avoided, but because the demands of morality cannot be satisfied without asking the self to submit to limits imposed by morality itself. In this sense, Hauerwas believed that without allowing ourselves and others to suffer we could not be human or humane. He acknowledged we generally think all kinds of suffering should be avoided. In order to see the value of this line of thinking, Hauerwas challenged us to ask ourselves what we would think of anyone who did not have the capacity to suffer, including God. This person could not bear grief or misfortune, and thus, would in effect give up the capacity to be human or divine. It is our capacity to feel grief and to identify with the

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misfortune of others which is the basis for our ability to recognize our fellow humanity (Hauerwas, 1986).

Hauerwas asked us to reflect on our reaction to someone who is suffering. The other person becomes a stranger who is suffering and our first reaction is to be repelled. When a person experiences suffering personally, suffering tends to alienate that person from his or her personhood; "this thing that is happening to me is not me" (Hauerwas, 1986, p. 25).

The majority of articles or books that contain references to suffering equate it with the concept of pain. Traditional medical science emphasizes the relation of physical pain to suffering. According to Kahn and Steeves (1986), there is "an obvious relationship between the extent of pain and/or psychological distress and suffering" (p. 625). A different perspective is offered by Cassell (1991b):

> The central assumptions on which twentieth-century medicine is founded provide no basis for an understanding of suffering. For pain, difficulty in breathing, or other afflictions of the body, superbly yes; for suffering, no. Suffering must inevitably involve the person--bodies do not suffer, persons suffer. (p. vii)

Cassell (1982), a physician, warned that medical education, research, and practice give little attention to the problem of suffering. He blamed both medicine's traditional concern for treating the disease and the mind-body dichotomy that is inherent in medical care for the paradoxical situation in which doctors cause suffering in their care of the sick. Furthermore, he noted suffering is by no means limited to just physical pain even though physical pain

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remains a major cause of human suffering and is the primary image formed by people when they think about suffering.

Copp (1990b) added to the difficulty of understanding suffering by equating pain and suffering in this manner: "Whereas suffering is a major thread in the tapestry of the humanities, in the health profession pain is valued as a sign, symptom, and signal, the basic purpose of which is to derive a diagnosis, a solution to a problem, or a therapy" (p. 2). Reflecting on the treatment of suffering by modern health science centers, Copp (1990b) suggested that suffering is a term to be avoided like the word "death" was two decades ago. Because suffering is not to be discussed, recorded, or valued, there is no repository of data concerning the experience of pain and suffering except by the patient.

Pernick (1983) related a contrasting viewpoint by postulating "strictly speaking, pain may refer to the complex of physical and emotional effects produced by aversive sensations; suffering refers only to the experience of anguish and mental distress" (p. 34). Cassell (1982) concurred that a person can suffer enormously when confronted with the distress of another person, especially a loved one. Adding further to this thought, Cassell (1991b) stated "people can suffer from what they have lost of themselves in relation to the world of objects, events, and relationships" (p. 40).

From the viewpoint of Brallier (1992), "those who deeply love a person who is suffering and dying are likely to be very vulnerable while caring for that person" (p. 219). She believed health care providers must be aware of the

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vulnerability of the significant other, family, and friends of the individual who is suffering and offer comfort and support to them.

Donley (1991) related suffering to pain: pain is expressed physically while suffering exists as an inner condition of the person. Additionally, Donley (1991) noted "pain is to be understood as a clinical manifestation of that mysterious inner reality, which we call suffering" (p. 180). Kahn and Steeves (1986) concurred with Donley when they noted "suffering is an experience of an individual self and therefore must, in some way, be related to the self that suffers" (p. 625). Any conceptualization of suffering must address the importance of self in the experience, according to Kahn and Steeves (1986). This new conceptualization of suffering must take into account that it is a response distinct from the response of pain or psychological distress, although they are frequently related (Kahn & Steeves, 1986).

An idea which emanated from Moulyn (1982) centered on the thought that "pain is equated with suffering because we never experience suffering without pain" (p. 191). He further demonstrated that one can experience pain without suffering by noting the example that a pinprick does not lead to suffering. Other authors (Cassell, 1991a, 1991b; Copp, 1990a; Hanson, 1987; Kahn & Steeves, 1986; Steeves, 1988) concurred with the belief that pain may or may not cause suffering.

Suffering is described by Kahn and Steeves (1986) as being not only distinct from pain, but it also represents another level of individual response. Reflecting further on this thought, Kahn and Steeves (1986) articulated that

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suffering is not grounded in the same cause or stimuli but derives from the individual's evaluation of the significance or meaning of the pain experienced. Copp (1990a), a nurse educator who has written about suffering for a number of years, shared insight about the relationship of pain and suffering in this manner:

> For several years, it was my opinion that suffering was pain related, and the relationship of pain to suffering was based on the potency and duration of the pain itself. But only a portion of patients who manifested both excessive pain potency and duration admit to suffering, whereas others, with what might be self-confessed or -assessed as less potent pain over a shorter period of time, report great suffering. (p. 247)

A more elaborate view of the relationship of suffering and pain was devised by Fordyce (1980) as a depiction of four waves. Nociception is the first wave and means the thermal or mechanical impingement on a nerve or groups of nerves. The second wave that ripples out is pain itself and represents the actual perception of the damage to the nerves. Suffering is the third wave; this includes the negative emotional reactions caused by the activation of the higher centers of the nervous system by the pain. Pain behavior which reflects the presence of nociception is the fourth wave. Fordyce cited the critical importance of examining this entire process in an individual in order to understand and help the person who is suffering.

There are conflicting definitions of suffering in the literature. The Westminster Dictionary of Christian Ethics (Childress & MacQuarrie, 1986) defined suffering in the following manner:

> Suffering is the opposite of action. In action, a person freely initiates a series of events in order to bring about some desired state of affairs. In suffering, a person undergoes a series of events initiated from outside and leading to a state of affairs which is not desired. The "problem of

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> suffering" is part of the wider problem of evil, and that is a metaphysical or a theological problem rather than an ethical one. (p. 608)

The conclusion to the definition of suffering in the above dictionary contains this statement: "Because so much suffering has [an] apparently senseless character, it is generally regarded as a duty to relieve suffering, whenever possible" (p. 608).

Speaking of the plurality of descriptions of pain, Degenaar (1979) said, "Neurologists speak in terms of nerve impulses, psychologists in terms of emotional qualities, philosophers in terms of sensations, feeling, suffering and meaning, and theologians in terms of guilt and punishment" (p. 28). Soelle (1973/1975) noted the word "suffering" "expresses first the duration and the intensity of pain and then the multidimensionality that roots the suffering in the physical and social sphere" (p. 16).

Having read everything he could find on suffering, Boeyink (1974) became convinced that "never has there been a word used with such an uncritical assumption that everyone knows what they are talking about" (p. 86). The meaning of suffering is context dependent; the closer suffering is to pain, the more objective it is and "the more the interpretative context presupposes a widely shared agreement that this is the kind of suffering that is unnecessary and that therefore ought to be alleviated" (p. 88).

Cassell (1991b) defined suffering as "the state of severe distress associated with events that threaten the intactness of person" (p. 33). This definition is in accordance with one given by Smith (1987) in which he posited:

> Suffering is a kind of identity crisis. It represents a threat to the self. It often involves pain; it disrupts the control the self exerts over its world. A

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> threat to the identity of the self is a necessary and sufficient condition for the existence of suffering. (p. 256)

Hill (1992) agreed that suffering results in a disintegration which "implies an inability to maintain composure, integrity, or intactness--essentially a debacle--for whatever reason internal or external" (p. 70).

Concurring with Cassell (1991b) and Smith (1987), Kahn and Steeves (1986) suggested that "suffering is defined as an individual's experience of threat to self and is a meaning given to events such as pain or loss" (p. 623). Boeyink (1974) also believed suffering is a threat to one's composure, integrity, and the fulfillment of intention.

Niebuhr (1963) stated because suffering is the exhibition of the presence in our existence of that which is not under personal control or of the intrusion into our self-legislating existence of any activity operating under another law than ours, it cannot be brought adequately within spheres of teleological or deontological ethics. Also, Niebuhr (1963) said "it is in response to suffering that many and perhaps all men...define themselves, take on character, develop their ethos" (p. 28).

Steeves, Kahn, and Benoliel (1990) observed that "unlike medical conditions, suffering can be experienced by groups as units as well as by individuals" (p. 721). According to Hill (1992), "persons burdened with the physical and psychological stress of caring for these individuals over long periods are also considered sufferers" (p. 71).

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Steeves, Kahn, and Benoliel (1990) conducted research relative to nurses' interpretation of the suffering of their patients. Graduate nursing students were the informants in this study and they were asked to give synonyms, phrases that defined elements of suffering such as cause, phrases that set conditions on or limits to previous remarks, and stories about patients that illustrated suffering. The researchers grouped the informants' statements according to observed similarities and themes. These themes were used to interpret the meaning of the data as a whole.

Steeves et al. (1990) found the progression of themes began with informants conceiving of suffering as a medical condition, then thinking of suffering as an experience of their patients, and finally considering suffering as a personal experience. The nurses described suffering as a condition in terms of its causes, its course, and its effects. A noteworthy observation of these nurses was that a loss of body intactness is a cause of suffering.

When describing suffering as a medical condition, the nurse informants stated phenomena such as childbirth and simple fractures were painful situations but these events did not involve suffering because they were so short lived. An obvious characteristic of suffering, as cited by these nurses, is that the suffering person must be conscious since "suffering is inextricably tied to knowing" (p. 721). They also felt suffering was not open to investigation and diagnosis as were medical conditions (Steeves et al., 1990).

To many of the nurses in this research study, suffering was very difficult to assess because it was defined by the individual patient and, thus, varied from

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person to person. Suffering depended upon the patient's response to symptoms or the patient's perception or interpretation of the condition. In turn this interpretation or perception depended on how it affected the patient's belief system or whether it damaged any part of his or her real identity (Steeves et al., 1990).

The nurse informants realized too many aspects of suffering were not open to objective, detached scrutiny; therefore, they began to view suffering as an experience of patients. Describing the experience of suffering led these informants to note that a prevalent characteristic of suffering is the loss of control. They believed this loss of control distinguished pain from suffering (Steeves et al., 1990).

The reactions to the term "suffering" were very emotional for many of these nurses. The informants believed the word had bad connotations and thinking about the suffering of their patients made them feel helpless. At this point, Steeves et al. (1990) noted the personalization of suffering leading to the suffering becoming that of the nurses themselves.

This personalization of suffering led some informants to assert that they (and their colleagues) caused some of the suffering of their patients. Realization of the belief that nurses contribute to suffering led some nurses to desire to leave nursing or to leave certain clinical settings (Steeves et al., 1990).

The researchers concluded the meaning of suffering to nurses is not static. The findings of this study suggested "nurses' views on the essential nature of

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suffering undergo modification as they become socialized into the work culture of nursing and the meaning of being a nurse" (Steeves et al., 1990, p. 724).

Another pertinent finding by Steeves et al. (1990) centered on the assertion that:

> Movement from viewing suffering as a condition to suffering as an experience required some period of time for exposure to a variety of patient situations. As well, this shift required that the nurse's views of suffering be mediated through a different belief system--one of suffering as a variable human experience affecting either individuals or groups. (p. 725)

Included in the results from this study was the observation that when nurses personalized suffering, it appeared to represent a cognitive conflict between the objective ideals of the medical model and the subjective realities of the suffering experience inferred from observations of patients and experienced in their own feelings of helplessness when faced with tragic and difficult patient situations (Steeves et al., 1990).

There was no evidence that <u>suffering as an experience</u> and <u>personalized suffering</u> replaced the idea of <u>suffering as a condition</u>. According to Steeves et al. (1990), the findings suggest these different meanings of suffering "could exist simultaneously in subconscious functioning of the mind, being drawn to the surface selectively in response to a nurse's current clinical situation" (p. 725).

In a commentary made in response to the article by Steeves et al., Ferrell (1990) said "the patient's experience of suffering is the antecedent to the nurse's experience, yet the two phenomena are separate" (p. 729). She compared the experience of suffering as an individual experience to the knowledge of the

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concept of pain; both can only be measured by the experiencing person (Ferrell, 1990).

Steeves et al. (1990) in turn responded to Ferrell's comments:

> What is the relationship between an experience and an observed experience? Do vicarious experiences cause suffering? Can compassion and empathy be a source of suffering? Perhaps what is called for is a new way of looking at suffering. If suffering is conceptualized as an experience, something that happens to people, then the suffering of nurses when they witness the suffering of another is difficult to explain. If, however, suffering is thought of as a way of experiencing the world rather than an experience, this phenomenon becomes more understandable. (p. 731)

In an earlier article, Kahn and Steeves (1986) suggested a different kind of approach to nurse inference of patient suffering. They argued that:

> If suffering is understood as an experiential meaning given to an event like pain, then the nurse's problem is one of interpreting the meaning of another's experience. This can be done only through the interaction between nurse and patient in which the nurse experiences the patient as suffering or not. It is a question of interpretation, a kind of practical clinical hermeneutics. (p. 628)

Continuing with a hermeneutical line of reasoning, these authors conjectured that inference of patient suffering depends not on any one quality of the nurse alone, such as the belief matrix of the nurse, nor on any separate quality of the patient. Instead, inference of patient suffering depends upon "the interaction of three elements: the text, the context, and the reader" (p. 628). These elements constitute a whole that is essentially inseparable. The encounter between the nurse and the patient is this whole. This encounter is a transaction in which meaning is constituted and interpreted. Embedded within the encounter, the patient's experience of suffering is a text the reader-nurse must interpret within a

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given context and which can be defined as containing particular physical, psychological, and sociocultural environmental features (Kahn & Steeves, 1986).

Battenfield (1984) concluded "conceptual notions" such as suffering are "never inert and easily defy structure" (p. 36). Battenfield continued by stating "writers seem to be unable to weigh, challenge, or confine the concept of suffering by linguistic parameters" (p. 36).

Many authors have attempted to describe the essence of suffering but most have failed according to Battenfield. She reflected on the complexity of depicting the concept of suffering in this manner:

> The analogies, insinuations, and profundities gleaned from the literature referred sensitively and intimately to suffering but touched only fleeting on its total essence. Writers grasped for finite words while struggling with infinite meanings as they searched their own sufferings and the sufferings of their fellow human beings. (p. 37)

Breton (cited in Moulyn, 1982) presented a paper in April 1979 on human suffering at the First Congress on Suffering held at Notre Dame University. He contended suffering is a "process which differentiates us from inanimate matter." He also sees "suffering as the enigma which makes us aware of our frailty and our impermanence" (p. 192). Suffering may also be viewed as a defect in personal power; thus, individuals may place unrealistic demands upon themselves and others to manage attitudes and lifestyles in order to avoid acknowledging these defects (Brallier, 1992).

Sarano (1970) believed suffering encompasses just one meaning among other possible meanings given to pain. Steeves (1988), in his doctoral research on the experiences of suffering and meaning experienced by bone marrow transplant

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patients, emphasized suffering is more than a private, experiential phenomenon which is distinct from pain; for him, it represents a unique level of individual response. Elaborating on this belief, he noted that pain is usually grounded in some neurological or physical cause or in a psychological loss or trauma with the perception of pain or loss being mediated by an individual's "self" or self-concept. A central premise of his research is that suffering also involves the "self" but is not grounded in the same cause as pain. Suffering is derived from the significance or meaning of the pain experienced.

The phenomenon of suffering cannot be reduced beyond the whole person according to Kahn and Steeves (1986). Copp (1974) defined suffering as the "state of anguish of one who bears pain, injury, or loss" (p. 491). Starck (1992) viewed suffering as a "perception or interpretation rather than an actual set of objective signs and symptoms" (pp. 127-128).

Noting the temporal element of suffering, Cassell (1991b) believed "for a situation to be a source of suffering, it must influence the person's perception of future events" (p. 36). Elaborating upon the temporal nature of suffering, he suggested:

> A sense of time is necessary for suffering; more than a future, there must also be an enduring past. I must have some sense of how I am constituted and what I can do to fear the loss of a piece of myself--and for that I must have a past. The person's idea of self must include others in order for the person to know what he or she can do or be. We are what we are in part because there are others with whom we can compare ourselves. Self-knowledge is also constituted of the reactions to oneself of others. Our knowledge of self (and, thus, the whole) must include the world around us; knowledge of abilities and projected future actions would otherwise be meaningless. (p. 211)

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Hanson (1987) reflected on the temporal nature of suffering and its relationship to pain in this statement:

> Suffering involves pain that lasts for a while; it must have a kind of duration. That is, if our perceptions were discontinuous, if they did not involve memory and anticipation, we could not suffer. Suffering involves a sense of the continuity of the self in time. Our pain must be recalled or expected for us to be able to speak to be a sufficient condition for the existence of suffering. (p. 255)

Copp (1990a) observed that suffering may be exacerbated by an individual's perception or misperception of the relationship of the body to time, space, and place. The yearning for that which is familiar is prevalent in individuals experiencing suffering. With the loss of the familiar, "one feels figuratively, literally, and symbolically lost," (p. 249) and this leads to the sensation of whirling in space when conscious and swirling and struggling through layers of consciousness when not conscious (Copp, 1990a).

Steeves, Kahn, and Benoliel (1990) conducted research on nurses' interpretations of the suffering of their patients. One of these researchers, Steeves, eloquently articulated the meanings embedded in the concept of suffering in this manner:

> Suffering may be understood as the vision of the world that exists between an old meaning system that has been challenged and the revised meaning system that will take its place. Inside that gap one can glimpse meaninglessness. The gap is a time when events are not explainable by any system of understanding, and one has to consider the arbitrariness, the contingency, of all explanatory systems. To put it another way, perhaps suffering can be understood as a failure of meaning. A person who is suffering continues to experience the world; time passes and events occur, but the events do not make sense. They are without meaning. The kind of senselessness and meaninglessness that is associated with insanity is not what is meant here. Not all the rules by which one makes sense of

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> reality are changed; probably the only rule missing is the one that helps answer the questions that begin with "why?" (p. 731)

The concern with the meaning and purpose of suffering is voiced by Copp (1990a) when she noted the many questions asked in an effort to understand why those who are "vulnerable, those of tender age, the innocent, and those whose lives have been exemplary in demonstrating the highest of human values" (p. 249) have to suffer. Controversy abounds when children experience profound suffering. Addressing the suffering of a child with advanced cancer, van Eys (1992) stated:

> It is my understanding that suffering in that context and probably in general, means the perception of undeserved adversity. It is the parent or caregiver who uses the word suffering. The child does not have that rich a vocabulary. In other words, for the child, suffering is an adult concept. (p. 117)

Children do not have adult reasoning or adult knowledge. But children are no different from adults when they experience the feelings associated with abandonment, loneliness, separation, pain, and fear. Children suffer when they experience these emotions (van Eys, 1992).

Frankl (1959) reported that suffering "is an ineradicable part of life, even as fate and death" and "without suffering and death human life cannot be complete" (p. 106). Frankl wrote a great deal about the experience of suffering without ever precisely defining it. Lukas (1986), a protege of Frankl, also did not define suffering, instead, he and Frankl focused on psychotherapeutic strategies to help suffering individuals find meaning in their experiences and thus, take charge of their lives. Starck and McGovern (1992b) used Frankl's

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terminology, existential frustration, to depict the suffering of the human spirit that can result from confusion about or lack of meaning in one's situation. Starck (1992) believed suffering is a teacher about life.

From an existential perspective, suffering is a part of the lived experience; therefore, how it affects the whole person must be examined. Life has purpose and meaning to an existentialist and a primary function of a person is to seek meaning and purpose. The meaning or meaninglessness of suffering is an important component of understanding the experience of suffering (Starck, 1992). Brallier (1992) stated "it is our spirit that searches for the meanings in life and in suffering" (p. 210).

DuPont and McGovern (1992) explored suffering from a different perspective by claiming that suffering, unlike pain, is not a straightforward biological process. They believed suffering requires meaning. "Without meaning, the ill person, like a sick animal, can be in pain but cannot suffer in the sense that ill people commonly suffer" (DuPont & McGovern, 1992, p. 160). These two authors agreed with Frankl (1959) that the uniquely human aspect of suffering is that it is bound inextricably with the meaning of the experience of the sufferer. Suffering requires an experience of meaning at a fundamental and highly personal level (DuPont & McGovern, 1992).

According to Starck and McGovern (1992b), meaning in suffering should be sought by both the sufferer and the caregiver. They noted:

> The professional caregiver has the role of facilitating positive outcomes and finding some sense of purpose. Suffering has the potential to transform the sufferer and/or caregiver and offers an opportunity for the

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> sufferer and/or caregiver to experience discovery and growth and to give and/or receive compassion and love. (p. 28)

A common theme in the literature is that suffering may be educational. Rabbi Soloveitchik (Kushner, 1981) stated, "suffering comes to ennoble man, to purge his thoughts of pride and superficiality, to expand his horizons" (p. 20). Furthermore, "the purpose of suffering is to repair that which is faulty in a man's personality" (p. 20). Echoing this thought, Copp (1990a) wrote that the state of suffering can enable the sufferer to gain a deeper appreciation of humanity's experience through the centuries, thus, leading to an understanding of the human condition. According to Starck and McGovern (1992b), "suffering offers an opportunity to search for meaning and, at the same time, extrapolate a teleologic view of its occurrence" (p. 25). Starck and McGovern (1992b) posited "in spite of societal/cultural and religious/spiritual teachings, it is from human suffering that humans, individually and as a race, have most profoundly and effectively learned, and thus found meaning in suffering" (p. 26).

Hauerwas (1986) observed that seldom is suffering a school for building character, but rather a test for character. An experience with suffering may reveal a person as being better or worse than he or she thought himself or herself to be. Suffering can just as easily destroy a person as it can make a person more resolute. Therefore, suffering cannot be justified because it may provide a person with an occasion to grow (Hauerwas, 1986).

According to Cassell (1982, 1983) and Kahn and Steeves (1986), there are three common aspects to the experience of suffering. The first aspect centers on

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the assertion that suffering is the result of distress. Feelings such as pain, loss, fear, and loneliness can result in distress. Second, suffering usually involves alienation which results when people feel a loss of connectedness to others. This sense of alienation may be increased when the suffering individual perceives that others do not understand the experience of suffering; it appears to the sufferer that these others remain in a place free of suffering even when performing sympathetic acts for the sufferer. The third aspect of the experience of suffering is that suffering commonly includes the feeling of despair. Despair occurs when the suffering person feels trapped and alone in his or her misery.

Coupling the suffering experience with dying adds a profoundly different perspective. Foley (1987) noted as many as 80 to 90 percent of cancer patients being treated for the terminal phases of their disease may have significant pain; thus, the control of that pain is an extremely important part of relieving suffering in that person. Bonica (1987) pointed out there is evidence that, in some situations, as many as 80 percent of those individuals with cancer who are suffering from pain are not receiving adequate pain management. Many people, diagnosed with cancer, are immensely afraid of suffering. Within the spectrum of suffering, this is one of the most dreaded fears. According to Brallier (1992), "despite the efforts of modern medicine, suffering remains a hallmark for the cancer experience" (p. 203).

Benedict (1989) conducted a study to determine the incidence of suffering associated with lung cancer. Thirty adults were in the sample for this study with their mean age being 60 years. All of these individuals had a diagnosis of

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primary pulmonary malignancy. Their mean smoking history was 50 pack years. The patients participated in a structured interview that included questions about physical, psychological, and interactional aspects of the cancer experience. Suffering was rated on a five point Likert-type scale for each of the aspects under study. The major findings of this study include: 10 per cent of the patients experienced no suffering and 50 per cent experienced very much suffering. Suffering was statistically greater in those individuals with known metastatic disease than in those with no known metastasis. Cited as the sources of greatest suffering were pain, disability, anxiety, changed daily activities, weakness, and fatigue. The suffering associated with physical aspects was found to be greater than that reported for the psychological and interactional aspects of the cancer experience.

For many of the people dying from cancer, finding meaning in death is not as difficult as finding meaning in the suffering along the way (Brallier, 1992). Brallier also observed that health care professionals cannot supply meanings of life to the person who is suffering. What can be done is to "be with, and encourage the person who is dying to listen carefully to his or her own inner spiritual voice" (p. 213).

Brallier (1992), in speaking of the health care providers' role, noted:

> Providing care to people who are suffering as they are dying is an awesome responsibility, calling for the highest level of knowledge, sensitivity, tenderness, compassion, and willingness to be empathic. Those of us who have taken on the challenge of caring for and about persons dying of cancer agree that, although we may feel overwhelmed at times, we most often feel enriched by the meanings we find in our work and by

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> the act of helping relieve some of the suffering we witness and empathetically know. (p. 204)

Health care professionals who intend to exercise control over the person who is dying "are operating from an intrapsychic process that blocks their expression of compassion, one of the very few things they can give the dying person at that point" (Brallier, 1992). These blocks to compassion frequently are due to fears about the possibility of one's own suffering and death. An additional common source of blocks to compassion is fear of becoming emotionally vulnerable to the individual who is both suffering and dying. "Allowing oneself to be open to empathetically feeling to the pain of someone who is in the process of dying, then suffer the pain of losing that person when death occurs, can be very discomforting" (Brallier, 1992, p. 215).

Allowing prejudices to compromise the quality of care rendered to those who are suffering from the disease of cancer must be eliminated by caregivers. Discriminatory behavior based on negativity regarding the dying person's racial, ethnic origin, religious background, or sexual preference may increase the suffering of the individual (Brallier, 1992).

The suffering of significant others can be just as severe as, if not more so, than the person with cancer, because of the perception of having even less control than the dying person feels (Brallier, 1992). According to Brallier, the degree of suffering experienced by other family members and friends of the person dying of cancer depends in large part upon the degree of suffering of the dying person.

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Those who have a diagnosis of cancer may suffer from the illness itself and from the treatments. This double threat may leave the person feeling extremely vulnerable. Health care professionals must sensitively and empathetically recognize the vulnerability of the suffering individual (Brallier, 1992).

Vulnerability may extend from persons who are suffering to those health care professionals who are caring for them. Brallier believed caregivers will suffer less if they continue to create or discover meaning in the intense and rewarding work they have chosen. One common meaning is that of genuinely caring for the dying person, those who love that person, one's self, and the process and experience all are undergoing. Brallier (1992) said:

> One of the greatest challenges for us as professional caregivers is that of initiating and remaining in an empathic relationship with a person who is dying. Doing so means allowing ourselves to fully perceive their pain and other kinds of suffering. Remaining open requires expenditure of emotional and spiritual energy but allows us to respond with approaches that are comforting and effective. When we know that our interventions significantly reduced a person's suffering, we can feel enormously revitalized by the meaning we find in our compassion and acts of caring. (pp. 223-224)

This mutual vulnerability may lead health care professionals to treat the person who is suffering as though he or she had a communicable disease and isolation techniques were necessary (Copp, 1990b). When the patient attempts to grope verbally for meaning to attach to his or her pain and suffering, health care professionals may protect themselves with a form of shunning. Instead of fearing a microorganism, the professional is afraid of confronting their own mortality or, even worse than death, their own suffering experience (Copp, 1990b).

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Attempts to examine the concept of suffering have led some to deduce that suffering is good for people. Cassell (1991b) said persons may be able to "enlarge themselves" (p. 44) in response to suffering and therefore they grow from this experience. Extending this thought, Cassell (1991b) noted assigning meaning to a condition often reduces or even resolves the suffering associated with it. It is common to seek a cause for the suffering within past behaviors, beliefs, or values. Thus, Cassell explained, "the pain or threat that causes suffering is seen as not destroying a part of the person because it is part of the person by virtue of its origin within the self" (p. 45). This belief may be compared to the concept of karma in Eastern theologies which is a complex form of defense against suffering, because suffering is seen to result from behaviors of the individuals in previous incarnations.

Speaking to learning from suffering, Starck and McGovern (1992) maintained, "health care professionals have a primary responsibility to help patients recognize, feel, and accept suffering for what it is, not the enemy, but rather the teacher" (p. 26). These authors neglected to recognize that not all health care professionals believe suffering teaches anything and most likely the predominate number of health care professionals view suffering as the enemy or an obstacle to be overcome.

Smith (1987) also depicted suffering as fundamentally pedagogical. Smith used the following analogy to describe this function. "As weights, obstacles, courses, and calisthenics are necessary for the development of the physical self, so pain, regret, and disappointment enable the formation of a vigorous, virtuous

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character" (p. 258). Some individuals claim that people can grow as they suffer (Smith).

Debating whether suffering is educational and good, Smith (1987) emphasized genuine suffering is something that appears purposeless and postulated "suffering is not an intrinsic good but the occasion for moral action on the parts of self and others" (p. 260). He had additional thoughts related to this aspect of suffering:

> By calling the person's identity into question, suffering can be the occasion for moral growth. Thus, we find that most people we respect are people who have suffered in one way or another. But it is important not to draw fallacious inferences from this fact, for moral growth can occur without suffering--through education, imagination, and argument--and suffering can destroy persons as well as helping them to grow. Thus, suffering is not necessarily an instrumental good. (p. 260)

However, Soelle (1973/1975) believed suffering does make a person more sensitive to the pain in the world and can teach an individual to put forth a greater love for everything that exists.

Soelle (1973/1975) held myriad perceptions of suffering. She stated what really matters in the suffering experience is whether the suffering becomes our passion, in the deep double sense of that word. According to Soelle (1973/1975):

> The act of suffering is then an exercise, an activity. We work with the suffering. We perceive, we express ourselves, we weep. To consider the tearless male as an ideal is to acknowledge clearly that nothing is learned from suffering and nothing to be gained from it. We bury or else we unearth what we have hidden within us; we throw off or else take on a burden in suffering; we conceal ourselves from others or else we exhibit ourselves to them. Our hopes can die or they can grow in suffering. The bitterest pill is that "learning from suffering can come to naught." (p. 125)

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Luehrman (1977) suggested through suffering many people find important meanings for their lives in relation to God and their fellow creatures of the world. According to Luehrman (1977), "suffering purifies, refines, and ennobles people on their inner being" (p. 18).

Examining why people suffer, Weatherhead (1936) wrote:

> The man who inquires into the problem of suffering may be compared with one who from some sunny street, steps into the comparative gloom of a vast cathedral. After the blaze outside, all seems dark. As his eyes grow accustom to the darkness, he notices unsuspected windows which throw light upon the way he threads [sic] . . . and in the end there is no darkness to make him afraid. (p. 25)

Moulyn (1982) interpreted the intrinsic value of suffering to be in its propensity to "clear a path toward mature inalienable happiness" (p. 3). After a person has gone through the crucible of suffering, he or she reaches a state of bliss, according to Moulyn. Owing to the fact that people have to accept being thrown into the world, they also have to accept periods during which they suffer. Moulyn continued by stating the value and the meaning of suffering are that "it heals the blemishes and the fractures in our problem-ridden existence" (p. 4). He described the gift of periods of firmly grounded happiness and bliss that the healing power of suffering bestows upon humans. The major problem noted by Moulyn (1982) is how to differentiate suffering from the welter of emotional states with various qualities, intensities, and durations, which accompany suffering.

The majority of writings on the subject of suffering are found in theological literature. Lammers and Verhey (1987) acknowledged one of the

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great temptations in religion is to deny the seriousness of suffering and as a part of that denial to choose the "easy and comfortable" thought of "suffering as constituted solely by physical pain" (p. 246). Furthermore, according to Lammers and Verhey (1987), in order to see the state of suffering honestly we must "nurture truthfulness and humility" (p. 247). Embedded in this view is a critical point made by these authors that humility is necessary because we can never know another person's suffering. Elaborating upon this thought, Lammers and Verhey (1987) posited:

> Pain crowds out a full awareness of the surrounding world for those who are suffering, yet they become aware at the same time that others do not know what they are experiencing. Consequently, sufferers often feel isolated precisely at the time when human contact is most needed. Pain relief alone is thus a necessary but incomplete response to suffering; the resultant alienation must be addressed as well. There is a further problem for the sufferer. Those who care for them are tempted to categorize suffering and to deny that there is an element of suffering which is singular, which cannot be experienced by anyone else. (p. 247)

Humility is a requisite attribute for those caring for individuals who are suffering because suffering makes it clear to all that its victims are not in control of the world (Lammers & Verhey, 1987). The consequences of this for the sufferer is a sense of powerlessness both in how the individual confronts this suffering and in the face of meaningful action in the world. Lammers and Verhey (1987) acknowledged there are consequences as well for those who care for those who suffer. Those individuals are:

> . . . tempted to shun the suffering because they stand as a sign of the brokenness of the world. That is why truthfulness is so important a contribution. Without a truthful acknowledgment of the brokenness of the world, caregivers are tempted to remove all traces of the pain and

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> suffering, even if that finally requires the removal of the sufferers. (p. 247)

According to Lammers and Verhey (1987), our culture holds a dualistic conception of humanity and suffering which centers on the belief that if suffering is present, humanity must be absent. In order to maintain humanity, suffering must be fought at all costs, even if it means large doses of anesthetizing drugs. As a result of these extreme measures, one does not have to witness suffering. It is my opinion that this aspect of suffering needs careful and deliberate consideration by the health care professions. Certainly the education of health care professionals needs to include an examination of how sufferers are treated.

Religious writings are replete with questions and answers related to suffering, such as: Why does suffering exist? Do humans and animals deserve to suffer? Is suffering something that simply and arbitrarily strikes individuals, good and bad alike? Does God suffer with humans? Is there a reward for suffering? Does suffering have a point or is it a part of the world that has no reason or purpose? Should meaning be the focus for those who are suffering? Why do the innocent have to suffer?

Heitman (1992) advanced the supposition that suffering is considered to be fundamentally a religious problem by many theologians and boldly states suffering is the most fundamental problem of religion. When individuals who believe themselves to be nonreligious experience suffering, they are often prompted to ask deeply spiritual questions and many who are avowedly religious

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question even their most fundamental beliefs when struck with adversity (Heitman, 1992).

Noting that every traditional explanation of suffering ultimately concludes that part of the final answer remains a mystery beyond human understanding, Heitman (1992) believed a degree of faith is required to transcend suffering and to live with its mystery. Furthermore, she advanced the theory that suffering has no meaning and therefore uncontrollable suffering challenges the very value of life. She said:

> Around the world, victims of adversity are generally offered two interpretations of their suffering: Either they are reaping the fruits of their own actions, or their suffering is an opportunity for spiritual growth. In either context, sufferers are counseled to reflect on their lives and their goals, rectify past wrongs, change their behavior, and accept suffering that cannot be alleviated. (p. 92)

Heitman (1992) held the view that an individual's experience of suffering may also be made more painful by others, whether family, friends, caregivers, or total strangers, whose interpretations of religious and cultural ideals may place additional burdens on the sufferer. She offered special words of caution to health care providers who work in places such as emergency rooms by noting long term exposure to masses of people who are in extreme need may make their desperation seem much less appalling because it is so common. Caregivers may find it easy to disregard the suffering of an individual because there are so many others with equally or more compelling problems (Heitman, 1992).

Agreement with Heitman is offered by Moss (1989), when she stated one of the most dangerous pitfalls of the professional commitment to caring for those

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who are suffering is their constant demand for help may overwhelm even the most dedicated caregiver. Often a sense of personal powerlessness stemming from the feeling that helping individuals who are suffering makes no difference in the long run, may lead caregivers to emotional exhaustion, desensitization, and indifference or, as it is commonly known, a state of "burnout" (Moss, 1989).

According to Heitman (1992), when suffering is prolonged, caregivers may direct anger toward the sufferer who has not improved, the experts whose treatments have not succeeded, or toward God who has not intervened. Each of these responses may also reflect self-directed anger at being unable to cope with the burden of caring for a person who is suffering (Heitman, 1992). Gorlin and Zucker (1983) wrote that caregivers may respond to their patients' suffering with anger and, when confronted with patients who complain or express hostility or frustration, may blame them for failing to accept their suffering nobly.

Caregivers may have other responses to caring for those who are suffering. Heitman (1992) addressed this perspective in this manner:

> Caregivers, too, may wish to curse God for the suffering of the patients whose pain they witness daily. Because many therapeutic interventions seem only to add to patients' suffering, practitioners may grow angry at their patients, colleagues, or professional standards for "making them" impose anguish in the guise of therapy. (p. 98)

A further occasion for rejecting the sufferer may result when suffering is interpreted as divine punishment or the result of bad karma. This association with evil may prompt others to reject the sufferer as contaminated (Heitman, 1992).

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Speaking about the responses of caregivers to the experience of suffering, Sherwood (1992) posited:

> Because we are in caregiving professions, it is expected we will care and give of ourselves. We have a moral duty to care. Our basic human philosophy is based on the intrinsic worth of every individual. We recognize basic human dignity with respect for personhood. We have a moral duty to care for the person's welfare because we have accepted the role of caregivers. Most of us have taken some oath of that declaration. For nurses, it is the Nightingale Pledge; for physicians, it is the Hippocratic Oath; for ministers, it is a Covenant and Ordination. What effect does this constant moral obligation have on us? How do we as caregivers respond to the experience of human suffering? (p. 106)

Sherwood adduced the primary purpose of caregivers is to "improve the human condition, to produce positive changes, to encourage growth, to enable others to live life to its fullest, to alleviate suffering" (p. 106). She noted when caregivers are unable to instill hope, empower others, encourage independence, or help improve another's condition, they often experience a sense of frustration and failure. Sherwood (1992, p. 106) asked this question: "How do we balance the stress of constant exposure to suffering with our moral duty to care amid concern for our own well-being?"

In describing suffering, Hanson (1987) pointed out "the School of Suffering has a demanding curriculum that includes practical experience as well as thinking and reading" (p. 279). The experiential requirement makes this school different from any humanly designed institution of higher learning because most of its students have not requested entrance (Hanson, 1987).

Starck and McGovern (1992a) edited a very comprehensive book in which they identified suffering as being the hidden dimension of pain. These authors

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concurred with others who have noted that suffering is often related to similar concepts such as pain, loss, grief, loneliness, and despair; however, Starck and McGovern (1992a) believed each of the above identified concepts is a building block in the total suffering phenomenon. Furthermore, they offered the perspective that "as a concept, suffering is a social construction" (p. xii) because we have permitted society to shape our values and views to make it so. Cassell (1992) noted "the social nature of suffering is highlighted by the isolation imposed by suffering" (p. 6).

The insensitivity of society makes suffering worse and visible suffering is a taboo (Starck & McGovern, 1992a). These authors stated that frequently suffering is silent, although the violence that often causes it is not. According to Starck and McGovern (1992a), suffering tests the meaning and purpose of life for those who suffer and for those who are caregivers. The premise that suffering is taboo is also advanced by Bulger (1992) and he declared that a national discussion should be held aimed at demystifying the subject of suffering. Bulger (1992) reflected that a myth has been created about suffering and this must be re-shaped to include suffering into the "inescapable stuff of life--a part we can work to minimize, seek to prevent whenever possible, but a part of life which will not go away in its entirety from any of our lives" (p. 63).

Cassell (1992) believed the fundamental reason so little is known about suffering is that the reductive methods of science, which are very useful in comprehending nature, have inevitably lead away from an understanding of suffering. A crucial premise of Cassell's research and writings is the point that

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suffering is particular because a person may know that another suffers and even know the external source of suffering, but can never fully know from what or where the suffering arises within the individual. Additionally, Cassell (1992) observed "it is not the severity of the pain or the insult that is crucial to suffering, but rather what is believed it represents or will become" (p. 6).

Considering another perspective of suffering, Cassell (1992) postulated the psychology of suffering could be thought of as a psychology of self-conflict. Even when the source of suffering is acute pain, Cassell believed suffering involves self-conflict because the integrity of the person is threatened. Heitman (1992) believed Cassell's focus on the individual's search for integrity, positive meaning, and transcendence in the face of suffering has much in common with theological perspectives on suffering.

In his description of suffering persons, Cassell (1992) claimed suffering persons lose their transcendent connection to others. Even though we can feel them (or their absence), they do not feel us. These sufferers "feel isolated in a medium that is itself and by the group remains unacknowledged, so they are doubly isolated" (p. 10). Stressing the importance of transcendence in suffering, Cassell (1992) suggested suffering may be overcome by transcendent means such as spirituality. Starck and McGovern (1992b) agreed with Cassell by observing even though a person is suffering, it is still possible to find meaning in life by transcending the suffering. Frankl (1959) stated meaning is found through self-transcendence in which one gets outside the self or rises above the self. Frankl used logotherapy as the method to treat suffering and asserted the goal of

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logotherapy is to bring the suffering into connection with the meaning the patient can accept.

The concern, and subsequent implications, that meaning may not be found in suffering is voiced by several writers. People do not want to contemplate that suffering has no point (Hauerwas). According to Hauerwas (1986), "it seems infinitely preferable to suffer for a wrong, even if we think the suffering is inappropriate to the wrong, than to suffer for no reason" (p. 31). In a later book, Hauerwas (1990) suggested that scholarly speculation does little to comfort the soul of the person who is actually suffering. If health care providers give those who are suffering theoretical and religious reasons for why they are suffering, but fail to suffer with these patients, they, in Hauerwas' (1990) opinion merit the rebuke Job delivered to his comforters "Ye are all physicians of no value" (Holy Bible, Job 13:4).

Noddings (1989, p. 122), when writing about pain as natural evil, questioned, "if suffering itself has no purpose and if we see separation and helplessness as states that increase suffering, what recommendations can we make about the social management of pain?" She stated:

> Unlike physicians, nurses concern themselves more with suffering than with the mere maintenance of life. Because the medical science model does not drive them so forcefully, they are less likely to see patients as cases, and although their training includes large amounts of problem solving, their proximity to sufferers prevents their being distracted by technical and scientific problems. (pp. 128-129)

She further noted nurses cannot absent themselves from patients like physicians can. This assertion by a person who is not a nurse may reflect the ideal state the

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public desires from those in the nursing profession. Many nurses do absent themselves from their patients in many ways. They may never be present when they are with these suffering individuals, they may focus on the technological aspects of the care of the person, and they may assign the majority of care to aides.

Noddings (1989) explored some difficult topics in her book. She agreed that we need to consider whether the compassionate instinct to "let die" is in part a desire to save the self as well as the patient from further suffering. When physicians and nurses are at their humane best, they should consider it may be part of their task to help patients find meaning in suffering (Noddings, 1989). Disagreeing with other writers about the religious significance of suffering, Noddings (1989) rejected suffering as necessary to build souls. Suffering is an affective event which can act as an impetus in a search for meaning, but according to Noddings:

> . . . that meaning must go beyond the suffering itself, for everything we find there is evil. It is in our response to evil that we find an opportunity to enhance meaning in our lives. Suffering is not required to bring out the best in us or to teach us the meaning of its opposite. (p. 130)

The perception of the suffering experience may be influenced not only by the present suffering experience, but also by the memory of past sufferings--one's own and others'--and by the anticipation of future suffering (Starck & McGovern, 1992b).

One of the few nursing studies related to suffering was conducted by Steeves (1988). This study has relevance to my research; thus, it will be

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discussed in detail. The significance of Steeves' (1988) study to nursing cannot be overestimated. He emphasized the importance to researchers of identifying and beginning to understand the phenomena with which nurses in practice are concerned. Expanding on this he stated, "this sort of knowledge does not lead to causes or effects or models of interactions, but to an appreciation and understanding of the complexity of the lived experience of the patients who are cared for by nurses" (p. 25).

Steeves (1988) noted the considerable lack of research and understanding of the concept of suffering in the literature. He believed the phenomenon of suffering is distinct from pain. As a basis for his research, Steeves used the definition of suffering that he and Kahn (1986) proposed several years ago: suffering is an experience in which some crucial aspect of one's own self or existence is being threatened. The integrity of the person's own experience of personal identity is the focus of the meaningfulness of such a threat. He maintained that pain may or may not invoke suffering. According to Steeves (1988):

> . . . whether suffering is invoked by pain depends more on the meaning the individual gives to pain in relation to the integrity of personal identity than it does on the amount, degree, or type of pain. Any threat to personal integrity, whether painful or not, can invoke suffering. (p. 7)

The paucity of health-care literature, particularly nursing literature, related to experiences of meaningfulness in life is also noted by Steeves (1988). He utilized three different bodies of literature in order to conceptualize and define the phenomenon of experiences of meaningfulness: aesthetics, health and

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meaningfulness, and phenomenology. These three are briefly discussed in the following paragraphs.

It is important to note the difference between the words "meaning" and "meaningfulness," stressed Steeves (1988). He cited:

> Experiencing meaning is an everyday, even an every moment occurrence. To be human and to perceive the world is to experience meaning. All the objects and actions people perceive are provided possible meanings by the culture in which they live. (p. 10)

Contrastly, experiencing meaningfulness may be a rare occurrence. Meaningfulness may denote a transcendent or higher order of meaning; it is the meaning that lies behind the meaning of objects and events (Steeves, 1988).

As Steeves (1988) examined health and meaning, he found a review of literature on these concepts:

> . . . leads to the conclusion that an illness drives an individual to look for meanings and for meaningfulness, that the meaning and meaningfulness found affect coping, and that there is a hierarchy of experiences with certain kinds of meanings on the bottom and meaningfulness on the top. (p. 11)

At the basic level, illness leads individuals to search for meaning in the sense of knowing what the illness means to them and how they will manage the effects of it. The next level of illness causes one to seek meaning in an attempt to understand the rules of reality that allowed them to become ill. This particular level of meaning is often linked with coping. At the highest level of the hierarchy of finding meaning in the face of illness, there is the discovery of the general meaningfulness of one's life or experiences (Steeves, 1988).

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Using phenomenology, Steeves (1988) described how individuals derive meaning from their existence and examine their experience. The following are some of the assumptions Steeves (1988) utilized in his research:

1. Meaningfulness can be experienced by people.
2. Experiencing meaningfulness is a positive thing because people are not totally fulfilled without experiences of meaningfulness.
3. People are able to cope better with suffering when they have experiences of meaningfulness in their lives.
4. Meaningfulness experiences are tied often to suffering.
5. These experiences of meaningfulness alter how one perceives suffering and how one copes with it.
6. Certain personal and environmental conditions are associated with the occurrence of an experience of meaningfulness.

Steeves (1988) used hermeneutic interpretive techniques on data collected utilizing ethnographic methods. A thematic analysis of the text followed in which he attempted to increase understanding of the phenomena of suffering and experiences of meaningfulness. Six major themes related to suffering and to meaning resulted from the thematic analysis. Three themes centered on suffering; these were (a) informants suffered because they no longer possessed their own lives in the sense that their time was not their own; (b) they suffered because they experienced major changes in their social relationships, which resulted in an alteration of their interpretations of their personal identities; and

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(c) they suffered because they experienced major changes in their relationships to their bodies, resulting in interference with their sense of personal unity.

In his research, Steeves (1988) found three themes concerning meaning for these individuals who were suffering. There appeared to be a hierarchy. On the most basic level of meaning, informants used specific techniques to interpret the environment and the changes in their bodies in order to manage immediate suffering. On the second level, informants were concerned with personal identity and role; as a result, they renegotiated their place in the social structure. On the highest level, the informants attempted to understand the total meaning of their experiences. Transcendent understanding and some experiences of meaningfulness were included in the final level of meaning.

In summarizing the importance of his doctoral research, Steeves (1988) noted that the major significance for nursing is the exemplars it might supply to nurses who care for those who are suffering. Also, Steeves (1988) contended his study helped to establish the usefulness of his proposed definition of suffering. He believed the informants actually described his definition of suffering in the stories they shared with him. Their suffering did affect their sense of integrity and personal identity. Steeves suggested this definition of suffering could serve a guide to a complete exploration of this phenomenon.

Many individuals who suffer fear they will be unable to endure. Hanson (1987) stated this fear in an eloquent manner by noting "whatever the particular circumstances, being pushed to the margins of life in some form or other is nevertheless a universal feature of human suffering" (p. 249). Some other

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apprehensions noted by those who are suffering include the fear of being alone or abandoned, fear of the unknown, fear of never attaining relief from suffering, fear of losing control, fear for loss of personhood, self, or identity, and fear of financial difficulties.

Davitz, Davitz, and Rubin (1980) authored a book on nurses' responses to patients' suffering in which they identified responding to patient suffering as a central aspect of nursing. They declared "because coping with patient pain and psychological distress is a major part of professional nursing practice, understanding the process of how nurses judge patient suffering is extremely important" (p. 1).

The suffering of another is inferred rather than directly observed (Davitz et al., 1980). Nurses are constantly interacting with individuals who are suffering. Beliefs about suffering influence the judgments a nurse makes about how much pain or psychological distress the patient is experiencing (Davitz et al., 1980). These researchers found nurses consistently differ in the overall level of suffering they infer about patients.

As part of this research project, Davitz, Davitz, and Rubin (1980), talked to a large number of nurses about their reactions to patients' suffering. One of the most interesting insights, pertinent to this dissertation research, concerned the differences between nurses' reactions in their current practice and their reactions when they began their nursing education. This finding led them to study the changes in nursing students' beliefs about patients' suffering over the course of

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their formal education. There were very definitive patterns of change during their nursing education experience.

Davitz et al. (1980) began their research with the assumption that most nursing students are especially sensitive to the pain and suffering of others. When nursing students were questioned about why they had chosen nursing careers, one of the major factors revealed was a desire to alleviate suffering. These researchers note the day-to-day experience of working with suffering individuals may become personally distressing. As a result of this distress, these individuals develop mechanisms which help maintain psychological distance between themselves and the suffering of their patients (Davitz et al., 1980).

Participants in this part of the research study were 1,014 nursing students and 58 graduate nurses with less than one year of practice who had graduated from diploma, associate degree, and baccalaureate degree nursing programs. These participants were administered the Standard Measure of Inferences of Suffering questionnaire and selected students from each school were interviewed.

Findings include the observation that the ratings of first year, fall-term students differed significantly from all other groups. Furthermore, ratings of physical pain and psychological distress decreased sharply between the fall and the spring quarters of the first year (Davitz et al., 1980).

These inferences of physical pain decreased dramatically between the fall and the spring of the first year and then remained at about the same level throughout the entire program of education and during the first year of practice. In contrast, inferences of psychological distress increased sharply between the fall

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and the spring of the first year and continued to rise during the second year. Davitz et al. (1980) boldly stated "the data incontrovertibly show that inferences of suffering about patients are affected by education" (p. 101). According to these researchers, the three factors that might account for these changes are the (a) process of becoming acculturated within the subculture of nursing, (b) the changes in students' inferences that occur as a result of repeated exposure to patients who are suffering (including the expectations that a student will respond as a professional), and finally, (c) the assertion that students had learned to set priorities. Learning to set priorities had led them to become more realistic, realizing that there is only so much that can be done about a person's pain (Davitz et al., 1980).

Elaborating upon the findings, Davitz et al. (1980) conjectured the lower ratings for physiological pain by the students may show that, as students progress in school, they learn that some physical pain relief measures are effective. Furthermore, the changes in the psychological aspects indicate that very early in their educational experience nursing students are sensitized to the psychological dimension of suffering. Explaining the results in more detail, Davitz et al. (1980) stated:

> The findings of this research suggest that, while nursing education is highly successful in sensitizing prospective nurses to the psychological distress of patients, it may at the same time desensitize students to patients' pain. Having sensitized students to patients' psychological distress, it is not at all clear that nursing education also prepares nurses to deal effectively with this distress within the limitations confronted by most nurses in actual nursing practice. (p. 105)

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The reason why nursing education is unable to prepare nurses to function effectively with the psychological distress of suffering individuals is because in actual practice, nurses have only a brief period of time to spend in interactions with these patients (Davitz et al., 1980).

The two aspects of change that come about with actual nursing practice after graduation are that the nurse becomes more realistic and also becomes more compassionate and understanding. These changes are explained by the increased selectivity of nurse's reactions in contrast to the universal empathy of their nursing school experience (Davitz et al., 1980). According to Davitz et al. (1980), "many young people enter nursing with a strong sense of idealism that is reflected in a kind of universal sympathetic reaction to everyone who is suffering" (p. 119). The realities of clinical practice often change this idealism in graduate nurses and they realize they cannot spend time with everyone who complains; they cannot relieve the suffering of every patient; they do not feel honestly sympathetic towards everyone; and, they cannot prevent death in every case (Davitz et al., 1980).

Educational experiences were a significant source of professional confidence in the opinions of the empathic graduate nurses studied in this project. Those nurses told Davitz et al. that their years of education were rigorous, demanding, and highly structured and occasionally they resented the demands and the discipline, but in retrospect, they talked about their experiences in nursing school with a great sense of pride. The researchers found those nurses who were the most empathic with suffering individuals had encountered role

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models during their formal education experience or early in practice who exercised an enormous influence upon them. In describing these models, the nurses mentioned characteristics such as self-discipline, calmness, commitment, and poise (Davitz et al., 1980).

The nurses who were identified as the most empathic towards those who were suffering repeatedly emphasized throughout the interviews that the nurse's relationship with the patient was the core of nursing. Unquestionably, the most important source of professional satisfaction for those nurses was the caring for others. Emphasis on the intrinsic reward they experienced in helping another person was voiced by all these empathic nurses. A vital component of their caring for others was the process of teaching others to care for themselves. From their different perspectives, they viewed nursing as a calling, rather than just a job; however, this was not meant to suggest any religious implications for this group of nurses. Davitz et al. (1980) explained:

> Nursing was a profoundly meaningful part of their lives. It was not the only source of meaning; their interests and activities outside nursing were both generally varied and satisfying. But the values derived from nursing were extraordinarily important to them. (p. 95)

There were many more pertinent findings in this landmark study of nurses' inferences of the suffering of their patients. Due to the significance of their research, further discussion is warranted. Davitz et al. (1980) discovered the nurses in their study judged lower-class patients, both male and female, to suffer more pain with the same illness or injury than did middle- or upper-class patients. Furthermore, these nurses believed that lower-class patients suffered

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greater psychological distress with certain illnesses than did middle- or upper-class patients.

Nurses who participated in this study believed children, ages 4 to 12, experienced considerably less psychological distress than any older age group. The rationale they presented for this belief was that children do not really understand the meaning of their illnesses; therefore, they are less likely to be psychologically upset. Davitz et al. (1980) responded that although there is some validity in this reasoning by the nurses, "it neglects the very important possibility that the major source of a child's anxiety may be somewhat different from that of adults" (p. 18).

When evaluating the suffering of patients from different ethnic origins, the nurses in Davitz et al. (1980) study expressed the beliefs that Oriental, Anglo-Saxon, and Germanic patients have the least pain and psychological distress; Jewish and Spanish patients experience the greatest suffering; and Black and Mediterranean patients rated in the middle, between the other groups.

Black nurses, in comparison to white nurses, believed patients suffered more psychological distress, regardless of whether the patient was black or white. On the other hand, white nurses saw less psychological distress, regardless of whether the patient was black or white. Davitz et al. (1980) concluded "the race of the nurse appeared to be the crucial factor, not the race to the patient" (p. 37).

Davitz et al. (1980) asked whether the fact that an individual nurse has personally experienced a good deal of pain and suffering contributes toward that

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nurse's inference of a relatively high degree of pain and suffering in others who are ill or injured. Also, they questioned if one has experienced considerable psychological distress in one's own life, does that experience make the person more sensitive to the psychological distress in others? When Davitz et al. examined these questions prior to the data gathering part of their study, they had projected that possibly as a result of repeated experiences with people in pain and distress, a nurse might become less sensitive to the suffering.

Results from this portion of the study indicated the nurses' ratings of their own pain were directly related to their ratings of pain in others. That is, nurses who inferred high degrees of physical pain in patients also reported more painful experiences in their own lives. Conversely, nurses who reported less painful personal experiences with pain rated relatively low physical pain in patients. The finding that nurses who have experienced moderate to severe pain are more sensitive to patients' pain has definite implications for the education of nursing students. According to Davitz et al. (1980):

> It certainly does not mean that nurses have to suffer themselves in order to empathize with the suffering of their patients. But it does suggest that in one way or another, a nurse should learn about the experience of pain. Personal experience with pain is only one way in which this can be achieved. We also learn from the experience of others if we pay attention to these experiences, if we listen to what others say, and if we read what others have written. (p. 44)

Other findings in this important study include the assertion that age, experience, and positions of the nurses were not related to judgments about the degree of suffering of their patients. Conversely, Davitz et al. (1980) found the cultural orientation of the nurses made a difference in how they expected their

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patients to respond to suffering. For some nurses, stoicism and self-control were expected in the face of suffering; for other nurses, free expression of feelings related to the suffering experience was accepted as normal.

Davitz et al. (1980) maintained the nurses' inferences of relatively low suffering among patients may be viewed, in part, as a defensive or distancing mechanism that permitted the nurse to maintain her own psychological integrity in the face of daily contact with individuals experiencing pain and distress. These researchers stated:

> This mechanism is similar to Harry Stack Sullivan's concept of selective inattention as a means of dealing with anxiety. According to Sullivan, a commonly used technique for reducing anxiety is a selective lack of attention to the source of the threat. Believing that patients do not suffer a great deal of pain or psychological distress is a form of selective inattention. (p. 77)

However, judgments about the number or degree of nurses' personal psychological distress experiences were not significantly related to judgments about the psychological suffering of patients. A very interesting discovery from this part of the research was "nurses who tended to infer relatively high suffering in patients also tended to prefer those aspects of nursing that concerned relating to their patients, while those who inferred less suffering preferred the more technical aspects of nursing" (Davitz et al., 1980, p. 42).

The subjects in the above study were significantly affected by whether or not the patient made a statement indicating that he or she believed he or she was suffering. The nurses assumed the patient who complained of distress was

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suffering more than those individuals who did not verbalize their suffering (Davitz et al., 1980).

One other pertinent finding in this research was the degree of suffering inferred related to the amount of visible pathology associated with various disease conditions. Davitz et al. (1980) concluded this finding strongly suggests the nurses were using an acute pain model, rather than a more generalized model of suffering, as the basis for their judgments.

Addressing the need for further research on suffering, Kahn and Steeves (1986) stressed it is:

> . . . essential for full understanding that research into suffering does not reduce the unit of analysis beyond that of the living, embodied person. Suffering cannot be studied in terms of molecular or neurological parameters and as a lived experience it remains more than just a collection of behaviors. (p. 630)

This central philosophical premise of Kahn and Steeves (1986) is shared by Cassell (1991a). Cassell believed knowing the suffering of others requires an exhaustive understanding of what makes them the individuals they are and a comprehension of when the suffering person feels whole, threatened, or disintegrated. This understanding necessitates gaining knowledge of the ideas held by suffering individuals regarding their identities, their views of the past, present, and future, their relationships to others and their environment, their aims, and anticipated actions (Cassell, 1991a).

Cassell (1991a) believed three kinds of information are required to understand what is involved in suffering. The first kind of information includes natural facts which should not be confused with scientific facts. Second, there

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must be knowledge of the values of the individual which includes desires, concerns, needs, fears, and interests. The final kind of information is aesthetic knowledge because in Cassell's opinion, a complex whole cannot be known apart from aesthetic criteria. When Cassell referred to aesthetics, he was speaking to order and harmony, and by implication, the disordered and the disharmonious. Since individuals exist within a temporal dimension, we see them over time and we make aesthetic judgments about the "fitness" of an event or behavior to the living-through-time individual (Cassell, 1991a).

Suffering leads to a disruption of the total person which can be seen in the loss of central purpose, marked by an aimlessness of behavior or reversion to behaviors that are primarily responses to immediate needs, no matter how conflicting the responses may be (Cassell, 1991a). Cassell believed suffering is the enemy of purpose.

Frequently health care providers may assume another person is suffering not because they know it to be true, but because they would suffer in the same circumstances (Cassell, 1991a). A profound belief is stated by Cassell (1991a):

> We are all involved with humankind but we mostly do our best not to know it. That knowledge of suffering is possible does not make its recognition obligatory. Every form of intelligence that relates the suffering of others can be denied and reinterpreted. Perhaps the discomfort that the suffering of others inevitably causes is sufficient explanation for the withdrawal of most observers. Perhaps it also explains how little cognizance--even disavowal--there is of the inescapable intimacy in which we are all bound. More likely this repudiation is an aspect of the pursuit of individuality that has been part of the intellectual program of Western culture for centuries. (p. 31)

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Donley (1991) concurred with several viewpoints of Cassell. She observed that the work of nurses brings them into direct contact with human suffering. However this presence and the knowledge of suffering do not insure compassion on the part of the nurse. Donley advanced the idea that the spiritual response to the problem of suffering requires the "other" to enter into the reality of suffering so that a sense of communion and solidarity with the sufferer develops. This response of sensitive accompaniment is called compassion in the Christian tradition. Donley (1991, p. 179) stated "the compassionate person need not offer meaning or alleviation. Rather, the 'other' offers a quiet sharing of the experience and helps the person to sustain the burden of suffering."

Expanding on this thought, Donley (1991) articulated "nursing's response to suffering persons runs parallel to the religious tradition: accompaniment, meaning giving, and action" (p. 181). She believed the search for meaning need not compete with efforts to remove suffering. "Persons who suffer should be enabled to find meaning in suffering and to have persons accompanying them who can offer words to express the meaning of it all" (p. 180).

Donley (1991) stated suffering can be made tolerable by compassion, by prayer, by acceptance, by words that give meaning to what seems to have no meaning, by the realization there is no shame in suffering, and by the transformational belief that suffering can bring about good for the person who suffers and for others. She believed extant health care literature explains the problem of suffering within the physiological and psychological parameters of disease and life situation. From these explanations, health care providers offer

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interventions to manage pain and to repress anxiety. Donley (1991) staunchly advocated the provision of compassion and spiritual support, in conjunction with physiological and psychological remedies, to those who are suffering.

The paradigm for nurses' spiritual mission advocated by Donley (1991) includes compassionate presence, meaning giving, and the alleviation of suffering. She thought if nursing reclaimed its spiritual mission, which was abandoned in the quest for science and specialization, efforts to relieve suffering would transcend concerns with race, culture, disease, or the ability to pay for care.

Aroskar (1991) observed another side of caring for those who are hospitalized. She believed nurses should question care and treatment of patients which verges on brutality or torture in settings such as intensive care units or nursing homes. These patients suffer in ways that are painful for many health care professionals to acknowledge since they may be contributing to the suffering of these individuals. A relational response to this assumption is provided by Soelle (1973/1975) when she stated that only those who themselves are suffering will work for the abolition of conditions under which persons are exposed to senseless, patently unnecessary suffering.

Illich (1975) spoke of pain as an invitation to the suffering individual to ask questions about the quality of his life. According to Illich:

> . . . medical civilization tends to turn pain into a technical problem, and thereby to deprive suffering of its inherent personal meaning. People learn to accept suffering as an inevitable part of their conscious coping with reality and come to interpret every ache as an indicator of their need for the intervention of applied science. (p. 93)

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O'Conner (1971) reflected that the individuals who experience suffering are closer to what is real. They are able to see the things that really matter and for a period of time they possess different values. She lamented that we have learned very little about suffering; hence, we are destined to suffer in the same ways again.

Helplessness and fear are experienced by those who suffer and intense pain cripples all power to resist; thus, these frequently lead to despair (Soelle, 1973/1975). She equated individuals who are suffering with those who are color-blind--they are both incapable of perception and lack sensibility.

In general individuals learn about the suffering of others only indirectly such as seeing starving children in another country on television. Soelle (1973/1975) stated this kind of relationship to those who are suffering is characteristic of our entire perception. Quoting Soelle (1973/1975):

> We seldom experience even the suffering and death of friends and relatives physically and directly. We no longer hear the death rattle and the moaning. We no longer touch the warmth and coldness of the sick body. The desire to remain free from suffering, the retreat into apathy, can be a kind of fear of contact. (p. 39)

Soelle believed the first step toward overcoming suffering is to "find a language that leads out of the uncomprehended suffering that makes one mute, a language of lament, of crying, of pain, a language that at least says what the situation is" (p. 70).

Consistent with Soelle's thinking, she made a strong statement that all extreme suffering evokes the experience of being forsaken by God and everyone. No longer does an individual have anything in life to give her or him meaning.

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The person perceives life was just an illusion, an error, a guilt that cannot be rectified, and a void that cannot be filled. There is a feeling of total annihilation. Using further theological explanations, Soelle (1973/1975) reflected that the cup of suffering becomes the cup of strength. Whenever a person empties that cup, he or she has conquered all fear. He or she is a different person upon returning from the suffering experience.

It is not possible to remove oneself totally from suffering, unless one removes oneself from life itself, no longer enters into relationships, or makes oneself invulnerable (Soelle, 1973/1975). A vital point made by Soelle (1973/1975) is that "suffering can bring us to the point of wishing that the world did not exist, of believing that non-being is better than being" (p. 107).

Few authors have addressed the influence of suffering upon those caring for suffering individuals. Joseph (1991) believed when nurses openly engage with clients, they experience energetic absorption of their client's pain, suffering, and fear and they resonate with their client's frustration and anger. If the client's need is great, the energy of the caregiver may be drained. Lack of self-renewal and self-care skills along with a tendency to empathize with the suffering of clients may lead to a tendency for nurses to energetically withdraw. The nurse may focus on tasks and procedures rather than being with the client who is suffering (Joseph, 1991).

Gadow (1989) described the tendency for nurses to take a disembodied view in order to avoid feeling the pain and suffering of their patients. She believed it takes courage and devotion for nurses to consciously make the choice

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to be fully present and energetically open in a compassionate way with patients who are suffering. Gadow does not explain why, in an earlier (1988) writing, she recommended the disassociation from one's own body in order to deal with patients who were suffering. She stated:

> The inflicting of pain for any purpose requires disassociation from one's own body in order not to suffer with the person in pain. In circumstances where much suffering is witnessed and much inflicted, as in long and agonizing treatment, protecting the caregiver from pain is a necessity. That protection is afforded only by disassociation from one's own body in order not to emphatically [sic] recognize the patient's pain. (p. 10)

Taylor and Watson (1989) are the editors of a very comprehensive book on human suffering and human caring. They viewed suffering, psychological and physical, as being universal in scope. These authors acknowledged that the level of suffering often seems to determine the quality of human existence. The primary motivation for self-understanding and self-transformation is the human condition fraught with suffering. As described by Taylor and Watson (1989):

> . . . suffering is not something to be discarded by religious traditions. In fact, it is seen as central to the task of giving meaning to the world. A religious worldview claims there is meaning and purpose in the world. As there is suffering, it too must be given a role in that meaning and purpose. (p. 4)

Relating suffering with religious connotations, Taylor (1989) stated, in a sense, suffering stands at the very center of a religious response to the world. He defined a religious response as one that strives for meaning and purpose in the nature of the universe. Taylor saw a universe that is merely random and ultimately meaningless as the antithesis of any religious worldview. It is in this reasoning that Taylor found a paradox. He stated:

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> On the one hand, from a religious point of view, all changes are for the best, must be for the best. On the other hand, a number of these things that are supposedly for the best precipitate an inordinate amount of suffering. (p. 12)

Taylor suggested the solution to this paradox is to realize if the religious worldview is to persist, then suffering must be seen as not unrelated, but always secondary to the meaning and purpose of the universe. He explained it more specifically by observing suffering cannot form a meaningless component of an otherwise meaningful universe. "Suffering bears a direct relation to any projected meaning of the universe and cannot be divorced from it" (Taylor, 1989, p. 12).

According to Taylor (1989), there are remarkably few (if any) exceptions within the religious response to suffering that do not cling to the religion's structure of meaning. Taylor (1989) expounded:

> With tenacious perseverance, the religious worldview deepens its own understanding of the human condition and of the response called for in time of need. As we examine the breadth of religious traditions, we see that suffering is a central problem, which all too universally defines the human condition. (p. 15)

Abrams (1989) recounted that, in general, religious viewpoints see pain and suffering as evil but he believes this is not necessarily the case. It was his opinion in order to heal, a person has two choices: to remove pain and suffering or to give them meaning.

Little (1989) said "suffering is at once the central puzzle of and the basic reason for religion" (p. 53). He partially agreed with Nietzsche in contending

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that the matter of suffering lies at the bottom of all attempts to reason about human existence and conduct. Additionally, Little (1989) stated:

> . . . we may begin to suspect that human beings are not entirely free to think about the problem of suffering in just the way they please. The experience of suffering may be so special that only the suffering in one way or another, can make it sufferable. (p. 71)

Watson (1989) proposed a framework of human caring for health care providers to cope with those who are suffering. The human center must be the starting point in this process. One way to get to the human center, referred to by Watson, is through a "deeper engagement in notions such as human caring and the humanities" (Abrams, 1989, p. 125). Watson viewed human caring as involving values, a will, a commitment to care, knowledge, caring actions, and consequences. She saw care as a state of mental suffering since the action of caring means a stir of emotion or a call to the heart rather than to the mind. Using the paradigm of human caring and the humanities allows for human dimensions of suffering to be present in both the care provider and the care receiver (Watson, 1989). Mumford (1970) stated this type of intersubjective human flow described by Watson (1989) has the potential to allow the care giver to become the care receiver by receiving the awareness of suffering experienced by the other, and vice versa.

Watson (1989) explained the nurse may participate in the experience of suffering of another person by regarding or touching the body, mind, and spirit of the patient. This caring relationship involves being a part of the suffering person's immediate lived reality. A caring paradigm does not view suffering as a

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pathological problem that demands clinical therapy and distancing to achieve a cure, rather, in the Kierkegaardian existential sense, it views suffering as objectively and subjectively real (Watson, 1989).

Picard (1991) spoke of the difficulty some patients experience in finding their voice when they are suffering. This stifling of one's voice may result from the unspeakable nature of the suffering, the fear of causing others to suffer, or the newness of the situation. This loss of voice or disconnection is part of the experience of suffering (Picard, 1991).

It is important for nurses to be familiar with works from fiction, poetry, drama, music, and religion in order to be able to identify appropriate metaphors to use in assisting patients to find their voice (Picard, 1991). This can be done because voice develops through metaphor. Also, films, stories, and plays contribute to a caregiver's awareness of suffering and compassion.

Embedded in Smolkin's (1989) treatment of the concept of suffering are philosophical foundations of the phenomenon. He questioned whether all inner suffering is the same in terms of its philosophical importance. Regardless of its etiology, pain seems to have the same effect on sufferers in two respects. First, extreme suffering elicits metaphysical speculation in nearly everyone. Secondly, pain tends to isolate the sufferer from most of humanity, especially in the Western world. These isolating qualities of pain are instrumental in directing the sufferer toward a metaphysical re-examination of life (Smolkin, 1989).

Several authors have considered the isolating quality of suffering. Dostoevsky (1880/1957) questioned:

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> Suppose I, for instance, suffer intensely. Another can never know how much I suffer, because he is another and not I. And what's more, a man is rarely ready to admit another's suffering. (p. 218)

Addressing the isolation of those who are suffering, Scarry (1985) noted that suffering:

> . . . though indisputably real to the sufferer, it is, unless accompanied by visible body damage or a disease label, unreal to others. This profound ontological split (between the sufferer and all others) is a doubling of pain's annihilating power: The lack of acknowledgment and recognition (which if present could act as a form of self extension) becomes a second form of negation and recognition, the social equivalent of the physical aversiveness. (p. 56)

Noted theologian Dorothee Soelle (1973/1975) said all instances of extreme suffering evoke the experience of being forsaken by God.

Lewis (1962), another noted theologian who has written prolifically about the meaning of pain and suffering, stated "the real problem is not why some humble people believe people suffer but why some do not" (p. 104). Furthermore, he asserted that the old Christian doctrine of being made "perfect through suffering" is not incredible. Smolkin (1989) agreed there is a prevalent notion in the religious literature that struggle and suffering are necessary in order to obtain spiritual peace and beatitude.

Kierkegaard, in all of his writings, emphasized that suffering must be embraced as the only path that will bring a person to self knowledge and salvation. According to Kierkegaard (1946):

> . . . the fact of having suffered in the world for the truth is one of the requisites for becoming eternally blessed . . . . For Him, thou canst love only by suffering, or, if thou lovest Him as He would be loved, thou wilt have suffering. Remember, one lives only once. If that is let slip, if thou

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> hast experienced no suffering, if thou hast shirded [sic] it--it is eternally irremediable. (p. 459)

Smolkin (1989) used the analogy of therapeutic ratio in pharmacology to relate to the ability of humans to tolerate pain and suffering. Acknowledging the great difference in how individuals are able to tolerate pain, he said the suffering which destroys some persons spurs others to achievements that win for them the Nobel prize. Pharmacologists know there is a dose that is helpful and a dose that is toxic or lethal. Quoting Smolkin (1989):

> Pain may have a therapeutic ratio that differs among individuals. Some dose of pain may be necessary for human development, for focusing one's attention, for stirring questions that may lead to a positive orientation of one's life. But each human has a threshold beyond which pain is poison. Medications can be prescribed with such ratios in mind, but pain seemingly is distributed randomly. Many are poisoned, and for these poor souls there is no consolation, for they are dead inside. (pp. 49-50)

Smolkin (1989) also noted stoics believe much of human suffering is caused by the ignorance of the way the universe is constituted and if they can succeed in enlarging that knowledge and world-view, they can succeed in reducing the amount of suffering in the world.

Wood (1958) wrote that Bertrand Russell was a "passionate sceptic." According to Wood, Russell insisted that the existence of suffering be accepted, and that no energy should be expended in the search for its meaning. Russell believed the acceptance of harsh and unpleasant truths was a part of any worthwhile creed for living. He believed the world is a horrible place and implored people to give up any belief of any cosmic justice because such a belief

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leads only to disappointment and anger at the universe and this a sterile and profitless response to suffering (Wood, 1958).

Smolkin (1989) interpreted Camus' stance on suffering by comparing him to the view of Bertrand Russell. Camus did not agree with Russell that one should not waste energy in questioning why humans suffer. Camus asserted meaning does emerge in the lives of individuals when they rebel against the absurdities of life. He did not endorse any religious connotation for suffering. Camus wanted people to be supremely alive and to create meaning in a world that has none. By being rebels against the harsh and unpleasant truths, Camus believed humans can find that meaning (Smolkin, 1989).

In summary, suffering may be viewed from multiple contexts and is associated with many meanings, inferences, and feelings. Despite the fact that there is a difference between the concepts of pain and suffering, they are frequently equated. Smolkin (1989) eloquently summarized the difficulty in objectifying and universalizing a definition of suffering when he offered this overview of pain:

> Some see pain as a trivial aspect of a universe of unspeakable grandeur and perfection, and can derive joy from running as a thread through such a sublime tapestry. Others opt to affirm the idea that humans are deeply flawed by self-idolatry, and that punishment will continue to be truly just, until all turn to God and are redeemed by Grace. Other groups, despite their recognition that humans are flawed by unrepentant self-infatuation, reject the spectre of a sadistic God, and embrace a self-limited God whom they envision as always "with" the sufferer. Still others adopt a cultivated insensitivity, a partial death in life, a blunting of life's joys as well as its pains, and which may leave its advocates less caring about the pain of others. Finally, there are those who rebel, proclaiming pain to be an outrage, and spurning any explanation which attempts to justify it. They wage a war they recognize as ultimately futile against an uncaring cosmos

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> and endeavor to establish an emphemeral [sic] oasis of human love within the vacuum of reality. (pp. 80-81)

Educational Context

Weiler (1988) stated "the empowerment of students means encouraging them to explore and analyze the forces acting upon their lives" and "respecting and legitimizing students' own voices" (p. 152). The educational context for this research is founded upon the concept expressed by Weiler; the lived experience of students must be heard in order to educate and empower them. Through the use of the descriptions and stories of students who have cared for suffering individuals, an entire realm of undiscovered territory related to educating nursing students to care for those who are suffering may be revealed.

Speaking to the use of descriptions of experiences of nurses with patients, Parker (1990) said:

> Responsiveness within the context of the nurse-patient relationship means a willingness to accept a patient's invitation to be a close traveling companion on an uncertain journey. Experiences of intense pain, abandonment, and fear of living and dying are shared in an effort to construct the meaning of seemingly meaningless experiences. The coconstruction of meaning is a dynamic process that necessitates engaged listening, authentic responsiveness, mutual disclosure, and negotiation. (p. 38)

The concepts expressed by Parker can be transferred to the educator-student relationship. Faculty can assist students in constructing meaning from experiences that seem meaningless. This type of dynamic interaction requires that educators "take a look at teaching through a different lens" (Bevis & Murray, 1990, p. 326). A curriculum revolution or a shift in paradigms for nursing education has been described by many authors (Allen, 1990; Bevis, 1990;

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Bevis & Murray, 1990; Chinn, 1989; Clayton & Murray, 1989; Diekelmann, 1989, 1990; Donley, 1989; Martin, 1989; Waters, 1989). Referring to the curriculum revolution in nursing education, de Tornyay (1990) noted nursing students must experience empowering experiences firsthand before they are able to provide empowering care to their clients.

Diekelmann (1990) wrote of a new approach to the education of nursing students; she named it "Nursing Education as Caring, Dialogue, and Practice." Describing the caring component of her model, Diekelmann (1990) acknowledged nurses have a common commitment to care whether it is through the provision of nursing care, teaching students, or conducting research. The primary focus for this caring component is that of comportment or more specifically how "we go about creating communities within which we practice, teach, and conduct research that are caring" (Diekelmann, 1990, p. 301). Diekelmann (1988) defined curriculum as a "dialogue among teachers, practitioners, and students on what will constitute the knowledge in the nursing curriculum and what role experience will play in the curriculum" (p. 144).

Expanding on the thoughts related to dialogue, Diekelmann (1990) noted:

> Our conversations need to be dialogues in which we hold mirrors up which reflect and call one another forth. Dialogue is engaged listening, seeking to understand, and being open to all possibilities. By being fully engaged in the situation, through dialogue, we seek to get the story "right." Reflecting and probing, we search for words that disclose and bear witness to our understanding. Dialogue is central to nursing education and the revolution. (p. 301)

Diekelmann (1990) believed attention must be paid to the lived experiences of students, educators, and clinicians. I agree because a central premise of my

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dissertation is that from listening to the explanations of nursing students who have cared for those who are suffering, "new possibilities for curriculum and instruction will emerge" (Diekelmann, 1990, p. 301) from their day to day experiences. She described explicitly how educators can learn from the experiences of students by stating:

> Teachers-as-learners are always open to new possibilities, constantly transforming and being transformed. Learning becomes teaching. Learning is hearing. It is not merely listening but hearing, in the sense of dialogue and meaning. (p. 303)

Not only is it critical that students reflect on their lived experiences, according to Diekelmann, but also faculty must reflect on their lived experiences in order to recapture the moral sense of teaching and its relationship to learning.

Earlier, Diekelmann (1989) suggested that "perhaps understanding the students' lived experiences and the meanings of evaluation will help us transform evaluation as a part of practice in teaching nursing" (p. 27). As she says, educators engaging in:

> . . . hermeneutic inquiry in which they continually find themselves addressing difficult questions that have meaning for them in the context of teaching reflect the teacher-as-learner. The teacher moves from being an information giver and facilitator to the explorer of meanings with students--their understandings of their experiences. We need to develop a pedagogy that is attentive to the histories, futures, and experiences that nursing students and teachers bring with them to school, as well as the experiences of nurses and our patients. (p. 37)

Benner (1991), using some thoughts from Gadamer, defined "experience" from a phenomenological perspective as "the adding of nuance, the amending or changing of preconceived notions or perceptions of the situation" (p. 2). Alluding to the importance of using lived experiences as a method of teaching-learning,

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Benner (1991) said "narrative accounts uncover meanings and feelings in ways that shed light on the contextual, relational, and configurational knowledge lived out in the practice" (p. 2). The following quote speaks to a premise for my dissertation research:

> Narratives are essential to convey and preserve knowledge about the skill of involvement (getting the kind of involvement and interpersonal distance to fit the situation), because relational skills always involve the concrete other and are always context dependent. These are stories of gaining personal knowledge. (p. 9)

Referring to narratives of disillusionment as being storylines of discovering the broken promises and the limits of others' knowledge, Benner (1991) noted many of these narratives reveal the experiences of nurses as they confront unavoidable suffering and death. Given that the culture avoids suffering and death, when they are discussed, it is in the form of problems to be solved or as indicators of personal failure. The prevalent medical model offers few metaphors and no spiritual practices for facing suffering and death. Therefore, nurses must learn from their firsthand experiences about this cultural silence and avoidance (Benner, 1991). She described the concept of suffering:

> A major cultural theme and value is the avoidance of suffering. However, in practice, unavoidable suffering is often exacerbated by separation and a lack of adequate language, metaphors, rituals, practices, and meanings in a suffering- and death-avoidant culture that promises continuous progress and technical solutions. Suffering is removed to the hospital room, where patients, families, and nurses are left to work out ways to communicate and comfort one another in the face of unavoidable suffering. (p. 14)

Benner has conducted a significant amount of research related to the acquisition of knowledge and skills in the various stages of the career of a nurse. She believed nursing students enter a new clinical area as novices with little

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understanding of the contextual meaning of recently learned textbook terms. I question whether nursing students cause additional suffering to occur in their patients due to this lack of skill and clinical judgment. On the other hand, does this lack of skill and clinical judgment lead to suffering on the part of the nursing student? Another question relevant to this topic of discussion is whether nursing students are prepared in their nursing education experience to care for those who are suffering or do they obtain most of their knowledge from other resources such as philosophy courses, electives, liberal arts courses, teachers, parents, ministers, role models, or personal experience. These questions should be addressed in future research.

A major component of the theoretical context for my research is the work of Barbara Carper (1978) on the fundamental patterns of knowing in nursing. Carper wrote "with each change in the shape of knowledge, teaching and learning require looking for different points of contact and connection among ideas and things" (pp. 22-23). Four components of knowledge were identified. Empirics, or the science of nursing, is the first pattern of knowing. This is the factual, descriptive element of knowing that is ultimately aimed at developing abstract and theoretical explanations. She pointed out the empirics pattern is exemplary, discursively formulated, and publicly verifiable.

The second component is esthetics, the art of nursing, which has not received much attention by nursing education to make it explicit as a way of knowing. Carper (1978) asserted this reluctance to properly acknowledge esthetics as a fundamental way of knowing in nursing may originate in the

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vigorous efforts made by nursing in the not-so-distant past to eliminate the image of the apprentice-type educational system. According to Carper, empathy is an important mode in the esthetic pattern of knowing. A crucial point to the theoretical foundation for this research on the experiences of nursing students as they care for suffering individuals was made by Carper in this quote:

> The more skilled the nurse becomes in perceiving and empathizing with the lives of others, the more knowledge or understanding will be gained by alternate modes of perceiving reality. The nurse will thereby have available a larger repertoire of choices in designing and providing nursing care that is effective and satisfying. At the same time, increased awareness of the variety of subjective experiences will heighten the complexity and difficulty of the decision making involved. (pp. 17-18)

One further relevant point made by Carper is that esthetics is the knowing of a unique particular rather than an exemplary class.

The component of personal knowledge is the third pattern of knowing delineated by Carper (1978). She believed this pattern to be the most difficult to teach and to master. Personal knowing focuses on the knowing, encountering, and actualizing of the concrete, individual self. According to Carper, one does not know <u>about</u> the self; one strives simply to <u>know</u> the self. Personal knowing can be depicted as a standing in relation to another human being and confronting that human being as a person. Carper claimed that personal knowing extends not only to other selves but also to relations with one's own self. A nurse utilizes personal knowing by refusing to approach the patient-client as an object and instead strives to actualize an authentic personal relationship between two persons. Carper described the realm of personal knowing as being subjective, concrete, and existential. In her words "it is concerned with the kind of knowing

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that promotes wholeness and integrity in the personal encounter, the achievement of engagement rather than detachment; and it denies the manipulative, impersonal orientation" (p. 20).

The final pattern of knowing explicated by Carper (1978) is the ethical or moral component. She acknowledged appealing to ethical rules often fails to provide answers to difficult moral choices which must be made in the teaching and practice of nursing. The ethical component of nursing as described by Carper, focuses on matters of obligation or what ought to be done. She proposed:

> The ethical pattern of knowing in nursing requires an understanding of different philosophical positions regarding what is good, what ought to be desired, what is right; of different ethical frameworks devised for dealing with the complexities of moral judgments; and of various orientations to the notion of obligation. (p. 21)

Summarizing these components of knowing in nursing, Carper (1978) stated:

> Each pattern may be conceived as necessary for achieving mastery in the discipline, but none of them alone should be considered sufficient. Neither are they mutually exclusive. The teaching and learning of one pattern do not require the rejection or neglect of any of the others. (pp. 21-22)

Nursing educators should question whether students learn ethical knowledge from their experiences with suffering individuals. Does the students' personal knowing influence their experiences with suffering individuals? Does empirical knowing "overshadow" the experiences of students when they care for suffering individuals? What can students learn esthetically from their experiences with persons who are suffering? An additional facet of the

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educational experience of students that should be investigated by educators concerns whether students utilize other patterns of knowing than empirical; if they use other ways, where and how do they learn them?

Chinn (1992) wrote about the "discomforts of knowledge" in nursing and noted nursing has traditionally been concerned with the most simple, fundamental, and essential of human experiences. She issued a warning by noting "in a world that increasingly values the abstract and complex, and that profits from mystification and obfuscation, that which is simple becomes a taken-for-granted commodity deserving of little serious attention" (p. vii). Guided by this belief, Chinn (1992) contended that nurses care for those who are in pain and who are suffering "in ways familiar to no other professional group" (p. vii). She urged a return to the teaching and learning of the fundamental and essential arts upon which the practice of nursing is built. The essence of her article is found in this statement: "I hope that nurses will collectively move boldly into a future where knowing about, and doing something about human needs for comfort and relief from pain are clearly within nursing's realm" (p. vii).

John Dewey, a well known educational theorist, questioned why so many individuals wonder what became of the empirical knowledge they were supposed to have amassed. Two points made by Dewey (1963) are relevant to my dissertation research:

> One trouble is that the subject-matter in question was learned in isolation . . . . It was segregated when it was acquired and . . . is so disconnected from the rest of experience that is it is not available under the actual conditions of life. [When we ask] where has it gone to, the right answer is

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> that it is still there in the special compartment in which it was originally stowed away. (p. 48)

Also, he stated:

> It is contrary to the laws of experience that learning of this kind should give genuine preparation . . . . What avail is it . . . if in the process the individual loses his own soul; loses his appreciation of things worth while, of the values to which these things are relative; if he loses desire to apply what he has learned and, above all, the ability to extract meaning from his future experiences as they occur? (pp. 48-49)

Maxine Greene is another educational theorist whose works provided guidance for my research. In 1978, in discussing the landscapes of the learning experience, she stated "to be in touch with our landscape is to be conscious of our evolving experiences, to be aware of the ways in which we encounter our world" (p. 2). Greene (1978a) proposed a:

> . . . human being lives, as it were, in two orders--one created by his or her relations with the perceptual fields that are given in experience, the other created by his or her relations with a human and social environment. It is important to hold in mind, therefore, that each of us achieved contact with the world from a particular vantage point, in terms of a particular biography. (p. 2)

From Greene's perspective, learning is a conscious search for some kind of coherence or sense and it is "a process of effecting new connections in experience, of thematizing, problematizing, and imposing diverse patterns on the inchoateness of things" (p. 3). Nursing educators who are teaching students to care for others would most likely agree with many tenets of Greene. For instance, Greene (1978a) presented the view that the more fully engaged a person is with other individuals, the more that person can look through others' eyes; thus, that person

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becomes more richly individual. Also, she posited "learning involves a futuring, a going beyond" (p. 39).

Similar to Carper's (1978) argument about the importance of ethical knowing, Greene (1978a) suggested attentiveness to this component of knowing ought to permeate many of the classes which are taught. She believed it is important for educators to be critical thinkers as well as authentic, concerned, and caring persons who live in the world. Stressing the importance of ethical knowing, Greene (1978a) stated "the roots of moral choosing lie at the core of a person's conception of herself or himself and the equally important fact that choosing involves action as well as thought" (p. 48).

For Greene, attentiveness to one's history and one's own self-formation, may open up to critical awareness much of that which is taken for granted. She saw curriculum being used as a means to acquire this knowledge of one's experiences in order to seize a range of meanings by persons open to the world. According to Greene (1978a), "we begin interpreting our experiences with the aid of a 'stock of knowledge at hand,' recipes available by the culture for making sense of things and other humans beings, for defining our situations as we live" (p. 214).

Greene (1978a) advocated the use of all patterns of knowing in the learning landscape. Through acts of consciousness, aspects of the world present themselves to living beings. She declared "consciousness thrusts toward the world, not away from it; it thrusts towards the situations in which the individual lives his or her life" (p. 14). Furthermore, these acts of consciousness include:

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> . . . imagining, intuiting, remembering, believing, judging, conceiving, and (focally) perceiving. Alone or in collaboration, they bring individuals in touch with objects, events, and other human beings; they make it possible for individuals to orient themselves to, to interpret, to constitute a world. (p. 14)

In the words of Greene (1978a) are many aspects of the phenomenological philosophy and method. She believed "consciousness as perspectival grasping is our way of encountering the natural and human world" (p. 15). Ordinary persons close their eyes to their situatedness or their location in an intersubjective world. The result is they become unable to think about ways in which their perspectives are affected by their involvement, projects, and their work. Persons are always grounded in experience in an ineluctably human reality (Greene, 1978a).

The experiences encountered in everyday life are the paramount reality (Greene, 1978a). Greene (1978a) noted:

> This is the domain in which we do our work, interact with others, and try to bring about the changes that will sustain our purposes. Although we are likely to take it as "given," normal, fundamentally unalterable, the world of everyday life is what is because we have learned to interpret the experiences we have together on the basis of our own previous experiences and those handed down to us by our elders . . . . Each of us, because our biographies, our projects, and our locations differ, encounters the social reality of everyday from a somewhat distinctive perspective, a perspective of which we are far too often unaware. (pp. 16-17)

Greene (1978b) observed that learners can build up a structure of meanings as they get older and as they experience diverse teachers and teaching situations. She agreed with Dewey and Sartre that what a person becomes, what a person makes of themself, depends upon what they do with their life. Furthermore, she stated:

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> . . . what we do cannot be simply routine and mechanical; it must be conscious, interested, committed. If it is not, if we content ourselves with being behaving organisms rather than reflective persons engaged in ongoing action, the quality of our selfhood becomes thin and pallid. (1978b, pp. 26-27)

Applying these thoughts to educators, Greene (1978b) proposed that teachers who are out of touch with their own existential reality may not be personally present to others or in the situations of their lives. They tend to treat learners as objects or things and fail to assist their students in acquiring meaning in learning situations. Educators who are "willing to take the risk of coming in touch with themselves, of creating themselves, have to exist in a kind of tension because it is always easier to fall back into indifference, into mere conformity, if not into bad faith" (Greene, 1978b, p. 31). Some educators prefer to be teachers who choose to keep order and simply disseminate as many bits of knowledge as they can. Greene (1978b) emphasized that it is:

> . . . quite different from the choice to create a situation in which knowledge can be sought and meanings pursued. It is quite different from the choice to institute the kind of dialogue that might move the student to pose their own worthwhile questions, to tell their own stories, to reach out in their being together to learn how to learn. (p. 32)

The final element in the philosophy of Maxine Greene relevant to my research is her belief that:

> Those who chose themselves as keepers of the academic disciplines may come to realize that the perspectives made possible by the disciplines are meaningful when they illuminate the experience of the learner, when they enable him or her to order the materials of his/her lived world. (p. 33)

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Assumptions

The following assumptions have influenced me and are foundational for my research. Some assumptions are related to and are derived from nursing and other disciplines which guided the research; other assumptions are from the lived experiences of the researcher.

1. Suffering has been studied relatively well in the disciplines of religion and philosophy but studies are virtually non-existent in the health care professions, particularly nursing. My survey of the literature confirms this assumption.

2. A more comprehensive understanding of the lived experience of caring for suffering individuals is needed.

3. Pain and suffering are not mutually exclusive concepts but may be studied separately in order to understand them more comprehensively.

4. Pain and suffering are pervasive, multifaceted, subjective phenomena. They are different but inextricably related concepts. A person can experience pain without suffering. Suffering can be relieved even "in the presence of continued pain by making the source of the pain known, changing its meaning, and demonstrating that it can be controlled and that an end is in sight" (Cassell, 1991, p. 36). Pain can be studied in terms of physiological parameters while suffering cannot. Suffering is a response of self and often involves a loss of voice or connection.

5. Human suffering is a lived experience of the total person (Kahn & Steeves, 1986).

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6. Suffering may have multiple meanings for a person.

7. Individuals who are suffering and health care providers who care for those who are suffering are confronted with existential concerns such as the meaning and purpose of suffering, as well as the meaning and purpose of life, living, dying, and death.

8. The meanings(s) and purpose(s) attributed to suffering by an individual (both the one who is suffering and the one who is caring for that person) profoundly affect their physical, psychological, social, and spiritual reactions to the experience of suffering.

9. Personal experience with suffering may alter or modify the manner in which one cares for individuals who are suffering.

10. There is no single entity that is pain nor is there a single entity that is suffering.

11. Individuals who are suffering often need someone to "help" them; "be with" them; "understand" them; "truly be present"; "be authentic with" them; "exhibit compassion for" them.

12. Nursing is a lived dialogue that incorporates an intersubjective transaction in which a nurse and a patient meet, relate, and are totally present in the experience in an existential manner (Paterson & Zderad, 1970-1971).

13. "Nursing is the ability to struggle with other man [sic] through peak experiences related to health and suffering in which the participants in the nursing situation are and become in accordance with their human potential" (Paterson & Zderad, 1988, p. 7).

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14. Nurses, on a daily basis, are confronted with many facets and forms of suffering and are challenged to understand it and be successful in its relief.

15. Nursing lacks adequate descriptions of caring for those who are experiencing suffering or of those who are caring for individuals who are suffering.

16. Insight into students' experiences in caring for suffering individuals can be learned through their accounts of the lived experience.

17. To understand the nursing student's response to caring for suffering individuals one must study the response in its context; the context is where that which a person values and finds significant becomes visible.

18. Nursing students can learn how to care for those who are suffering by utilizing the four fundamental patterns of knowing as delineated by Carper (1978): empirical knowledge, ethical knowledge, personal knowledge, and esthetical knowledge.

19. Nursing faculty can influence the manner in which nursing students care for suffering individuals.

20. Nursing faculty are inadequately prepared to "teach" students how to care for those who are suffering.

21. The classical causal model of empirical science is inappropriate as an approach to study the lived experience of nursing students while caring for those who were suffering.

22. Phenomenological philosophy and method are warranted for this research in order to describe the world-as-experienced by nursing students, thus

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enabling me to discover the common meanings underlying students' experiences in caring for individuals who were suffering.

23. In the phenomenological perspective, persons are beings who are engaged in and constituted by their interpretive understanding.

24. "Meaning in life is never predetermined. It is discovered by each person in his/her own living" (Kreidler, 1984, p. 175).

25. "The more fully engaged we are, the more we can look through others' eyes, the more richly individual we become" (Greene, 1978b, p. 3).

Summary

Suffering is a concept which has been discussed and debated in theological and philosophical writings; however, the nursing profession has shown limited interest in differentiating it from the concept of pain. This review of the literature focused on the subject of suffering and the acquisition of knowledge relative to educating a student to care for an individual who is suffering, as viewed through or related to theological, philosophical, medical, educational, phenomenological, and nursing contexts. Missing from the knowledge of caring for suffering individuals are the voices of nursing students as they describe their experiences of caring for individuals who are suffering.

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CHAPTER III

RESEARCH PLAN

The purpose of this study was to illuminate the lived experience of nursing students when they cared for individuals who were suffering. The research design of this study was phenomenological. The use of the phenomenological method was congruent with the purpose of this study. Scudder and Mickunas (1985) made a cogent case for the use of phenomenological methods in educational studies such as this doctoral research:

> The philosophy of education is concerned with the structures of experience on which education rests and out of which it emerges. These structures are coextensive with what phenomenology calls the lived world of meaningful relationships, articulated in cultural traditions and directly accessible through dialogue. (p. 6)

Additionally, Scudder and Mickunas (1985) stated phenomenologists contend the meaning of education is to be found in the lived world of teaching and learning. Definitely this research should enhance the meaning of education because it captured the essence of the lived experience of nursing students when they cared for suffering individuals. Knafl and Howard (1984) said "rich descriptive findings ultimately advance nursing science through illustration, sensitization, and conceptualization" (p. 17).

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Introduction to Phenomenology

Phenomenology has been called a research method without specific techniques. Phenomenology assumes there is something in the nature of human experience, beyond sheer reason or sensory observation, which will produce knowledge (Davis, 1978). Implicit in the phenomenological perspective is the acknowledgment that research must always question the way the world is experienced. This notion is further described by van Manen (1990) in this statement:

> Since to know the world is profoundly to be in the world in a certain way, the act of researching--questioning--theorizing is the intentional act of attaching ourselves to the world, to become more fully part of it, or better, to become the world. (p. 5)

This inseparable connection to the world is called the principle of intentionality. Colaizzi (1978) defined intentionality as a unity of human existence and the world, "a unity so vital and basic that either one is absurd and inconceivable without the other" (p. 54). Intentionality is defined by van Manen (1990) as the inseparable connectedness of the human being to the world. The fundamental structure of consciousness is intentional. In other words, all thinking is always thinking about something. Intentionality is only available retrospectively to consciousness. It is impossible to experience something while reflecting on the experience even if this experience is itself a reflective acting (van Manen, 1990). Thus, phenomenology assumes the temporality of the person.

In conducting phenomenological research, the very secrets and intimacies constitutive of the world are questioned. Moreover, research is a caring act

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because we want to know that which is most essential to being (van Manen, 1990). Swanson-Kauffman and Schonwald (1988) related "the very worth of a phenomenological portrayal of reality must be judged in terms of how validly the researcher represents the experiences of those who live the reality" (p. 98). Several authors (Bergum, 1989; Cassell, 1991a; Guba & Lincoln, 1989; Parse, 1989; Polit & Hungler, 1987; van Manen, 1990; Watson, 1989) cited the fact that the classical causal model of empirical science with its tendency to "observe and explain" is inappropriate to study lived experience of humans in which the approach of "interpreting and understanding" is needed. Polit and Hungler (1987) believed a phenomenological approach rests on different assumptions than the philosophical underpinnings of logical positivism. That difference is related to the nature of humans and how that nature is to be understood.

Bergum (1989) observed that phenomenological research explores the humanness of a being in the world and it is "a drama, an interactive involvement of both the researcher and the researched" (p. 43). The essence of phenomenological research is captured in this quote by van Manen (1990):

> The point of phenomenological research is to "borrow" other people's experiences and their reflections on their experiences in order to better be able to come to an understanding of the deeper meaning or significance of an aspect of human experience, in the context of the whole of human experience. (p. 62)

Phenomenology is the rigorous adherence to the phenomenon as it appears and unfolds in the descriptions of subjects who have lived the experience under study (Parse, 1989). On the basis of subjects' descriptions, the nature of the phenomenon is revealed by uncovering the essences and meaning of the

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experience (Parse, 1989). The individual's lived experience is always determined by his or her history; all his or her previous experiences are enmeshed in this experience. Schutz (1970) stated it in this manner:

> Our knowledge of an object, at a certain given moment, is nothing else than the sediment of previous mental processes by which it has been constituted. It has its own history, and this history of its constitution can be found by questioning it. This is done by turning back from the seemingly ready-made object of our thought to the different activities of our mind in which and by which it has been constituted step by step. (p. 111)

According to Polit and Hungler (1987), phenomenologists "emphasize the complexity of humans, the ability of humans to shape and create their own experiences, and the idea that 'truth' is a composite of realities" (p. 21).

Oiler (1986) said the only consciousness that has meaning to us is the human experience in a world of others, objects, and events. Furthermore, she stated "the body is our access to the world and hence the means by which experience occurs" (p. 70) and perception is the access to human experience. The perceived world is what is studied in phenomenological research, not subjective phenomena. "Phenomenological description is always contingent . . . on the perspective given in experience and presented in perception" (Oiler, 1986, p. 72).

Valle and King (1978) stated phenomenologically-oriented research seeks to answer two related questions: What is the phenomenon that is experienced and lived, and how does it show itself? They believed regardless of the particular variations of a phenomenon, the same phenomenon is seen as:

> . . . having the same essential meaning when it is perceived over time in many different situations . . . . Only after seeing different reflections and

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> varied appearances on repeated occasions does the constant unchanging structure become known to us. (p. 15)

The phenomenological researcher is presented with the challenge to "reveal the meaning of the task: to understand and accurately capture the experience of the participant" (Knaack, 1974, p. 110). The perceived world is a totality in which relations are comprised and organized; a totality open to an infinite variety of perspectives, merging, for each individual, into a unique lived style (Boyd, 1988).

Boyd (1988) also agreed with other writers that multiple realities are possible owing to the fact that there are multiple capacities for awareness and expression. The range of human expression, or ways to present one's awareness, strengthens links to the world through bodily involvement with things, others, and one's self. Boyd (1988) stated:

> The idea of existence as an embodied consciousness intending toward a world of things and others eliminates traditional conceptions of subjective and objective. For any given person, existence is involvement in a world . . . . I can know the world only through my bodily involvement with it. This way of knowing is individual and unique . . . . (p. 71)

According to Boyd (1988), phenomenology "takes us not only into a world of new words, but also into radically different ways of thinking" (p. 66). Speaking to the educational correlation to phenomenology, Boyd (1988) posited "a phenomenological perspective is antithetical to a curriculum process that established fixed patterns to be imposed on the particularities of students and teachers" (p. 67).

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The social situation that a nurse is involved in is constituted by the knowledge the nurse brings to work and the meanings brought to and found in the nursing situation. Boyd (1988) believed nurses have choices concerning the perspective they assume in the world. This allows nurses to have power over the nursing reality they constitute. Citing the relevance to nursing education, Boyd observed nursing educators transmit a nursing culture to students by teaching them what nursing is, who nurses are, and the character of nursing situations; in other words, educators teach them a nursing perspective. Two very relevant questions to this research are asked by Boyd (1988):

> In view of the potential and need for diversity within the nursing perspective, what attention is given to the individual student's biography and its blend with the nursing perspective? What alternatives are extended to students to create a personal style that reflects a unique integration of their lives? (p. 77)

She cautioned that the nurse educator's reality is not the student's.

Boyd (1988) noted the nurse's role with its knowledge, skills, and perspective is, as Merleau-Ponty (1962/1978) would say, a "voluntary adoption of a position" (p. 355) from which truths are constructed. Informed by experience in coexistence, the nurse can assume her or his role and therefore, can construct objective understandings which are continuous with lived reality. Boyd (1988) believed this is accomplished by "disciplined reflection and active efforts to increase awareness, assume new perspectives, and perceive anew" (p. 79). Additionally, nurses reach toward the world through their roles. "Acting in the world, they are in simultaneous contact with the world and self in nursing experience" (Boyd, 1988, p. 79).

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Schutz (1970) postulated the aim of understanding another person has two meanings: understanding one's lived experience of the other and understanding the lived experience of the other person. Boyd (1988) stated imagining the experience of suffering by a patient enables the nurse to transcend perception of the patient as object by calling upon personal experiences of suffering. This can be done because the nurse has experienced the patient in coexistence; "the patient is one whose relation to the world is constituted like our own" (Boyd, 1988, pp. 80-81). Boyd asserted the nurse's past experience with suffering may have been a vicarious experience but this is helpful in understanding another's actual experience of suffering.

A nurse can utilize the reflective mode of awareness to disengage as much as possible from her or his "historicity" (Boyd, 1988, p. 82) in order for personal perception to be more fully revealed. "One can 'stand over against' his or her existence in experience by recalling experience and thinking back on it" (p. 82).

Boyd (1988) argued that phenomenological approaches are needed by nurses in order that perspectives may be clarified and to understand the meanings these perspectives bring to nursing practice situations. Boyd (1988) stated:

> Meaning . . . is generated in nursing experience. Our concepts about nursing need . . . to take direction from the experience of nursing. In modes of awareness that reduce the layers of meaning superimposed on experience by our values, beliefs, and knowledge, we can expect to find experience presented in ways that adhere more closely to lived experience. Intuiting, empathizing, imagining, and reflecting awarenesses each seize the world from a particular grasp of meaning in experience. (p. 83)

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Ray (1985) advocated the use of qualitative methods such as phenomenology to conduct research because nursing has both scientific and humanistic care dimensions. Through the use of descriptions of experiences, the "discovery of universality" (Ray, 1985, p. 85) is permitted and the meaning of holistic values and comprehensive approaches to caring for others are explicated. Merleau-Ponty (1962/1978) emphasized that phenomenology "seeks to recover a naive contact with the world" (p. vii) and on the other hand it "is not a reflection of a previous truth, but like art, brings a truth into being" (p. xx). Burch (1989) asserted phenomenology in constituting itself:

> . . . must constitute a truth not yet realized within lived experience and thus in some sense other than our everyday self-understanding; and in constituting itself, it must appropriate a truth already immanent in the intelligibility of lived experience and thus in some sense an essential part of our everyday self-understanding. (p. 195)

Emphasizing another attribute of phenomenology, van Manen (1990) posited reflection is not introspective but retrospective. Reflection upon lived experience is always recollective because it is reflection on experience that is already passed or lived through. Delineating other characteristics of phenomenology, van Manen (1990) observed it is a systematic, explicit, self-critical, and intersubjective study of its subject matter. It is explicit in that it attempts to articulate, through the content and form of text, the structures embedded in lived experience. The self-critical attribute is the sense that it continually examines its own goals and methods in an attempt to come to terms with the strengths and shortcomings of its approach and achievements. Phenomenology is intersubjective because the human science researcher needs the

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other in order to develop a dialogic relation with the phenomenon and thus validate the phenomenon as described. It is systematic in that it uses special modes of questioning, reflecting, focusing, intuiting, and others (van Manen, 1990).

Swanson-Kaufmann and Schonwald (1988) found that four basic strategies are inherent in the phenomenological method: bracketing, analyzing, intuiting, and describing. An essential requirement of phenomenological research is the identifying and setting aside of preconceived ideas, assumptions, and expectations of the researcher; this is entitled "bracketing." Bracketing is the holding in abeyance of all elements or assumptions that may limit the researcher in maintaining an open mind during the research process. This suspension of the researcher's beliefs and expectations is essential to understand the meaning of the lived experience for the subject. Bracketing should occur both prior to and during the actual data gathering in an attempt to accurately portray the reality of the informants.

Swanson-Kaufmann and Schonwald (1988) postulated "because phenomenological inquiry is a process with unclear beginning, conclusion, and a continuous effort to reconcile personal knowledge and beliefs with the witness of informants, several leaps of faith are necessary" (p. 99). The first element of faith is that the experiences and knowledge of the researcher, while valid, may not be the reality of the informants. Second, the researchers must believe they are capable of eliciting and hearing the reality of those they seek to describe. Third, it must be believed that the personal stories of the informants will express

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reality sufficiently unique or cohesive so that any a priori assumptions of the researcher will not influence their interpretations (Swanson-Kauffman & Schonwald, 1988).

Phenomenological research, according to Swanson-Kauffman and Schonwald (1988), requires the rigorous gathering and analyzing of interview data which constitute the empirical aspect of the method of study. This phase of research involves establishing a plan through which data may be located, gathered, recorded, sorted, retrieved, condensed, and verified.

Regarding the intuiting phase of phenomenological research, Swanson-Kauffman and Schonwald (1988) declared the "outcome of phenomenological inquiry depends on the researcher's ability to engage with the informant's reality" (p. 101). The intuitive phase of data gathering and analysis requires that the investigator approach each informant's study with an empathic sense and to be hyperattentive to both personal and informant's thoughts and feelings about the data. In the final stages of phenomenological analysis, intuiting becomes an exercise that involves continuous critical reflection and discussion of concepts as they emerge from the researcher's experience of the multiple informants' reality. Swanson-Kauffman and Schonwald (1988) explained:

> When a phenomenon is finally understood, and its processes or categories identified, the researcher will find that new, incoming, empirical data will seem to fit or be subsumed under the now-defined categories. Being able to fit problematic situations under previously identified concepts is the hallmark of a saturated description of a phenomenon. (p. 103)

The final strategy prevalent in most phenomenological research is describing. If the investigator has truly described the components or categories

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of the phenomenon, then anyone who has experienced the phenomenon should be able to analyze his or her own reality with the identified components or categories (Swanson-Kauffman & Schonwald, 1988). This is the test of the success of this strategy.

The constant comparative method is a method of data analysis frequently utilized with qualitative research. According to Glaser and Strauss (1967), the purpose of this method is to generate theory more systematically by using explicit coding and analytic procedures. The constant comparative method is concerned with generating and plausibly suggesting many categories, properties, and hypotheses. Throughout the research process, as new data are obtained, they are constantly compared with previously collected data. The data are analyzed for their similarities and differences and are included in previous categories or coded as a new category. Categories are integrated or expanded until a unified whole emerges which becomes the predominant theoretical framework. As categories and properties emerge, develop in abstraction, and become related, their accumulating interrelations form an integrated central theoretical framework--the core of the emerging theory (Glaser & Strauss, 1967). Glaser and Strauss (1967) explained it in this manner:

> The truly emergent integrating framework, which encompasses the fullest possible diversity of categories and properties, becomes an open-ended scheme. It is open-ended because, as new categories or properties are generated and related, there always seems to be a place for them in the scheme. For substantive theory, the analyst is very likely to discover an integrating scheme within the data, since the data and the interrelations of the theory are grounded and lie so close together. (p. 41)

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Naturalistic Inquiry

Lincoln and Guba (1985) included phenomenology as another alias for the alternative paradigm of research they call "naturalistic inquiry" (p. 7). They elucidated some axioms of the naturalistic paradigm, and these served as methodological assumptions for my doctoral research. These axioms/assumptions are as follows:

1. There are multiple, constructed realities that can only be studied holistically. Inquiry into these multiple realities will inevitably diverge so that prediction and control are unlikely outcomes although some level of understanding can be achieved.
2. The inquirer and the "object" of inquiry interact to influence one another. The knower and the known are inseparable.
3. The aim of inquiry is to develop an idiographic body of knowledge in the form of "working hypotheses" that describe the individual case.
4. All entities are in a state of mutual simultaneous shaping so that it is impossible to distinguish causes from effects.
5. Inquiry is value bound. (pp. 37-38)

Fourteen characteristics of operational naturalistic inquiry were delineated by Lincoln and Guba (1985); they contend these characteristics display a synergism such that, once one is selected, the others more or less follow. These characteristics include: (a) a natural setting or context should be utilized because

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naturalistic ontology suggests that realities are wholes that cannot be understood in isolation from their contexts, nor can they be fragmented for separate study of the parts, (b) humans are the primary data-gathering instruments, (c) tacit (intuitive, felt) knowledge is legitimate because often the nuances of the multiple realities can be appreciated only in this way, (d) qualitative methods are preferable to quantitative owing to the fact that they are more adaptable to dealing with multiple (and less aggregatable) realities, (e) purposive or theoretical sampling is the choice because it increases the scope and range of data exposed, (f) inductive data analysis is preferred because it is more comprehensive than deductive measures, (g) the guiding substantive theory emerges from or is grounded in the data because no a priori theory could possibly encompass the multiple realities that are encountered, (h) the research design emerges rather than being constructed a priori since it is impossible to know ahead of time about the many multiple realities to devise the design adequately, (i) meanings and interpretations are negotiated with the human sources from which the data have chiefly been drawn because it is their constructions of reality that the inquirer seeks to reconstruct, (j) the case study reporting mode is preferable to the scientific report, (k) idiographic (i.e., in terms of the particulars of the case rather than in lawlike generalizations) interpretation is used, (l) focus-determined boundaries are set, and (m) special criteria for trustworthiness (credibility, transferability, dependability, and confirmability) are used rather than the conventional trustworthiness criteria of internal and external validity, reliability, and objectivity.

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Within the naturalistic paradigm, designs must be emergent rather than preordinate (Lincoln & Guba, 1985). They listed four reasons for the use of emergent design: (a) meaning is determined by context to such a great extent, (b) the existence of multiple realities constrains the development of a design based on only one (the investigator's) construction, (c) what will be learned at a site is always dependent on the interaction between researcher and context, and the interaction is also not fully predictable, and (d) the nature of mutual shapings cannot be known until they are witnessed. Lincoln and Guba (1985) portended "as the inquiry proceeds, it becomes more and more focused; salient elements begin to emerge, insights grow, and theory begins to be grounded in the data obtained" (p. 209).

In order for the design to emerge, the researcher must engage in continuous data analysis, so that every act of investigation takes into account everything that has been learned so far (Lincoln & Guba, 1985). These authors cautioned that the steps of purposive sampling, inductive data analysis, development of grounded theory, and specification of next steps in an emergent design interact and are reiterated multiple times in the course of any particular study.

Research Design

The research design used in my study was a phenomenological approach in which naturalistic inquiry attributes were utilized to generate an understanding of the lived experience of nursing students as they cared for individuals who were suffering. The research design consisted of four iterative steps: purposive

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sampling, intensive interviewing, inductive data analysis utilizing Giorgi's (1985) method, and uncovering the essential structure of the phenomenon.

Giorgi's (1985) method contains four essential steps:

1. Read the entire description in order to get a general sense of the whole statement.
2. Re-read the text with the specific aim of discriminating meaning units with a focus on the phenomenon being researched.
3. Reflect on the delineated meaning units and express the insight contained in them more directly.
4. Synthesize the transformed meaning units into a statement regarding the structure of the experience.

Speaking to the use of phenomenology, Giorgi (1985) explained:

> What differentiates the phenomenologically inspired method is the fact that a disciplined spontaneity is allowed to function whereby one first discovers the relevant meaning unit, or its category, and only later, based upon a subsequent analysis, explicates its actual full import. (p. 14)

I have 25 years of experience as a nurse educator and have taught the concept of pain for 20 years. Additionally, my master's thesis was on the concept of pain. I have given many presentations and written articles and a chapter in a medical-surgical textbook on the topic of pain and pain management by nurses. The expert and tacit knowledge related to the concept of pain and the knowledge gained from indepth research of the literature on suffering and phenomenology lead me to conclude the questions listed in the next paragraph were relevant for this study.

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Generic (i.e., all students with the exception of those who are registered nurses) undergraduate nursing students were asked the following introductory question in a taped interview: What level of student are you in college? The specific research question was, "What has been your experience in caring for an individual who was suffering?" Other questions that were asked are discussed in the procedures sections.

Setting

The setting for this study was in the southeastern part of the United States. Undergraduate nursing students were selected from a large university.

Sample

The sample population was taken from all generic undergraduate nursing students at a large university. A purposive, nonprobability sampling technique was employed. With purposive sampling, informants are selected because they are representative of the population of interest, in this case, generic undergraduate nursing students who have cared for someone who was suffering. The sample was small, 12 students, in keeping with the aim of illuminating and describing the richness of individual experience.

Procedures

Prior to interviewing any participants, I posed the research questions to myself in order to suspend and uncover presuppositions, beliefs, and biases about the study's phenomenon and to facilitate reflective awareness.

A copy of the study proposal and a copy of the informed consent form were submitted to the Institutional Review Board of the large university in order

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to secure approval to conduct the study utilizing students at that college. Also, the procedure for obtaining approval from the Georgia State University Institutional Review Board (where I was a doctoral student) was followed.

Upon receiving approval to conduct the study, written request/announcement forms were distributed to nursing faculty conducting classes. Faculty were asked to request student participation in this dissertation research. The request/announcement forms briefly summarized the purpose of the study and asked for volunteers. Participants were obtained by requesting students who have cared for someone they perceived to be suffering to be part of a research study to gain understanding of the experience of nursing students as they cared for these individuals. Places to sign their name and list their phone number were on the form. In order to obtain 12 volunteers who represented the different levels or classes of students within the institution, one student was selected from the first name-space on each request/announcement form. Subsequent students were selected from the second name-space on each request/announcement form continuing this procedure until 12 participants and 3 alternates were obtained. If one form did not contain the same number of students as the others, the next student on the next successively numbered form was the participant. Also, three students were obtained to serve as alternates in the event any of the first 12 volunteers were unable to participate.

Students who volunteered were told the purpose and possible benefits from the study and informed about the interview procedure. They were also told there was no foreseeable risk or discomfort involved by participating in this study.

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Participants were told they would be audiotaped and that the researcher would be making some notations during the interview. These notes included any observations deemed by the researcher to be relevant such as, nonverbal behavior and conditions of the environment. Students were told their names would not be recorded on any notes or transcripts from the interviews. Only the researcher and her Georgia State University dissertation committee had access to data during the study. All tape recordings were destroyed after the study was completed. Interview transcripts will be kept by the researcher indefinitely.

Participants were instructed there was no monetary compensation for participating in this study. The completed study was written as a dissertation as part of my doctoral studies. The results of this study will be used to prepare scholarly papers and presentations but the participants will never be individually identified. They were told they could ask any questions they wished at any time during the study. If they agreed to participate, students were asked to sign an informed consent form. The signed consent form was kept separate from the other study data and was not matched by code name or number.

Interview times were scheduled with participants. They were told the interview should last approximately one to one and one half hours. I was the sole interviewer. The purposes and method of study were approved by the appropriate human subjects research committees of Georgia State University and the selected institution prior to any interviewing.

The above information and instructions were verbally reviewed with each participant before the audiotaped interview was begun. A semi-structured

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interview guide was utilized. Questions were asked by the researcher throughout the interview to clarify content.

The nursing students were asked an introductory question: What level of nursing student are you? The main question asked was: What is it like to care for an individual who is suffering? Within this main question, several subcategories of questions were included, such as: (a) What were your thoughts, perceptions, and feelings about this situation? (b) Please describe what "suffering" is to you. (c) Did you have sufficient educational or life experiences to care for this individual? If yes, what were some significant experiences? (d) How did you "know" the person was suffering? (e) How did you learn to care for an individual who was suffering? (f) Did this experience cause you to question whether you wanted to continue in your nursing studies or influence you to desire to work in a particular specialty area after graduation? If yes, describe the effect it had upon you. (g) Did you or others intervene to mitigate or reduce the suffering of this person? If yes, describe what was done and its effects. How did this make you feel? The final question was: Please describe anything more about your experience with caring for this individual who was suffering that you believe to be important and about which we have not talked. The focus of all these questions was on the lived experience rather than the process of experiencing.

Analysis of Data

Audiotaped interviews were transcribed verbatim and observations were added at the appropriate places in the typed version of the interview data. The

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data were analyzed utilizing the four-step process delineated by Giorgi (1985). First, I read the entire description of each participant several times in order to get a general sense of the whole statement. Giorgi (1985) stated that nothing is more involved than a simple reading of the text and the ability to understand the language of the describer. Multiple readings may be necessary in order to get a grasp of the "sense of the whole" (p. 10). Second, the text was re-read with the specific aim of discriminating meaning units with a focus on the phenomenon being researched. Giorgi (1985) said "since one cannot analyze a whole text simultaneously, one has to break it down into manageable units" (p. 11). He believed meaning units are segments of data that potentially reveal some aspect of the phenomenon. The third step was to reflect on the delineated meaning units and express the insight contained in them more directly. The final step was to synthesize the transformed meaning units into a statement regarding the structure of the experience. This final step uncovered the general description of the phenomenon being studied.

Trustworthiness

According to Lincoln and Guba (1985) the basic question in relation to trustworthiness is:

> How can an inquirer persuade his or her audiences (including self) that the findings of an inquiry are worth paying attention to, worth taking account of? What arguments can be mounted, what criteria invoked, what questions asked, that would be persuasive on this issue? (p. 290)

Qualitative criteria identified by Lincoln and Guba were utilized in my study to establish the trustworthiness of the findings. In Guba and Lincoln's (1989)

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opinion, the four concepts of credibility, transferability, dependability, and confirmability are the naturalist's equivalents to the rigor criteria used within the conventional research paradigm for many years. The conventional criteria for judging the rigor of inquiries include: internal validity, external validity, reliability, and objectivity. According to Guba and Lincoln, these terms make clear the inappropriateness of the conventional terms when applied to naturalism and provide alternatives that stand in a more logical and derivative relation to the naturalistic axioms. The four criteria, as delineated by Lincoln and Guba (1985), which were utilized for my naturalistic, or qualitative, inquiry are discussed in the following paragraphs.

The first means by which Lincoln and Guba (1985) believed the qualitative researcher can meet the trustworthiness criteria is the process of credibility. Credibility was established in my study by utilizing the technique of persistent observation. Lincoln and Guba (1985) noted "the purpose of persistent observation is to identify those characteristics and elements in the situation that are most relevant to the problem or issue being pursued and focusing on them in detail" (p. 304). My study focused on exploring what were perceived to be salient factors in an interview situation and then exploring them in detail.

Transferability is the second means devised by Lincoln and Guba (1985) to establish trustworthiness. They suggested the establishment of transferability is very different from the establishment of external validity by the traditional researcher. The qualitative researcher can only set out working hypotheses together with a description of the time and context in which they were found to

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hold. My study provided the thick description necessary to enable someone interested in making a transfer to reach a conclusion about whether transfer can be contemplated as a possibility.

The third and fourth means to establish trustworthiness, dependability and confirmability, were established in my research by an inquiry audit. The members of my dissertation committee served as auditors of the process by which the interview records were kept and the records from the point of view of their accuracy. In determining the acceptability of the records, these individuals attested to the rigor and dependability of the inquiry. Examination of the product of the research--the data, findings, interpretations, and recommendations--and the attestation that it is supported by data established the rigor and confirmability of the inquiry.

Protection of Human Participants

Approval for the study was secured from the Georgia State University Institutional Review Board (where I was a doctoral student) and from the selected university.

Interviews were audiotaped with the participants' prior and informed signed consent. Participation in the interview was further evidence of consent. Participants were given an opportunity to sign the consent form (Appendix A) and to ask me any questions they had about the research process.

All interview and observational data were coded with identification numbers so that confidentiality was maintained. Recorded interviews were kept

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in a locked file with access restricted to the investigator. All tapes were destroyed upon completion of the study.

Summary

A phenomenological perspective was selected as the research method of choice for my dissertation because as Scudder and Mickunas (1985) contended:

> . . . the student's being-in-the-world must be understood as a complex system of horizons of the lived world. Such a lived world is fundamentally intersubjective, not a detached "objective" thing about which the study may learn without any involvement in it. (p. 22)

The purpose was to illuminate the lived experience of nursing students when they cared for individuals who were suffering. The rationale for utilizing a qualitative research method such as phenomenology was explicated in this chapter. It was acknowledged that implicit in the phenomenological perspective is the realization that conducting research must always question the way the world is experienced. The research design consisted of four iterative steps: purposive sampling, intensive interviewing, inductive data analysis utilizing Giorgi's (1985) method, and uncovering the essential structure of the phenomenon. Information relative to the setting of the study, the participants, the sampling technique, procedures for data collection, analysis of data, establishing trustworthiness, and the protection of human participants was discussed.

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CHAPTER IV

RESEARCH PROCESS

The research design consisted of a phenomenological approach in which naturalistic inquiry attributes were utilized to generate an understanding of the lived experience of nursing students as they cared for individuals who were suffering. The research design involved four iterative steps: purposive sampling, intensive interviewing, inductive data analysis utilizing Giorgi's (1985) method, and uncovering the essential structure of the phenomenon. This chapter is a discussion of the process and context of the inquiry through the iteration of the first three steps: purposive sampling, intensive interviewing, and inductive data analysis utilizing Giorgi's method. Information discussed in this chapter provides an audit trail of my decisions in the process of the inquiry. The provision of this audit trail will enable the reader to understand how the participants were selected, data were generated, and rigor and trustworthiness were accomplished.

Inquiry Process

Twelve generic undergraduate nursing students participated in this study. Each participant signed a consent form indicating voluntary and informed participation in this study (Appendix A). Written request/announcement forms were distributed to five faculty members each of whom were teaching in a different nursing course at the selected school of nursing. Three different levels

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(sophomore, junior, and senior) were represented in the courses taught by these five faculty members. The faculty were requested to distribute the request/announcement forms to the students in their classes and to ask students who had cared for someone who was suffering to sign up to be interviewed. The request/announcement forms briefly summarized the purpose of the research as being a study to gain understanding of the experience of nursing students as they cared for someone who was suffering. Places to sign their name and phone numbers were provided on the request/announcement forms. The request/announcement forms were returned to the researcher. Twenty two nursing students signed up as volunteers for the study.

In order to obtain 12 participants who represented different levels or classes of students within the institution, one student was selected from the first name-space on each request/announcement form. Subsequent students were selected from the second-space on each request/announcement form continuing this procedure until 12 participants and 3 alternates were obtained. The forms did not all have the same number of volunteers; therefore, the next student on the next successively numbered form was the next participant. Three students were obtained to serve as alternates in the event any of the first 12 volunteers were unable to participate. Two of the original 12 volunteers did not show up for their interviews and a third person canceled because of a family emergency but rescheduled the interview at a later time. Therefore two of the three alternates were utilized as participants in the study.

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I contacted volunteers by telephone and times and locations were arranged for the interviews. The interviews were held in a natural setting or a site chosen by the participants. Nine of the interviews were conducted on the campus of the selected university and three interviews were conducted on the campus of the college of nursing where I was employed. All interviews were set up at the convenience of the participants.

Before the interview began, I gave the consent form to the participants and emphasized that their names or any names they mentioned during the course of the interview would not be transcribed or used in any manner. The signed consent forms were kept separate from the other study data. Participants were told they would be audiotaped and that I would be making some notations during the interview. Only the members of my dissertation committee and I had access to the data during the study. All tape recordings were destroyed. The only information that does exist is the transcribed interviews which contain no identifying information.

The participants were told the interview should last approximately one to one and one half hours. However, no time limit was placed on the interview. The interviews continued until the participants felt they had exhausted their descriptions of the experience.

The introductory question asked of the participants was: What level of nursing student are you? The main question asked was: What is it like to care for an individual who is suffering? Within this main question, several subcategories of questions were utilized as a semi-structured interview guide. For

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the majority of individuals who were interviewed, I did not have to ask these questions because the participants answered the questions as a part of describing their experience of caring for an individual who is suffering. The questions were: (a) What were your thoughts, perceptions, and feelings about this situation? (b) Please describe what "suffering" is to you. (c) Did you have sufficient educational or life experiences to care for this individual? If yes, what were some of these significant experiences? (d) How did you "know" the person was suffering? (e) How did you learn to care for an individual who was suffering? (f) Did this experience cause you to question whether you wanted to continue in your nursing studies or influence your desire to work in a particular specialty area after graduation? If yes, describe the effect it had on you. (g) Did you or others intervene to mitigate or reduce the suffering of this person? If yes, describe what was done and its effects. How did this make you feel? The final question was: Please describe anything more about your experience in caring for this individual who was suffering that you believe is important and about which we have not talked. In an attempt to obtain more information regarding what the participants believed would have helped them or other nursing students to care for these individuals who were suffering, I asked them to describe what they would recommend that nursing educators teach them about this phenomenon.

It is interesting to note that with only two exceptions, the participants seemed very uncomfortable talking about their experience, particularly in the initial minutes of the interview. It appeared to me that they were very eager "to tell everything at once"; their words were very hurried and some of their

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nonverbal behaviors (such as tears, red flush covering their neck and/or face, twisting of body, wringing of hands, etc.) could indicate they were anxious about sharing these experiences. Yet no one appeared eager to leave after the interview had ended. After the recorders were stopped and I was gathering my materials, the majority continued to talk (despite having been given the opportunity during the interview to say anything else they felt was needed to explain their experience). Four of them commented after the taping was completed that they were so glad, relieved, and happy to have been able to finally share their experiences with someone. I was repeatedly thanked by the participants for "allowing" and "permitting" them to talk about these experiences with suffering individuals. The interviews seemed to be a means of catharsis for these participants.

Audiotaped interviews were transcribed verbatim and observations were added at the appropriate places in the typed version of the interview data. Each audiotape was listened to by me to verify the completeness of the typed transcripts. During the process of listening to the audiotapes, I listened for the participants' expressed or implied meanings and made notations on the typed transcripts. Expressive tonality of language was duly noted.

Utilizing Giorgi's (1985) method, I intuited and reflected on each participant's audiotape and transcription separately in order to understand the experience as described by the nursing student. Next all transcriptions were read in order to get a general sense of the whole statement. The entire text was re-read with the specific aim of discriminating meaning units with a focus on the

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experience of the nursing student in caring for someone who was suffering. Throughout the research process as new data were obtained, they were constantly compared to the previously collected data. The data were analyzed for their similarities and differences and included in previous categories or meaning units. I then reflected on the meaning units and expressed the insight contained in them. Finally the transformed meaning units were synthesized into a statement regarding the structure of the experience.

Methodological Rigor

Guba and Lincoln (1989) believed one way to establish methodological rigor is through the use of the trustworthiness criteria of credibility, transferability, dependability, and confirmability. They stated these criteria for judging the goodness, quality, or adequacy of an inquiry are called "parallel" or "foundational" (p. 233) criteria because they are intended to parallel the rigor criteria that have been used within the conventional research paradigm for many years. The conventional criteria for judging the rigor of research endeavors include internal validity, external validity, reliability, and objectivity. The qualitative criteria as identified by Lincoln and Guba (1985) and Guba and Lincoln (1989) were utilized in this study to establish the rigor or trustworthiness of the research.

Credibility

The credibility criterion is considered to be the parallel to internal validity in that "instead of focusing on a presumed 'real' reality, 'out there,' the focus is moved to establishing the match between the constructed realities of respondents

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and those realities as represented by the evaluator and attributed to various stakeholders" (Guba & Lincoln, 1989, p. 237). Credibility was established in my study by utilizing the techniques of persistent observation and peer debriefing.

Persistent observation occurred through the actual interviewing of the participants, transcribing the audiotaped interviews, listening to the audiotaped interviews to verify completeness of the typed transcripts, listening to the audiotapes in order to acquire an understanding of the expressed or implied meanings, analyzing the data, and writing observational notes both during and after the interviews. Direct observation of the participants during the interview process was an additional example of persistent observation.

Peer debriefing, through the use of two expert researchers, was the second technique utilized in establishing credibility. The expert researchers were two members of my dissertation committee. These individuals engaged me in extensive discussions of the experience of conducting the interviews, the actual transcribed interviews, the identification of significant statements from each of the interviews, the identification of the aggregate significant statements and thematic descriptions, the delineated themes or meaning units, and the verbatim statements used as illustrations of the themes or meaning units. They posed searching questions in order to help me understand my tacit and implicit beliefs, values, interpretations, and role in the research process.

Dependability

"Dependability is parallel to the conventional criterion of reliability, in that it is concerned with the stability of the data over time" (Guba & Lincoln,

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1989, p. 242). Dependability was established in my study by means of an audit or decision trail throughout the research process. The research process is documented in the audit trail described in the beginning of this chapter. Members of the dissertation committee served as auditors by evaluating the process and judging the methodological decisions that were made by me.

Confirmability

Confirmability is parallel to the conventional criterion of objectivity (Guba & Lincoln, 1989). Confirmability is like objectivity in that it is concerned with assuring that data, interpretations, and outcomes of inquiries are rooted in contexts and persons apart from the researcher and are not simply figments of the researcher's imagination (Guba & Lincoln, 1989). In a naturalistic inquiry, the assurances of integrity of the findings are rooted in the data themselves. "This means that data (constructions, assertions, facts, and so on) can be tracked to their sources, and that the logic used to assemble the interpretations into structurally coherent and corroborating wholes is both explicit and implicit in the narrative of a case study" (Guba & Lincoln, 1989, p. 243).

I used bracketing to assure confirmability. In bracketing I set aside personal and theoretical assumptions of the phenomenon of caring for individuals who are suffering. This bracketing occurred at the beginning of the study and rigorous attempts were made throughout the research process to not impose prior knowledge on the emerging data. Personal assumptions were made prior to the data collection and listed in Chapter III. Two members of the dissertation committee reviewed the verbatim transcriptions of all 12 interviews and the

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subsequent compilation of significant statements from all 12 interviews. Extensive discussion of these significant statements and subsequent identification of themes or meaning units were held between members of the dissertation committee and me. Examination of the product of the research--the data, findings, interpretations, and recommendations--and the attestation that is supported by data establishes the rigor and confirmability of the inquiry.

Transferability

Transferability is the fourth means to establish trustworthiness. It may be thought of as parallel to external validity or generalizability (Guba & Lincoln, 1989). In naturalist inquiry, the researcher cannot specify the external validity of the inquiry; the researcher can provide only the thick description necessary to enable someone interested in making the transfer to reach a conclusion about whether transfer can be contemplated as a possibility (Lincoln & Guba, 1985). The thick description for my research is provided in Chapter V. Researchers can decide whether the data base provided by my research allows transferability or applicability to other settings.

Summary

The purpose of this chapter was to describe how the research plan was actually carried out. Information was provided relative to the audit trail which described my decisions concerning the process of the inquiry. Other researchers may analyze the rigor and trustworthiness of this qualitative inquiry through the thick description and the explication of the research process.

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CHAPTER V

FINDINGS AND DISCUSSION

The purpose of my study was to illuminate the lived experience of nursing students when they cared for individuals who were suffering. The use of the phenomenological method as the research design was congruent with the purpose of this study. This chapter presents the major meaning units (Giorgi, 1985) or themes of the data.

Twelve generic undergraduate students enrolled in a baccalaureate nursing program in the southeastern part of the United States were the participants in this research. Ten of the students were females and two were males. At the time of the interviews, two students were sophomores, five were juniors, and five were seniors. Four of the senior students were graduating within one to two weeks after their interview. Although participants were not asked their ages, the majority announced their ages either during the interview or after completion of the taping. One student was in her fifties, three were in their forties, three were in their thirties, and two were in their twenties; the remaining three students appeared to be in their late twenties. At least three had bachelor's degrees in areas other than nursing and one person had a master's degree in another discipline. All twelve participants were employed in various jobs in order to earn money to attend school and, in some situations, to support a family.

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Five meaning units, or major themes, emerged from analysis of the data: remembering/knowing, listening/voicing, attending, standing inside/standing outside, and being with. The most ubiquitous and powerful theme to emerge was that of remembering/knowing. All participants remembered in vivid detail the experience of caring for an individual who was suffering.

Remembering the experience of caring for one particular individual invariably became linked with descriptions of how that event had influenced subsequent instances of caring for others who were suffering. The experience of caring for someone who was suffering became a profound stimulus for making a difference in the nursing profession. For many, the experience of caring for an individual who was suffering led them to select nursing as a career or caused them to choose to work in a particular specialty area in nursing, such as oncology or home health, during the time they were in school and after graduation. For one individual, the experience as a medic of caring for a close friend who died during the Vietnam War caused him to avoid nursing for over twenty years but inevitably led him to say he was "coming back."

This major theme of remembering/knowing had another element which was knowing the experience of suffering. Four fundamental patterns of knowing have been identified by Carper (1978): empirical, personal, ethical, and esthetical. All four of these ways of knowing or thinking about phenomena were evidenced in the data from the interviews.

The theme of remembering/knowing became more and more dense until it became fully saturated early in the interviewing process. Methods and conditions

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under which remembering/knowing occurred were elucidated and became the core theme of the research.

The second meaning unit or theme which emerged actually resulted from a folding in of one theme that seemed not to stand alone as strongly as the other five themes. Listening/voicing describes the listening by and voicing of the student. The voices of other individuals, such as the person who was suffering or the family or friends of those suffering or the nurse educators who were teaching the student, are also described in this dense theme. The preliminary theme which was folded into this category was that of attending to the personal. The voices of the students seemed to fit better in the meaning unit of listening/voicing rather than being alone in a category. The students voiced how they were physically, psychologically, and spiritually affected by the suffering they witnessed. They also delineated challenges they faced in preparing themselves to endure similar experiences in the future.

Describing the influence of nurse educators or nurses within the clinical settings was a strong category of listening/voicing. The voices of educators were very prevalent in the data generated from the interviews. Another powerful subtheme of listening/voicing was describing the feelings of frustration and powerlessness experienced by students when they challenged the poor quality of care given by some nursing personnel to suffering individuals or their families.

A fifth element of the listening/voicing theme was discovering self. Participants shared how they had "grown" from the experience, how they were

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"challenged," and how they experienced different emotions forcing them to reflect deeply upon the meanings of the experience of suffering.

Attending was the third major theme which developed and became saturated early in the interview process. All participants explicated what they did to care for and nurture the personhood of the individual who was suffering. Participants evidenced deep compassion for the individual who was suffering and others in similar situations. Especially strong within this category was the expression by the majority of participants that the individual who was suffering must have her or his pain managed at any cost. Individualizing the care of each person who was suffering was another predominate subtheme of attending.

The fourth theme, standing inside/standing outside, also became saturated early in the interviewing process. The majority of the participants noted descriptively the paradoxical coalescing they experienced. They wanted to care for the individual who was suffering but were disturbed by the feeling that they needed to "distance" themselves in order to protect their "vulnerability" and to allow time to recover and, thus, be able to care for others who were suffering. Language became replete with apologies and guilt feelings as they described this paradox of desiring to be with the person who was suffering while at the same time wanting to be on the outside comforting themselves.

The fifth theme, being with the family, describes the preeminent position of the family of the person who is suffering. Identified by all participants, this meaning unit became saturated early in the interview process. Students declared emphatically that the family must be acknowledged and cared for as well as the

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person who is suffering. Subthemes of this category included listening/communicating, caring/showing compassion, and connecting/putting oneself in the family's shoes.

The five meaning units described above were the core themes that emerged from the data. Each theme will be discussed and illustrated with verbatim quotes and illustrations. Listed below is the outline of the meaning units and their subthemes. Following the outline, each theme will be discussed and illustrated with verbatim quotes and descriptions.

MEANING UNITS OR THEMES WITH SUBTHEMES

1. REMEMBERING/KNOWING

**described the experience of suffering

(a) remembering the experience

(1) experiencing it

(2) anger

(3) sadness/loss

(4) being there

(5) frustrating/powerlessness

(6) emotionally draining

(b) making a difference

(c) knowing the experience

(1) defining the phenomenon

(2) personal knowing

* experiential knowing

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* interpersonal knowing

* intuitive knowing

(3) empirical knowing

(4) esthetical knowing

(5) ethical knowing

2. LISTENING/VOICING

**described the listening by and voicing of the student; the voice of others is heard through the language of the student

(a) caring

(b) becoming educated

(c) emulating role models

(d) describing the lack of role models

(e) discovering self

3. ATTENDING

**described the caring and nurturing of the personhood of the suffering individual

(a) maintaining human dignity

(b) showing compassion

(c) respecting

(d) caring/nurturing

(e) managing pain

(f) individualizing

(g) connecting/putting oneself in the suffering person's shoes

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4. STANDING INSIDE/STANDING OUTSIDE

**described the paradoxical situation of being with and caring for an individual who is suffering while also needing or wanting to distance oneself to protect one's vulnerability

5. BEING WITH

**described being with the family and recognized the preeminent position of the family

(a) listening/communicating

(b) caring/showing compassion

(c) connecting/putting oneself in the family's shoes

Remembering/Knowing

The concrescence of the theme of remembering/knowing came rapidly as individuals remembered, with varied emotions, feelings, and reactions, their experiences of caring for individuals who were suffering. Frequently, participants used the phrase "making a difference" to describe the challenge of caring for someone who is suffering. Defining "suffering" presented a challenge for the majority of individuals who frequently equated it with pain in their empirical assessments of the individual who was suffering; yet all emphasized that pain was distinct from suffering. Delineation of how they knew someone was suffering yielded very significant statements regarding the ways or patterns of knowing. These ways of knowing were in concordance with the work of Carper (1978).

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Describing the experience of caring for persons who were suffering was difficult for some participants. One student summed the challenge of putting the experience into words in this manner:

> That's a hard question to answer because first off we may differ on what we mean by suffering. I don't necessarily mean someone that's in pain but someone who's got some problems that are clearly causing them distress of some sort. It may be a terminal illness or it might be a newly diagnosed chronic disease or it might be an emotional problem . . . it's gonna be different . . . for each person.

Remembering the experience of caring for a person who was suffering was described in the following ways.

Remembering the Experience

Remembering the experience of caring for someone who was suffering seemed to be very painful for many of the students interviewed. Describing the experience, which may have occurred several years before being interviewed, appeared to be a catharsis for participants. Some would say "Oh, this is difficult" then offer expressions of appreciation for being "allowed" to share this experience with someone. Three participants cried during the process of remembering the experience. The majority of participants evidenced nonverbal behaviors (such as tearing of eyes, repeated twisting in chair, red flush developing on the neck and/or face, and wringing of hands) which could indicate anxiety. The speech pattern of most of the students tended to be a rapid, often stuttering type of speech; it sounded as though the individuals wanted to share the experience all at one time. The difficulty exhibited by these students in voicing their experience may be analogous to Picard's (1991) beliefs about

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patients who are suffering. According to Picard, the stifling of one's voice may result from the unspeakable nature of the suffering, the fear of causing others to suffer, or the newness of the situation. This loss of voice or disconnection is part of the experience of suffering.

There were six aspects of the theme of remembering which emerged as being important to the meaning of the category. These elements were experiencing it, anger, sadness/loss, being there, frustrating/powerlessness, and emotionally draining. Each will be explained in more detail.

Experiencing It

A very common belief of participants was that a person must have experienced suffering in order to "really understand" its meaning or to "really be able to care" for an individual who is suffering. One participant related:

> I do think experiencing it yourself can help you. I think you have to experience it. It's sort of like pain, you know, you really can't say for sure but you have a better understanding of maybe what's going on and can relate.

Another participant, who had experienced suffering as a child watching her mother die from cancer, stated her struggle enabled her to relate to the children of a young woman who also died from cancer. She noted:

> I felt for her children because I knew that they were now parentless and you know, I just can identify in ways that people can't know. I think I view things a lot differently because of that. Both of my parents are deceased.

Speaking of having compassion for others who are suffering, one participant said:

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> I doubt seriously that it's something you have a priori; I think you have to have experience. You have to be yourself challenged or be in some kind of conflict or struggle before you have compassion for others.

Referring to understanding the suffering of family members, one student stated "it's hard to till you've been there. Now I know where they're coming from . . . ." This same student shared how he experienced suffering in Vietnam, where he served as a medic. He described the influence of this occurrence:

> I still suffer because of an incident in Vietnam. . . . one of my best friends and seven other guys . . . because of the way they were, and there was no hope for them. . . . to this day, twenty-three years later, I'm still suffering. . . because they never came home. . . . I suffer having to go face them at The Wall. I haven't been able to do that. . . . before I could get into nursing, I had to work through that . . . .

He continued his story by relating how his friend and the other men had been out a few days and did not return when expected. The medics needed what these men had and therefore, they went to find them. These men were found:

> . . . skinned alive, and disemboweled, between trees and still alive. [these men died] And we buried them . . . we left one of my best friends over there. So I haven't been able to go to The Wall yet. And that's been kind of eating at me, but when it came right down to it in the long run, that's the reason I'm in nursing now. Is to help maybe get over some of what I've been suffering but also that I could offer something to some people. (my friend) was suffering then. And I can't imagine how. I was the one that was holding what was left of him in my hands, and . . . . That was like him putting his head on my shoulder to me. . . . it took over twenty years to get over that, to be able to come back . . . and face somebody in bed.

Living with "parents [who] were sick and were very miserable people and both of them died very young" left a strong imprint upon one participant who learned to utilize her intuitive talents when she studied massage therapy prior to re-entering nursing school for the second time. She shared this about the effect

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of the teachings in massage therapy school and how her past experience with suffering came forth:

> . . . what they taught you was to feel what was going on with that body. . . . learning not to have my own agenda but see what that person's agenda was. I had already developed that unconsciously with my parents; they were both alcoholics and they . . . would rage and so I would learn when it was safe to come close and when . . . it wasn't and so . . . it was like I was tapping back into that.

Describing a past endurance of being sick for "two or three years" and frequently hospitalized, one student responded:

> I know how it is to be in there for such a long time and for no one just to not say anything to you, just leave you . . . in the room by yourself. . . . talk about being lonely now, that's the loneliest place you ever been. All day long by yourself and maybe somebody coming in . . . for a second or two or just come in and give you medication . . . or do what they have to do and run back out. And not even really . . . care.

The narration of one person who had endured suffering while caring for her grandfather, who had congestive heart failure and had experienced a stroke, illustrates many facets of this experience. She related:

> . . . I was so tired that I would wake up every hour thinking that I would hear him calling my name. . . . in the long run, when you think about suffering . . . you always go back and think "What could I have done?" . . . it's something that stays with you. . . . this happened five or six years ago. And it's something that stays with you from then on and you always try to apply it to another situation and you always wonder if you did or did not do the right thing.

Personal suffering affected these students in a multitude of ways. The final example of this major aspect of remembering the experience focuses on a student, who, at age 17, cared for her mother who was dying of cancer. Her anguish is vividly evident in this excerpt:

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> . . . it's really sad because at the same time I was going . . . through a lot of my own pain. But at the same time . . . I just wanted to make sure that she wasn't in such tremendous pain . . . her brain tumors were horribly painful. I've heard them described worse . . . than a migraine . . . you just want to bang your head on a wall. . . . self brutality to me is . . . just something. You've got to think, well, they're talking about suicide, they're talking about wanting to physically hurt themselves . . . they try to do anything to distract them from this continuous pain.

These narratives in which the students remembered the experience are very descriptive of their lived experience of caring for individuals who were suffering. Many emotions and feelings are reflected in their descriptions.

Anger

Anger was an emotion expressed by several students. Primarily their anger was directed toward individuals who thwarted their efforts to alleviate the suffering of the individual they were attending. Listen to the voice of one participant as she said ". . . I felt real frustrated and I felt angry with her for not caring . . . and then that fear about 'Oh, gosh I'm going to become hardened like that when I've been in practice for years, too.'"

In one instance, anger was directed against a faculty member who told her class: "You are either living or dead--there is no such thing as dying." During the interview for this study, the participant hit her hand very hard on the table and exclaimed "Well, that's not true!" She had witnessed the dying of her mother from cancer, a cousin from AIDS, and several patients from AIDS. She was angry that an educator would say there was not a dying process accompanied by suffering for the individual and his or her family.

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One student indicated she was angry because the young patient for whom she was caring "was being deprived of some really good years." Another participant commented:

> People didn't like her because she wasn't cooperating . . . . My reaction to her was how sad, all this potential. People felt . . . she was abusing the system. She was using up hospital space. . . . she was hard to like, but I felt . . . a lot of anger over the way the system had dealt with her, but I also felt a lot of compassion for where she was at.

Referring to the suffering of his father who had cardiomyopathy and had also experienced a stroke, one participate shared the anger he felt:

> . . . towards the end it got very hard to see somebody you thought was strong have to be lifted up and put in a wheelchair. And you got mad at him sometimes because it was every ten minutes. And you tried to talk him out of it. . . . we all resented it and then how to handle that resentment.

According to Heitman (1992), when suffering is prolonged, caregivers may direct anger toward the sufferer who has not improved, the experts whose treatments have not succeeded, or toward God who has not intervened. Each of these responses may also reflect self-directed anger at being unable to cope with the burden of caring for a person who is suffering. Gorlin and Zucker (1983) believed that caregivers may respond to another's suffering with anger and may blame themselves for failing to accept the suffering nobly. The examples given by the participants illustrate this.

Sadness/Loss

There was a strong feeling of sadness and a sense of loss relative to the experience of caring for an individual who was suffering. One person expressed it in this manner:

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> I wanted (long pause) I felt very badly that I could see this beautiful woman locked inside her body or this wonderful soul inside there that really wanted to be released but it looked like all these outside influences were preventing that.

Also, she explained that "other caregivers will want to distance themselves from somebody that is really suffering. That is sad. That is real sad."

Elaborating upon the reality of caring for a woman dying of cervical and lung cancer, one student noted:

> . . . she was dying and she knew she was dying. She could hardly breathe and when I would help her sit up . . . she would look at me and go "I don't know what ya'll are gonna do with me." It was . . . very heartsickening and I felt, I don't know (pause), it's hard to explain. . . . it was really overwhelmingly sad that I could do nothing. I felt so helpless. . . . it was kind of scary. . . . it was scary, sad, and a kind of emptiness because . . . you're just totally helpless.

Several of the students commented on the feelings of sadness and loss when they contemplated the death of young individuals. One of the "young" patients was a 56 year old woman who "had a lot of living to do and yet she was confined to the bed." Alluding to the feelings of loss, one student referenced this experience:

> . . . in school you're not taught this (i.e., suffering), it's not brought up and you don't really experience it in your clinical so when you're faced with it, as I was through an externship working in a hospital . . . it's a sense of loss. You don't know where you're at with them, or . . . how to relate to them . . . in a real way.

The foregoing excerpts are congruent with the thoughts of Brallier (1992) that providing care to people who are suffering is an awesome responsibility. This responsibility may lead the caregiver to feeling a sense of loss and being overwhelmed with the challenge of caring.

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Being There

The fourth subtheme to emerge from the participants' descriptions of remembering the experience was that of being there. A student described how she "just tried to be there for her. " As one person remembered:

> I had a patient in one of my clinicals who was end stage renal disease. . . . the outcome wasn't very good for them and they broke down and started crying one day and asking "why, why, why?" . . . all I could say was "I don't know. Things happen regretfully like this sometimes." And I just sat and they just cried on my shoulder for awhile. And it seemed to make things better. It was just a sense of being there for somebody sometimes.

The student who richly illustrated this subtheme described a situation in which "I was not able to be here for this woman." This student was working as a licensed practical nurse while she was enrolled in the generic track for a baccalaureate degree in nursing. The woman she was talking about had a premature baby who was doing well. This mother came every day and stayed from 11 a.m. until 9 p.m. and the nursing staff complained about this despite it being a rule they established. The participant reminded the staff of this and admonished them to be thankful the mother cared enough to come. Within two weeks of discharge from the hospital, the baby had an inguinal hernia repaired and was on a ventilator when he came back to the neonatal unit after surgery. They were unable to wean him off the ventilator. The mother became "a picky mother who wanted the tape just right, asked a lot of questions, and would lean over the baby's bed and talk with her child." The student shared:

> The baby got sicker and sicker and finally died. It was on a day when I was not working. The mother became so upset that she started screaming, throwing herself on the floor, and hitting the wall and one of the nurses called security. . . . I was angry, it was like, 'God, why couldn't I have

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> been there for her.' I was really angry that I couldn't be there for her. And I just felt like I could have been able to at least hold her, you know even as tight as I could so maybe that she could calm down or something.

After the recorders were turned off, this participant again expressed her disappointment that she was not there when this woman really needed her. She told me that she had wanted to talk about this experience with someone. She seemed very distraught about this experience.

The last illustration given above describing being there for a person who was suffering is in synchrony with the results of a study (Steeves et al., 1990) about nurses' inferences of patients' suffering. Steeves et al. found that thinking about the suffering of patients caused nurses to personalize the suffering leading to the suffering becoming that of the nurses themselves. The student described above did personalize the suffering; her anguish was still evident in her verbal account and in her nonverbal behavior during the interview.

Frustrating/Powerlessness

The feelings of frustration and powerlessness were coupled by many participants as they remembered the experience of caring for an individual who was suffering. "There are times that . . . I feel very badly for them. . . . and kind of powerless." According to one student:

> . . . if I can get someone comfortable, get the bed straightened out and get them where they feel good and feel comfortable . . . you feel like you've done a little something for somebody. But . . . there are times . . . that can't be done . . . you feel very powerless. And frustrated . . . .

Through a description of the inadequate care a patient received while being treated in a dialysis unit, a student spoke of these feelings:

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> . . . her skin was real fragile . . . and the woman [a nurse in the unit] just didn't really take pains with it [the shunt insertion]. She sorta jerked her arm out . . . and slapped it in . . . . . . they should be what I call really sensitive to how they feel. And be more caring about it, not just run them through like you're a number. . . . that really flustrated [sic] me and . . . I didn't have any authority . . . couldn't do anything.

The feelings of frustration directed at a nursing staff who refused to properly medicate a patient suffering agonizing pain after having his leg amputated are revealed in this narrative:

> I could see myself almost on the verge of losing my temper with the staff. I was thinking . . . I'm a student . . . and this is really inappropriate . . . so I asked to be excused for . . . ten minutes or so, and I went downstairs and paced . . . . I paced the halls . . . and went into a bathroom and yelled at the walls a couple of minutes, cause I knew I was going to lose my temper . . . . I just could not imagine leaving someone laying there who was pretty much helpless, leaving someone laying there in that kind of agony. I just couldn't . . . even begin to understand that.

Additionally, the feeling that they, as nursing students, had no power in alleviating the suffering of a person came through in this interview:

> . . . I didn't expect I was gonna be so frustrated with some of the things. And I really didn't know how to handle it. At least, on the unit . . . . At home . . . you can . . . kick the couch and stomp around . . . and say all the nasty things you aren't going to say to somebody at the hospital. . . . but it was difficult on the unit because . . . I constantly had to remind myself of my place there. . . . this is my patient but I'm operating under his primary nurse's license and I am a student here and how to deal with the staff when you . . . really know they're wrong. This was very difficult for me . . . .

A final example of the strength of this topic is depicted in a quote regarding the feelings of one student about caring for a suffering individual: "it was very, very frustrating, very upset. It was very upsetting, very upsetting because I didn't feel enough was being done."

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Sherwood (1992) noted when caregivers are unable to instill hope, empower others, encourage independence, or help improve another's condition, they often experience a sense of frustration and failure.

Emotionally Draining

The sixth and final category that thematizes remembering the experience is that of emotionally draining. One student expressed her feelings this way: "Being with someone who's in constant pain . . . it's very draining. I don't know how much experience in the world someone could have but I still think they would also feel very much the same."

Deftly illustrating this feeling was the following excerpt:

> . . . it's hard . . . I think it's very emotionally draining. I took care of my mom when she had terminal cancer. I was very young, seventeen . . . constantly I was emotionally drained. I was tired. . . . it is continual worry. . . . you know whether they're a patient or family member you want to make sure that they're OK and they never seem to get over it and it's just continuously trying to keep them at some level . . . at which they're functional . . . at where they just don't break down and . . . say I've had enough.

According to Morse et al. (1992), constant exposure to patient suffering can emotionally drain the nurse. Consequently, the experience of shared suffering must be controlled by the nurse in order that the nurse may leave the suffering patient and care for other patients. Also, limiting personal involvement in the patient's suffering allows the nurse to avoid becoming emotionally drained and exhausted (Morse et al., 1992). Joseph (1991) stated when nurses openly engage with patients, they experience energetic absorption of the patient's pain, suffering, and fear. Additionally, the nurse may resonate with the patient's

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frustration and anger. If the patient's need is great, the energy of the caregiver may be drained.

Making a Difference

Several participants said they were in nursing because they wanted to make a difference. Caring for those who were suffering frequently was noted as a way to make a difference. Caring seemed to fulfill basic needs for these students. One person noted:

> I'm in nursing for different reasons than a lot of people. I have a particular political view and a particular philosophical view of the way things are and the way things ought to be. And, dealing with her and her suffering and her problems only reinforced my view of things. . . . it just pointed out to me why it is I'm doing what I'm doing. Even more powerfully. In fact, when you deal with individuals and you see that individuals are suffering, the effects and results of the lack of compassion, of a very cold world, hard world, to me that only reinforces my view of things. . . . part of why I am in nursing is because I really do think I can make a difference in some respect.

One participant who was graduating one week from the time of the interview stated the experience of caring for a suffering individual was:

> . . . the biggest challenge that I had; it was more of a challenge than doing any kind of injection or tube or catheterization. It is emotionally challenging and I think in the beginning it was emotionally draining for me.

This person described her inclination to:

> . . . choose patients that were in a lot of pain and were vocal about it rather than stoic, so that I could get use to that, so that I wouldn't suffer. . . . I think what drew me into nursing was wanting to keep people from suffering.

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Another comment was:

> . . . just hearing his story and listening to him, I thought why am I doing this, you know this can really get you down. But yet, I felt good afterwards. I felt like this for some reason was fulfilling a need in me.

When asked whether caring for her mother had influenced her decision to enter the nursing profession, this student's voice was powerful and beautiful. Before this experience she wanted to be a veterinarian like her father but seeing the cruelty to animals she changed her mind. She shared this:

> A great deal. A great deal. It influenced me a great deal. . . . I'd seen a lot of that [i.e., cruelty to animals] and that type of suffering and that's . . . when I decided I couldn't deal with that. . . . whereas human suffering, it was easier for me to grasp and do something about because they're able to communicate . . . and I can really understand that a lot better.

Making a difference was also depicted in these statements: ". . . once I started seeing that I could do something to make somebody feel better . . . I thought it was great." ". . . I felt like I could make a difference in that I like elderly people . . . and that's what I want to go into." "Now I have a purpose."

Knowing the Experience

Participants were requested to give their definition of suffering and then were asked to relate how they came to know the experience of suffering. All patterns of knowing as delineated by Carper (1978) were found in descriptions given by students. These patterns are: personal knowing, empirical knowing, esthetical knowing, and ethical knowing. Discussion of the definitions given for the phenomenon of suffering and the unique ways the participants came to know about suffering is provided next.

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Defining the Phenomenon

All 12 participants emphasized that emotional suffering is more profound than physical suffering. There was consensus that pain and suffering are different but all believed pain is a crucial element of suffering. This consensus was in concert with several authors (Cassell, 1982; Copp, 1990b; Donley, 1991; Kahn & Steeves, 1986; Moulyn, 1982; Steeves, 1988) who noted suffering is by no means limited to just physical pain even though physical pain remains a major cause of human suffering and is the primary image formed by people when they think about suffering. One participant stated: ". . . pain can go along with suffering but suffering does not have to go with pain. . . . narcotics can end the pain but the suffering would still be there."

There was discussion by one participant about the depth of emotional suffering as compared to physical suffering. Another student explained:

> . . . it's hard to say, it's both physical and emotional for sure and to me it seems like the fear is some of the most painful part . . . it's physical pain, it's fear, it's lack of control . . . it's a whole body disease . . . wanting things to be different than they are and feeling powerless. Though it can't be separated, it's more than pain. Pain is part of the whole thing. I honestly feel like the emotional aspects are what creates at least as much suffering as the physical.

This student was attuned to the belief of Boeyink (1974) that suffering is a threat to one's composure, integrity, and the fulfillment of intention.

Another student believed suffering:

> . . . is more than something that's physical. . . . something that is emotional has an emotional and spiritual dimension to it. I don't think you can suffer if your world view is intact, I don't think you're really suffering. You might be in pain, you might be in distress, you might have some economic problems but that's not the same as suffering. . . . I think

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> it's possible to suffer even if you're physically intact. . . . it's got . . . multiple, multidimensions . . . . I think it's . . . perspective.

This student's view aligned with Cassell's (1991b) definition of suffering as "the state of severe distress associated with events that threaten the intactness of person" (p. 33). Smith (1987) also had a similar stance in which he posited that suffering is a kind of identity crisis which represents a threat to the self. Furthermore, Smith believed a threat to the identity of the self is a necessary and sufficient condition for the existence of suffering.

Commenting on the definition of suffering, another student stated "it is kind of like eating away at many things. . . . things you wish you had done, things you wish you could do. . . . things you haven't done. . . . it is just a matter of sorting things out . . . that's what suffering is." A different side of the phenomenon is exposed in this definition:

> Suffering is the degree to which the way things are different from the way you want them to be. I mean if you like wanted to be a certain way, and it's not, you suffer. Whether that's physical or, you know. . . . it is almost like the difference between reality and the way . . . you thought it would be or should be or wanted it to be.

Echoing the sentiment that suffering means a loss of control for both the individual who is experiencing it and for those who care about and care for that individual, one student posited:

> Suffering is an emotion; the feeling that you can't control, can't help. . . . it's like a . . . loss of control itself, and it can be mental or physical. It's just something that's really plaguing you and you can't do anything about it. It kinda . . . overpowers yourself. It's a feeling of helplessness. . . . you can't do anything and nobody else can do anything for you. . . . you can alleviate that little symptom of pain but you feel . . . out of control.

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Another student agreed with the above comments about the loss of control. According to her, when a person has lost this feeling of control, he or she would do almost anything to escape the suffering. Feeling as though one has lost control is congruent with Niebuhr's (1963) conviction that suffering is the exhibition of the presence in one's existence of things that are not under personal control. Also, data from research conducted by Steeves et al. (1990) described loss of control as being a prevalent characteristic of suffering.

Suffering was also viewed as "not really being able to share, having to hold everything in, thoughts in."

Personal Knowing

Personal knowing is the discovery of self and others in a relationship through an encounter. This connection between self and others is through an authentic presencing and is characterized by "being there" and "connecting." Moch (1990) identified three components of personal knowing: experiential knowing, interpersonal knowing, and intuitive knowing. Some characteristics attributed to personal knowing by Moch are comparable to those delineated by Carper (1978). However, she identified three subcomponents of personal knowing.

According to Moch (1990), the personal knowing subcomponent of experiential knowing occurs when a person becomes aware through participation or by being in the world. Experiential knowing can be accomplished by means of self-observation, by observing others, through feeling, and through sensing (Moch, 1990). Moch also noted that "cognitive and spiritual processes enter into

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analyzing and deriving meaning from an experience, both during and after the encounter" (p. 157). Interpersonal knowing encompasses the increased awareness incurred through intense interaction and being with the other. Moch reflected "through interpersonal knowing, boundaries between self and other are diminished temporarily as intense connectedness is felt" (p. 157). Intuitive knowing speaks to the immediate knowing of something without the conscious use of reason (Schraeder & Fischer, 1986).

An example given by one student lends credence to Moch's (1990) claim that there are more components to personal knowing than those identified by Carper (1978). After the interview was completed, the student began talking again as she prepared to leave. She shared more indepth feelings in the 20 minutes after the tape recorders were turned off than she had related during the actual interview. Her comments were extremely meaningful in explicating the experience of caring for someone who was suffering and how that participant came to know the experience.

When the student mentioned in the preceding paragraph was 17 years of age, she cared for her mother who was dying of cancer. Over the course of one year, her mother had endured two mastectomies and four weeks of chemotherapy/radiation treatment but the cancer had not been eliminated. Physicians were recommending four more weeks of chemotherapy/radiation treatment. This student's older sister was very insistent the mother undergo this regimen of treatment. According to the participant, she was angry that her sister had visited their mother only a couple of times in the year she had been very ill

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and now wanted to coerce the mother into having more treatments. This student's tone of voice was very emotion filled as she recounted the first time her mother ever asked her what should she do about having further medical interventions to eliminate the cancer. She responded that she believed her mother had made a decision because she was questioning whether to have the second course of treatment. Furthermore, she informed her mother she would support her in any decision. Her mother decided not to have any additional treatment and this student was with her every day until she died. During the final days of life, her mother shared for the first time that the cancer had been diagnosed when she was 37 years of age. Soon after being diagnosed with cancer, her mother took her and her brother to church. The mother prayed to and bargained with God to be given 10 years to live in order to raise and educate her children and prepare them for life without her. During the time she was bargaining with God, she was looking at a window in the church. The window had a picture of Jesus with His hands on the heads of children. While the church congregation was singing and the mother was praying, she became aware that around the head of Jesus in the window was an extremely bright light. She was aware of a message that she was being granted 10 years to live. The participant said her mother related that "she couldn't hear the congregation singing because of the bright light." The mother lived 10 years.

This story illustrated the experiential, interpersonal, and intuitive components of personal knowing. Through feeling and sensing this participant came to know her mother on a deeper level. She left her mother only to attend

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school. Her mother convinced her not to quit high school and spent time preparing the student for life after her death. The student voiced the knowing she gained from observing her mother care for her and for others; this influenced her tremendously. With restrained but seemingly very deep emotion, she related how her mother's faith in God had been "passed on" to her and the sharing of this faith with her mother had sustained both of them. She described an intense connecting with her mother; thus she acquired interpersonal knowing. When I questioned how she knew to respond to her mother's request for assistance in making a decision, she stated "she just knew it intuitively."

Particularly significant statements were made by other participants about the acquisition and use of personal knowing. "I feel innately, I don't want to change that." When asked how she knew a person was suffering, she responded "a lot of it is just instinctive. Like you just know. You just kind of know. I think it's . . . that kind of connection and . . . I just related to her." One comment was "I knew he was suffering, you could just look in his eyes and see how empty he was."

One participant described a patient for whom she sensed something was wrong despite the fact an assessment of his status did not reveal anything abnormal other than a slightly elevated temperature. She recounted "I began to sense . . . I was worried about him, I didn't think he was doing well." When asked how she knew he was not doing well, she related:

> I don't know. I'm very sensitive because of my massage work; I can feel things and sense things that I guess a lot of people just can't because I have had my hands on people so much and I've done so much assessing

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> with my hands. . . . there was just something like a string being pulled real tight and I was worried about him. He was scared, he was really scared. . . . I began to feel real uneasy . . . I had a bad sense of what was going on.

When this student reported to the nurse who was caring for the patient after she left, the nurse rebuffed her fears and did not believe her. Upon returning to clinical, she discovered the patient had died the afternoon after she left the hospital. The man was 38 years of age and died from an embolism. She became very upset:

> I knew something and it freaked me out! It really did! I felt really weirded [sic] out. I feel weird cause I knew something was going on and I didn't know it at the time. . . . should I have acted on it, what could I have done?

When queried about how she learned to sense when someone was not doing well, this student described techniques learned in massage school (she was a massage therapist prior to coming into nursing school):

> They taught you to feel what was going on with that body . . . learning not to have my own agenda but to see what that person's agenda was. I had already developed that unconsciously with my parents, they were both alcoholics and they would rage and so I would learn when it was safe to come close and when . . . it wasn't and so it was like tapping back into that.

Each of the participants described the experience of interpersonal knowing in which they came to know the person who was suffering during the intense situations they shared. The connectedness they felt is illustrated by this student's comments about an oncology patient:

> . . . who was in so much pain, she didn't want you to touch her, she didn't want anything, and she would scream . . . she wasn't my patient [the first time this student saw her]. I did go in and help her get from the chair to the bed one day. She screamed and carried on. It took us 20

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> minutes to get her into the chair and I went "Man, I'm glad to get out of this one!" And the next week something said, "Go ahead, take her and just see how . . . ." Well we got along great! She was so responsive to someone just being compassionate . . . like when you were talking to her, just to put your hand on somebody, that is a miracle! Just to literally put your hand on somebody. It's like "I'm here" and "I'm hearing what you say." I found that one thing to be one of the . . . biggest nursing interventions I can do.

Each participant related how they had learned from the experience and through observing others. One student described an instructor who would stop and speak to patients on stretchers. These patients were not assigned to the students. The student was impressed that the faculty member appeared to genuinely care for others and said to herself "Oh good, it's OK for me to do that; I don't have to be just robot like." This is an ideal example of experiential knowing wherein the learner is open and attentive to the situation.

Empirical Knowing

Carper (1978) believed the pattern of empirical knowing represented knowledge accrued from sensory experience. It is classically expressed in the form of principles, laws, and theories that have general applicability. Empirical knowing rests upon assumptions of linear time. This way of knowing seeks to describe, explain, and predict. Empirics has been called the science of nursing. Joseph (1991) stated "empirical knowing of observable, verifiable phenomena is the knowledge of the explicate order, those phenomena that are physically manifest and that may be tangibly experienced and measured" (p. 55).

Participants used empirical knowing to describe how they knew a person was suffering. One student described it in this manner: " . . . based on looking

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at her . . . the sores, the shingles. She would dry heave a lot; you're suffering when you do that. She coughed a lot . . . she was poor." Another said: " . . . the mother was crying and was scared. . . . the father was kind of distant and kind of angry. . . . the mother looked scared and was feeling guilty." Describing how she assessed the suffering of an infant, one participant related: ". . . the bloating of the stomach or the bloating of the head, the pain, the suffering that they're probably going through with the way they're flailing their arms." A student offered this example of empirical knowing: ". . . he was pale and clammy and sweating and a very rapid pulse. . . . he was hallucinating, he was picking at the air, calling out to people that were not there."

Esthetical Knowing

> Esthetical knowing is called the art of nursing. Carper (1978) asserted:
>
> An esthetic experience involves the creation and/or appreciation of a singular, particular, subjective expression of imagined possibilities or equivalent realities which resists projection into the discursive form of language. (p. 16)

Joseph (1991) said esthetical knowing underlies the art of nursing because it perceives the whole patient or aspects of the whole and all the interrelationships involved in giving total patient care. The art of nursing, according to Carper, "involves the active transformation of the patient's behavior into a perception of what is significant in it--that is, what need is actually being expressed by the behavior" (p. 17). Carper also identified empathy as being an important "mode" in the esthetic pattern of knowing.

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One student expressed esthetical knowing in this manner: ". . . I felt very badly that I could see this beautiful woman locked inside her body or this wonderful soul inside there that really wanted to be released . . . ." One person commented: ". . . the art, I think that's the first step in healing." Empathy was clearly expressed by this student when he stated: "I don't feel sorry for them, I just feel for them."

Eloquently portraying esthetical knowing, one participant observed when a nurse becomes:

> . . . very personal with that person, it's kind of a continual dance . . . when the nurse or when I need to step in and when I need to step back and let them take care of themselves. It's just . . . it's real . . . it's not a real fine line that you cross. It's very blurry and it's just all of what is appropriate at that time that I seem to do that . . . works.

Ethical Knowing

The ethical pattern of knowing is called the moral component of knowing. This way of knowing is focused:

> . . . on matters of obligation or what ought to be done. Knowledge of morality goes beyond simply knowing the norms or ethical codes of the discipline. It includes all voluntary actions that are deliberate and subject to the judgment of right and wrong--including judgments of moral value in relation to motives, intentions, and traits of character. (Carper, 1978, p. 20)

Jacobs-Kramer and Chinn (1988) noted that "although ethical knowledge is communicable through language symbols, it is not public, verifiable, and common in the same sense as empirics" (p. 130). Parallel to Carper's (1978) argument about the importance of ethical knowing, Greene (1978a) suggested attentiveness to this component of nursing ought to permeate many of the classes which are

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taught. Greene stated "the roots of moral choosing lie at the core of a person's conception of herself or himself and the equally important fact that choosing involves action as well as thought" (p. 48).

Students expressed the ethical pattern of knowing in several ways. One student noted he is:

> . . . in nursing for different reasons than a lot of people. I have a particular political view and a particular philosophical view of the way things are and the way things ought to be. Dealing with her [a patient] and her suffering and her problems only reinforced my view of things. . . . it just pointed out to me why it is I'm doing what I'm doing.

Another participant recounted the experience of caring for a man with AIDS "who was not humble right before he died; he was arrogant." Furthermore, she remembered:

> I didn't feel really sorry for him because he had gotten it in a way that could have been prevented . . . he went out with a lady . . . that had AIDS. . . . wasn't his wife; he was cheating on his wife. So . . . you didn't feel as sorry for him as you would for someone that maybe would have got it through blood transfusions . . . . But still it was a life wasted.

A student questioned whether a person should be coerced into receiving treatments which were extremely painful. She stated:

> . . . it was my conscience because . . . once you did something and . . . they said "I don't want it" and it hurt so bad; you just had to take time to sit and think "Well, what is going on here?" . . . I guess I guided myself . . . because you have to look at the situation from a whole.

Greene (1978a) advocated the use of all patterns of knowing in the learning landscape. Through acts of consciousness, aspects of the world present themselves to living beings. These acts of consciousness include:

> . . . imagining, intuiting, remembering, believing, judging, conceiving, and (focally) perceiving. Alone or in collaboration, they bring individuals in

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> touch with objects, events, and other human beings; they make it possible for individuals to orient themselves to, to interpret, to constitute the world. (p. 14)

Listening/Voicing

Listening/voicing describes the listening by and voicing of the student. The voices of others may be heard through the language of the student. Other voices which may be heard include those of the person experiencing suffering, the family of the suffering person, the educators who have either been present or absent as role models for the student, and the staff of health care facilities who, for the students in this study, often presented very poor examples for the students. Brown (1992) emphasized the use of phenomenological research in education "is not to put us in command of our own and others' educational lives but instead to put us in 'touch' with those lives" (p. 50). The critical importance of listening/voicing is expressed by Benner (1991):

> Unavoidable suffering is often exacerbated by separation and a lack of adequate language, metaphors, rituals, practices, and meanings in a suffering- and death-avoidant culture that promises continuous progress and technical solutions. Suffering is removed from the hospital room, where patients, families, and nurses are left to work out ways to communicate and comfort one another in the face of unavoidable suffering. (p. 14)

Listening to the voices of these students enables one to be in touch with the meanings students found in caring for those who are suffering.

The theme of listening/voicing became saturated early in the interviewing process. Five subthemes emerged from the data. These five subthemes were: caring, becoming educated, emulating role models, describing the lack of role models, and discovering self. Each of these subthemes will be discussed.

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Caring

From the perspective of those who actually lived the experience, caring emerged in the form of immensely strong statements. One student emotionally described caring for a woman who was dying of cancer:

> . . . though she resembled no one in my family--my mother also died at 39--so immediately when I walk in and when I see and I don't even consciously remember thinking of this. It just like engulfs you . . . that's someone's mother or that's someone's father, or a brother or sister and that's automatically how I think. I think that really plays into how I talk to them and touch them and just exist around them . . . .

The voice of personal experience spoke through the words of a student as she described caring for her parents:

> Both my parents were sick and were very miserable people and both of them died very young. My role in the family that I assumed was to make everything better and [I] wanted so much for them to be well and happy and [I] did everything in the world that I knew how to do to make that happen and none of them ever worked.

The effect of caring for suffering individuals took its toll on these students. They voiced this burden in these ways: "When I'd go home I had a lot of anxiety built up; I was really stressed." "I was also going through a period of time when my aunt was dying of cancer. It was really cold . . . it just made me appreciate life. I didn't take anything for granted at that particular time." "It was a total reality check of how close life and death was, and it was just overwhelmingly scary." "I would go off by myself and have a good cry. Nobody really understands." One student said:

> If I had to continually take care of a patient that was in constant pain and the only relief they were going to get was literally from dying . . . to me continuously doing that every day I would get very burned out very easily.

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When asked how she dealt with caring for someone who was suffering, one student commented:

> That's very interesting. The only solution I found to deal with my own pain was, I'd go inside myself to look for answers and I spent [time] talking to a lot of other people, trying to figure out . . . gather advice. Gather more and more information until I was just bombarded . . . and my emotions took over. At that point, I found that meditation and my prayer . . . my own personal questioning and self-discovery helped a lot. Because my belief in a higher power is what helps me get through it, because there's only so much I can do . . . you just got to let go and let the higher power take over a little while.

Joseph (1991) observed that a lack of self-renewal and self-care skills along with a tendency to empathize with the suffering of patients may lead to a tendency for nurses to energetically withdraw. Gadow (1989) concurred with Joseph's views when she described a tendency for nurses to take a disembodied view in order to avoid feeling the pain and suffering of their patients. She stated it takes courage and devotion for nurses to consciously make the choice to be fully present and energetically open in a compassionate way with patients who are suffering.

Becoming Educated

Inherent in the subtheme of becoming educated is the voice of the student speaking of the presence or absence of educational preparation in caring for a person who is suffering. The majority believed courses in their undergraduate program did not educate them to care for suffering individuals.

The voice of educators is heard through the language of students. In several instances students evidenced their attentiveness to educators by citing exact words spoken by faculty. One specific lecture which impressed some

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participants was given by an instructor as part of a pharmacology course. This faculty member was named by several students; and, they were complimentary of the method she used to teach them about caring for the person who was experiencing pain. It is important to note these students believed that particular lecture prepared them to care for someone who was suffering. However, frequently their next comment would indicate they believed pain was different from suffering. Four students used a definition of pain composed by Margo McCaffery (1979) to describe what they had been taught about caring for someone who was suffering. One student referred to McCaffery's definition in this statement: "We are learning in nursing school that pain is what the patient says it is." While another participant voiced it in this manner: "They have told us that when they say they are in pain, they are in pain."

The voices of students who did not feel they had been taught about caring for someone who was suffering are reflected emphatically in several examples. One student shared: "We haven't talked about it so far in school other than just related to pain but not really that unto itself." Another student who was graduating the quarter shortly after being interviewed stated:

> I don't think I've learned anything specifically about how to care for someone who's suffering. Funny that you should say that, I don't think anywhere in the curriculum that issue of suffering has been addressed. The issue of pain, disease, chronic and acute illness; the issue of ineffective coping, things like that. But not something that's been identified as suffering. That's almost a theological concept, it seems to me. I don't think anything in the curriculum has addressed that directly.

Other comments from students were: "In school you're not taught this, it's not brought up and you don't really experience it in your clinical so when

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you're faced with it . . . it's a sense of loss. You don't know where you're at with them, or how to relate to them . . . in a real way." "It's not addressed at all formally, so I do feel a missing piece there."

One student revealed:

> They did not really [teach it] in school, it was like chapter so and so in the book and it was real important, but I think not a lot of time was spent. A lot of time was spent on the assessment and getting medical facts and skills down and how to document things. We are so inundated with the paperwork.

One final quote summarized this perceived lack of preparation:

> We talked about the grieving process and death and dying, but that's it. And that's maybe one or two classes out of four years. We approached it on the units. We see people suffering, but it's not approached in a post-conference discussion, when you're just come out of a room, when you see a patient that is very anxious because they are in a suffering situation. We don't discuss it. It's like nobody knows how to discuss it, I think maybe [that is] a reason why nobody's approached it.

Emulating Role Models

Several students stated that some faculty, clinical staff, course assignments, and clinical experiences helped them become educated to care for suffering individuals. A primary avenue for becoming educated was through emulating role models. This was an immensely strong subtheme which emerged from the interviews. According to Burns and Grove (1993), "role-modeling is learning by imitating the behaviors of an exemplar" (p. 14). A participant stated:

> If you watch instructors and other nurses, you see them deal with people in various ways, some of which are more effective than others. Generally, the instructors I've had have said things like "this is really sad" or "this child doesn't deserve this" or "this person has a lot to deal with." And what they are really saying to you is "they're suffering and we need to

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reach out to them in some way and we need to touch that somehow and people have different ways of doing that."

A student described a role model who was a staff nurse especially adept at caring for those who were suffering:

> It was funny, when she would be on the unit and I would go around with her . . . she could go and talk with patients, and [give them] back rubs at night . . . relaxation things she would do with them. And you wouldn't hear one of them request pain meds all night. And the other nurses . . . would hate to follow her . . . because they did not have the same techniques as this individual and the pain meds would be flowing like water. Because she [was] working on the 11-7 shift, you wouldn't see her until 4 in the morning because she was taking care [here the participant strongly emphasized the word "care"] of her patients. She'd go in and she'd talk with them a little bit as soon as report was over. She'd get around to all 6 or 7 of them. And then she'd say "I'll be right back. What can I do for you tonight to help you relax?" She'd roll them over, she'd give them the back rubs with the lotions, massages, whatever they would want to help them relax. Her patients would have walked over coals for her. She eased a lot of people, she took care of the families, too, while they were there.

Another student described a clinical nurse specialist who was his role model:

> She's very highly skilled, very intelligent, and a very well educated nurse. You'd know that by the way she talks but she doesn't deal with patients from that perspective. She deals with her patients each as an individual and she tries to understand them as individuals. . . . you just feel that when she's in the room. You can feel her trying to reach out to them, not expert to the patient, but person to person.

The deep respect and admiration for an instructor was evident in the words of this 45 year old student:

> I think she taught me a lot about . . . it was OK to feel. This clinical instructor . . . I thought she was so magnificent that I asked to get her again and I did, I was lucky. I think having her for two quarters in a row really helped me, ease me into . . . what was going to be required form. I think she was really able to help . . . because of her compassion. I would watch her--the way she was with a patient when she would come in or she

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> would be walking down the hall and a patient would be on a gurney, waiting for surgery or something, and it wouldn't be any of our patients . . . but she would just stop and put her hand on them and say something. I would notice her doing that and I would say "Oh good, it's OK for me to do that, I don't have to be just robot like."

One student selected an instructor who taught a class on oncology nursing to be one of her role models. The experience with this faculty member helped her make the decision to work in an oncology area after graduation. She described the influence of this instructor:

> I find myself reading articles that involve oncology or the oncology nurses, like [instructor's name]. She fascinated me . . . she was so positive and enthusiastic about it. Then I started seeing how I was with the patients and how really easy it is for me to be intimate with them . . . how much satisfaction I get from them.

Addressing the effectiveness of course assignments to educate a student to care for those who are suffering, one participant noted:

> We had a course [in which] one of our lecturers came in and she did a couple of days of lecture on pain management. . . . how to assess it, what to do about pain management and different kinds of therapies we can use. I think all along in our care plans we've had to give reasons why. Most of our care plans have to deal with some kind of alleviation of pain or pain experience. I guess . . . continually writing down all the different types of nursing implementation we can do and the rationale for that.

Compassion was identified by several students as being a distinguishing characteristic of role models they wished to emulate. One participant praised some faculty he had: "You could just tell by their demeanor that they had compassion for people. They could recognize suffering at all sorts of different levels." Listen to the voice of another student:

> I have noticed . . . of the really compassionate, very, very compassionate instructors and nurses that I've seen . . . [is their] eye-to-eye contact with somebody. . . . just the very accepting person, very understanding to

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> someone . . . willing to sit down and just talk if that's what they needed to do. I think those are the people who seem to deal best with someone else in suffering and be able to help them.

Compassion was also an important element in the voice of this student as she talked about a faculty member:

> . . . mostly it was her role modeling and her compassion. I just loved the way she was with patients. It was so caring. And she was real positive. I would see that she really cared about them but yet she would whistle down the hall. I mean she didn't take it on. I had a patient that died. And she counseled me a bit about that, and I think that had a lasting impression.

The concluding exemplar of the powerful effect of role models was shared by a student who had tears in her eyes as she related these examples:

> One of my instructors actually . . . when another student had talked about the loss of a child, actually sat down right beside her and just started bawling, crying her eyes out and I mean . . . she actually expressed her feelings with that person and I think that . . . the experience of that emotion actually gave relief to the person who was suffering. I actually witnessed that. And that was something that I . . . remember a lot. There's a nurse that I work with . . . and we had a patient who was dying; for some reason [the patient] just wanted to keep on and on and on, coming back to us and getting treatment. This nurse discovered that [the patient's] husband (who had died) virtually told her what to do at every moment of her life and she was . . . at such loss without him and that she needed someone to tell her what to do. The nurse went in there and held her hand and she said, "You know, I don't know if anyone has ever told you this before but it's OK if you just want to let go." The next day the patient died.

Describing the Lack of Role Models

Participants were very vocal in giving examples of faculty and clinical staff who demonstrated a lack of compassion or caring for a person who was suffering. Describing co-workers in a home health agency, one student said they frequently disparaged the clients: "I tended to hear comments, actually negative

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comments . . . they will say, 'I think she is a psych case': It is really kind of derogatory."

Describing the curriculum content pertaining to caring for those who are suffering, a student related:

> During my sophomore year, when we were taking pharmacology and basic skills, we had a segment on pain . . . and they talked about pain being whatever the patient says it is. However, I don't think it was enough to really prepare us for what we might be exposed to. I don't think I really was prepared for some of the attitudes of . . . some of the staff.

One participant worked in an emergency room as a nurse extern while he was in school and he cited:

> I find that a lot of emergency nurses get wrapped up in the idea of being an emergency nurse. "I'm at the action end of this business, and I have these skills . . . and I can stick an IV in anything." You have to stop and shake them every once in a while. . . . this is an individual human being we're dealing with right now. It's easy to get into that because it's very comfortable to draw that shell of confidence around you and hide behind it. It's when you stop being the competent professional nurse and start being another human being, in other words, trying to touch another person's life.

Another voice explained the importance participants placed on "having been there personally":

> I've had instructors who were very well educated and were very competent but hadn't walked the mile in other people's shoes and there was not a way they were going to be able to show anybody any compassion. Any real compassion.

A poignant example, which demonstrated lack of compassion and caring for those who are suffering, was given by one participant. This student told of a patient, with gangrene of the toes, who was admitted to have his second leg amputation. According to this student, the man did not give informed consent

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for the surgery because he was led to believe only his toes would be amputated. Her anger toward a nonresponsive, uncaring nursing staff and her anguish for the patient are reflected in her story:

> After surgery, he was in agony. He was a good distance from the nurse's station but you could probably hear him with doors closed four or five doors down the hall. It was disturbing to the other patients; it was very upsetting to us. The reaction from the staff was "Well you know he's just a moaner, he's just kind of this, that . . . ." When the doctor came in, he said "Oh, you know he's just kind of a complainer anyhow." It was all I could do not to say "Do you have any clue what kind of pain he might be in? If we're fortunate, we will never have to suffer that kind of pain." I couldn't get the nurses to get his narcotics out of the box because they said it wasn't time yet. The staff kept saying that they'd be giving him too much medication if they gave it the way the student wanted it done. Finally my faculty member insisted . . . his "po" meds must be given in order to augment his IV meds. His pain was to the point that he was just howling and he was hallucinating and it was really bad. It was very upsetting to a lot of patients that were there because they could hear him and it was obvious that he was in agony. I had a hard time with the attitudes of the staff about it. He was screaming. There was no whining about it, he was screaming, he was pleading to God to end his pain, and it was continuous, just continuous.

Discovering Self

As a subtheme of listening/voicing, discovering self emerged strongly for the majority of students. Participants expressed that they were challenged to learn more about themselves, believed they grew, and discovered they experienced paradoxical emotions such as compassion and anger toward the person who was suffering.

Caring for an individual who is suffering can be:

> . . . very rewarding, and sometimes I am embarrassed to say that to anybody, especially people outside the profession because like why should you feel rewarded for caring for somebody who is really feeling badly. We got very, very close and I learned a lot about myself. I learned some of what my limitations were. I learned where I could excel in areas that I

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> had no idea that I had certain capabilities. It was growth for me in addition to hopefully providing some comfort for her.

Other comments relative to the subtheme of discovering self included: "You know it made me feel so good." "It's sad, but it's like a reality check. It gets too close to dying . . . you're thinking about your own mortality. It's kind of like going through a little death of yourself." "You have to be able to deal with yourself in order to deal with someone else." "The hardest part for me was when they go through the stage where they're so angry because they can't do for themselves anymore."

A deep discovery of self occurred with this student as she cared for her grandfather:

> I don't know when I actually crossed that line where I started looking [at] it from a different perspective because . . . for so long I looked at [the situation] as though I was the one that was doing the suffering because I was having to take care of him and it hurt me to have to do that. And once I realized that . . . once I focused on him instead of me and my pain, then that's . . . when I started listening to him . . . .

Referring to a sociology class on death and dying, one student stated she discovered a tremendous amount about herself and "this course really opened my eyes to a lot of things I didn't know or things that I wasn't aware of." Also voicing the importance of courses which have the potential to lead to a deeper understanding of self, one person shared:

> I've tried to get other electives, like right now I'm taking the sociology of death and dying. I've taken an extra psychology course. It's very fascinating to me and I think the more that I understand the easier it gets to deal with that for myself personally.

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One student resigned from nursing school the second quarter in which she had clinical experience when three of her six patients died. She had this perspective:

> All of them [her patients] were in a lot of pain and the families were in a lot of pain and it was just too much. It was like I couldn't do it and that was when I started realizing it was . . . the dynamics of my family [her parents had been alcoholics who were very ill and died when she was relatively young] that were interfering--cause I was in my mid thirties at that point so I was old enough to begin to reflect. I had this urge to go into nursing as soon as I became self aware at all. I realized that I was trying, still trying to make my parents, you know the same drivenness, and I dropped out of school first because that kind of got me . . . . [I] realized that is not a good motive to be in nursing and . . . it is self-destructive. I went into therapy for several years and ended up deciding I really did want to be a nurse.

The theme of listening/voicing described the educational context of students as they learned to care for those who were suffering. As Weiler (1988) believed, the empowerment of students means respecting and legitimizing students' own voices. Listening to the voices of participants in this research is a powerful and moving experience. Beliefs and experiences of these participants are in accord with many authors who provided theoretical support for this doctoral research.

Teachers can become learners if they are open and attentive to messages students are sending through narratives and stories. Diekelmann (1989) stated the teacher-as-learner "moves from being an information giver and facilitator to the explorer of meanings with students--their understandings of their experiences" (p. 37). Benner (1991) said "narrative accounts uncover meanings and feelings in ways that shed light on the contextual, relational, and configurational knowledge

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lived out in the practice" (p. 2). Chinn (1992) contended nurses care for those who are in pain and who are suffering "in ways familiar to no other professional group" (p. vii). She urged a return to teaching and learning of the fundamental and essential arts upon which the profession of nursing is built. Greene (1978b) observed that learners can develop a structure of meanings as they get older and as they experience diverse teachers and teaching situations. Parker (1990) believed faculty can assist students in constructing meaning from experiences that seem meaningless. Augmenting the contention of Parker, Greene (1978b) proposed that teachers who are out of touch with their own existential reality may not be personally present to others or in the situations of their lives. They tend to treat learners as objects or things and fail to assist their students in acquiring meaning in learning situations.

Attending

Caring for and nurturing of the personhood of a suffering individual are depicted in the theme of attending. Experiencing suffering personally, tends to alienate one from his or her personhood; "this thing that is happening to me is not me" (Hauerwas, 1986, p. 25). Each participant showed immense care and compassion for individuals who were suffering or in pain. Seven subthemes emerged from this theme: maintaining human dignity, showing compassion, respecting, caring/nurturing, managing pain, individualizing, and connecting/putting oneself in the suffering person's shoes. These will be discussed in the following section.

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Maintaining Human Dignity

One student explained about maintaining the human dignity of a person who was suffering: "I want that person to see caring and concern and professionalism so that they feel the system's working for them." Another comment illustrated this subtheme:

> I think it's real sad when you get someone who's in pain and suffering and comes to you for help maybe in an inappropriate way but he's still reaching out to other people for help and what he gets is a whole lot of guilt, blame. He doesn't get the one thing he needs and that's compassion, understanding. . . . he isn't seen in his context.

Showing Compassion

Showing compassion was a very evident subtheme of attending to the person who was suffering. In my opinion, all participants in this study evidenced deep compassion for others. Compassion was mentioned frequently in the descriptions utilized to explain other themes and subthemes. One student told how she knew a person had compassion:

> It is obvious in their physical presence in that they are not pulling away . . . they're like close and connected. They'll look at you and touch you. . . . it is like they understand . . . you're suffering. Or acknowledging that it's hard for you right now isn't it, it's been rough for you. But mostly I think it is in the physical, the look on the face, whether they are focusing on you or whether their eyes are darting around or whether they are touching you or whether they are standing way far away and the expression of the face, and it's more . . . in body language.

Sincere compassion was heard in the voice of this student:

> You can see it in her face how frustrated she is, how upset she is . . . frustrated to the point that you'll see a few little tears start escaping, you know she's just miserable. She is absolutely miserable and she can't tell you where, she can't tell you why, she can't tell you how.

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One student showed his compassion in this manner: "Generally if I were to feel who was really suffering, irrespective of how they're acting or what the medical or psychological problem is with them, my first feeling is a real strong feeling of compassion."

These accounts reflect students were in agreement with Morse et al. (1992) that compassion demonstrates acceptance of the sufferer's plight and that expression of compassion by the nurse serves to strengthen and comfort the sufferer.

Respecting

Students seemed to respect persons who were suffering to such a degree they almost revered them. Considering the age disparity in the participants, this researcher believes it remarkable that this feeling seemed consistent among all of them. The majority of the participants spoke of respecting elderly persons. Frequently they described instances where an older person was treated with less esteem than they believed the person should have been accorded.

A participant cared for a patient who desired not to have further radical treatments in order to be kept alive. However, this man's physicians continued to add life support measures. The student was very disturbed that this man could not die with dignity. She shared the following:

> You just wear so many hats as a nurse . . . you're the advocate of the patient. I think this is the most important decision in a person's life is when they want to die. And I believe that deep within you . . . [is] obviously something bigger than we are supposed to understand. But there's a part of you that can choose that. And I respect that. I know . . . you're supposed to do everything you can and I would do what you're

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> supposed to do. But also it's a very personal and private choice [to die]. And I just wish that . . . the whole society would respect that more.

Caring/Nurturing

Essential parts of the theme of attending were the descriptions of the caring and nurturing of the person who was suffering. Participants delineated in detail how they rendered physical, psychological, and spiritual care to these individuals. One student worked as a home health aide and lived (on the weekends) in the home of the individual she described. She shared this:

> I had certain domestic duties, cooking and a little cleaning, helping her with her bath and stuff and doing her grocery shopping but mainly just to listen to her and try to divert her and sometimes if she got on a real long story and I saw that she was going into a depressive state, I'd try to get her out of that because I didn't think it was too good. I wanted so badly to make things right for her. I wanted her to see the world in a more optimistic light. At times her mind was so lucid that she could carry on such a wonderful conversation . . . . I felt badly when I wasn't able to bring her out more.

Another student described a situation in which her assigned patient was discharged from the hospital and she was allowed to choose another patient for the next day. She read the chart of a patient and went in to see him and "he was moaning and groaning and carrying on and I could feel myself constricting." However, the student decided to take care of him:

> I was anxious all night. [I] went in the next morning and he was still ranting and wailing; he'd had a hard night. He was admitted for abdominal pain and had an exploratory and the incision went all the way up and down his abdomen. He was running a high fever; he was very uncomfortable; he'd had hiccoughs all night and . . . it was wearing him out and they couldn't stop them and they were about to call the doctor and get some medicine to stop the hiccoughs. I'm a massage therapist and I know a lot about therapeutic touch and hands on kind of stuff, so I said to my instructor [she knew the student was a massage therapist] "Let me see what I can do before we call the physician." My instructor kind of

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> winked and said OK . . . . . I just put my hand on his chest and he was as tight as he could be. . . . instructed him how to relax under my hand . . . he was looking at me like I was crazy. But he did everything I said. The hiccoughs went away . . . . We were buddies after that and I felt a personal victory that I had not shied away from the pain and didn't scare . . . even though I was frightened of it, and I had gone ahead and gone into my fear. I felt uplifted and he was much relieved of his discomfort.

Managing Pain

Managing pain was the most dense of the subthemes under attending. The challenge of understanding that pain and suffering are different was expressed by the majority of students. In the words of one person:

> Before school I saw . . . suffering as just pain. Now I see it as you can suffer emotionally and this is . . . as important as suffering physically. Because if you are mentally distressed you can start physically feeling pain and . . . suffering altogether. So I think suffering is emotional. You can have emotional suffering as well as physical.

All participants addressed the issue of managing the pain of the person who was suffering. Participants had difficulty understanding why pain was not adequately controlled in individuals who were suffering. The students expressed disbelief and anger that more could not be done to alleviate or eliminate pain. Many thought pain should be relieved regardless of fears that the person could become addicted or that it might hasten death. The voices of these students spoke loudly on this topic.

One student said:

> You are dying . . . and she was and I hope she was doped up and she needed to be because there's no point in suffering. If you know it means addiction . . . big deal! There are more important things that are going on at that point.

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Another echoed this sentiment in her comment: "They're in pain. So give them medication if you've got that authority or if it's not enough, get with the doctor."

According to one participant:

> You get to a dilemma where you medicate them and you know you're depressing respirations but these people . . . are terminal and they're gonna die anyhow. And they know this . . . they're in hospice care for reasons so do you let them suffer or do you let them be comfortable even with that knowledge that you may be hastening the inevitable . . . . I just don't see the purpose . . . of letting somebody suffer. That just doesn't make sense to me whatsoever! . . . you worry about addiction where somebody's got six months to go, that's crazy!

Several participants cared for patients who were terminally ill from cancer. Various emotions were evident as they attempted to talk about managing the pain of these individuals. In the words of one student:

> I think the cancer pain is the hardest to deal with. Because they can't seem to describe it because your whole body aches . . . and there's not enough medication in the world, except for an overdose, which would . . . help relieve the pain of the cancer that some patients go through. If I had to continually take care of a patient that was in constant pain and the only relief they were going to get was literally to die . . . I think that I would get very burned out very easily.

Individualizing

Participants believed care of the suffering person should be individualized. One student stated: "My approach to people, especially in nursing, has always been to try to deal with everybody as an individual. That's not always easy to do." Excellent advice was offered by this student: "We've got to realize that there's more than just the illness there. We've got to remember that's a person with a history . . . and we've got to be able to relate to that. An analogy was used by a student to explain her view of individualizing care:

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> I just come at it [caring for the suffering] from a different viewpoint and it's like management. When you teach management, . . . you can teach it and it all sounds great in textbooks and when you go out and do it, it's so different because you leave out the most important thing and that's people. And you can't teach that. One person acts one way and another person another way.

A final quote on this topic:

> I think as a caregiver it is important to put your own worries aside or anything that might be troubling you that would pertain to you. Try as much as possible to put that aside and really focus on that person.

Connecting/Putting Oneself in the Suffering Person's Shoes

Many participants believed they were able to connect on a very personal level with the person who was suffering. They frequently used the phrase "putting oneself in the shoes of the other person" to explain what they felt health care providers should do in order to holistically care for the suffering individual. One participant said:

> I think it has actually been positive because what I learned about myself was that somehow I connected with her. I don't know really on what level, but I connected with her. There was improvement there. And I felt that I had something to give. And I hope that I can be able to do that . . . again throughout my career.

Also, another student said: ". . . it's . . . that kind of connection and I just knew that . . . I related to her."

Addressing the need to understand the person who is suffering, one student commented: ". . . one of the things you have to learn is to flip the equation around, put yourself in your patient's shoes and say 'OK, I'm looking

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out of their eyes now and what do I see?'" Cognizant of the importance of knowing the context of a suffering person, one student reflected:

> We've got to put ourselves in the bed and in somebody else's shoes and think about that and try to relate from that aspect. It's not easy. It's kind of like an out of body experience. You've got to figure out what would make me quit suffering so badly. What would make me feel better? What would ease that suffering? . . . it's pain for everybody to do that. But we learn more when we're in that pain area than we do when we're very comfortable by leaving it alone.

Standing Inside/Standing Outside

The theme of standing inside/standing outside described the paradoxical coalescing of being with and caring for an individual who was suffering while also needing or wanting to distance oneself to protect one's vulnerability. This was one of the most dense and powerful categories of data. Some participants seemed to feel guilty for admitting they needed to distance themselves from those who were suffering. Other participants perceived that professionals had to distance themselves in order to survive. Even with their limited amount of time in the nursing profession, these students were grappling with a dilemma that challenges many registered nurses. The voices of the participants were very expressive. One student stated:

> It's all right to sympathize with a person and have empathy for the person but you have to be able to deal with your emotions . . . because you see so much of it. You have to be able to separate it and go home. You just can't take everybody's troubles with you. If I'm going to help people I need to be emotionally strong as well as physically.

Another student shared that she would have difficulty working on an oncology unit because "a part of me knows I can't do that day in and day out

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because I'm too vulnerable. My heart is always open and I don't want to lose that and become hardened."

A participant cared for her grandmother and grandfather who both had cancer at the same time her aunt, age 32, was dying of cancer. These three individuals lived next door to her. She also had a sister who "broke her back" and she assisted with her care. She shared:

> Everytime something happened . . . they would just call and say "Well, would you come over?" I cared for all my family that was really ill. I think that the earlier that it is in you[r] stage of life . . . it prepares you. But it gets to be too close . . . . You have to constantly talk over your feelings. You have to deal with it, so you do it. You just get in there and do it and deal with your emotions. I just wanted to care for people.

Another student described the care of her grandfather who had congestive heart failure and had experienced a stroke. She and her mother cared for her grandfather in their home. It seemed to be quite painful for her to describe her feelings:

> This happened four or five years ago. And it's something that stays with you from then on and you . . . always wonder if you did or did not do the right thing. He had a hard time going to the bathroom . . . and as far as actually having to help him with that . . . it took a long time to get used to caring for him, just because he was a family member, and doing things . . . you had to. I had to distance myself from that and me, and to know that . . . was the best thing for him. When we had to get him up and help him around, it got to the point that it was very frustrating for me. Everytime I had to get him up and he couldn't do it, sometimes I would get mad and then he would get mad and . . . he even got to the point that he even said that he didn't think I loved him anymore. And he didn't think any of his family loved him anymore. That was a strain for us because that's when you stop and think "Well, what am I doing wrong?" And then you blame yourself forever. I think it [distancing] was just something that came about. I think it was just a gradual stage brought on by the frustration and maybe the pain of what was going on. After so long you realize that there was nothing that you could do . . . and you realized that there were just things that you had to do.

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When questioned about what she had learned in nursing school relative to caring for those who are suffering, a student responded:

> That it's a lot harder than I thought it was gonna be. I get home and I'm more upset that I thought I would be. I guess I never realized how much you really get to know some of these people. . . . their families are there and they're frightened by the whole thing and it is hard to know what to say to them. . . . you don't want to feed somebody false hope. I just figured I'd be able to kind of come into it and remain a little more detached than I find myself getting. Which I'm not sure is good . . . at least for me . . . but I think it's helpful in the patient care.

One student expressed what she did to relieve some of the stress accumulated from caring for those who are suffering:

> I get home and I'm upset and you know you got to be able to get that out of your system and get up the next morning and have it be a fresh day and not completely dwelling on things that happened the day before. You're not going to be effective and so I'm having to find my own little stress relievers when I get home. I walk. I've caught myself cleaning, scrubbing, and I look down and . . . you're really cleaning the same spot over and over again. Just to try to get it out and don't sit there and stew about it.

Another participant felt:

> I was strong enough to be able to be with a patient like that and not let it affect me. I didn't have a whole lot of people to share it with and so I would take it home with me sometimes and just think about it. I talked to my significant other about it and after a while I had to stop that cause he said if it was going to be a problem for you, you need to make some arrangements to care for someone else. I realized I can't get too close. You know I think there is a danger in doing that . . . . I believe I know where the line is and in trying to keep that so that they don't get too close.

This final concise statement epitomized the paradoxical situation these participants experienced: "I think it's hard to be a nurse and care at the same time."

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The paradoxical situation in the very dense theme of standing inside/standing outside described the desire of participants to be with and care for a suffering person while also needing or wanting to distance themselves to protect their vulnerability. Several writers have agreed with the need for health care providers to distance themselves. Gadow (1988) recommended the dissociation from one's own body in order to deal with patients who are suffering. Morse et al. (1992) stated that when nurses attempt to reduce their own emotional responses to the sufferer, thereby decreasing their personal investment in the suffering, they initiate responses or learned professional reactions such as therapeutic empathy, humor, distraction, and confronting. These types of responses result in pseudoengagement. The caregiver is able to remain somewhat detached, objective, and therapeutically "at arms' length" from the person who is suffering. These learned responses are often acquired in basic nursing education programs from experience and from the modeling of faculty and other nurses.

Being With

The theme of being with emerged from students' descriptions regarding the critical importance of being with the family of the person who is suffering. Students believed families can suffer as much as the patient.

All except one participant stressed they had been taught in nursing school to consider and care for the patient's family. Students declared the emphasis on being with the family in their time of need had been an integral part of every nursing course they had taken. According to one student: "I think the family is

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the most important thing I've been taught in nursing." Another student claimed: "When a person is suffering, it's not that individual. It's the family unit . . . you have to get with the family because they are going through their own little private suffering."

Three subthemes emerged from the theme of being with: listening/communicating, caring/showing compassion, and connecting/putting oneself in the family's shoes. Each subtheme will be illustrated with participants' quotes.

Listening/Communicating

The subtheme of listening/communicating described the value students placed on communicating authentically with families of individuals who were suffering. Several students stressed the importance of listening to the family in order to ascertain their needs. One student stated:

> You should always listen to what the family wants instead of trying to force what you believe is right on them. You need to care for the family. The patient may not necessarily be suffering. The patient might be able to deal with it more than the family and you have to treat everybody and not just the person with the illness. It spreads . . . the illness is a family illness.

A participant was asked what she thought students should be taught about caring for those who are suffering and she responded:

> The student should not be fearful of the situation and to understand that there are going to be times of frustration. You're going to have to deal with a lot of anger not only from your client but from the family. You should always listen. That's the most important thing . . . to listen. To everybody, including yourself.

Another participant emphasized communicating with the family:

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> I really pay attention to siblings if there are any, or other family members of the person who is suffering. I try to talk with them, get them involved because it helped me to become involved . . . if they wanted to. And if they don't, I sometimes take them aside and talk to them or . . . anything that I can do that would be therapeutic for them. I begin by asking them what I could do to help.

Caring/Showing Compassion

Students provided abundant illustrations of the compassionate care they rendered to the families of those who were suffering. According to one student, he cared for families by:

> . . . offering a shoulder or silence. Sometimes it's just put your arm around a patient's family member or just sit there and hold the patient's hand and offer it that way. Just somebody to be there for them. Now I think I could get involved with it and talk them through it. Because having been there, I know what they're feeling maybe. Before, when you didn't know . . . it's a task.

Relating a story her supervisor shared, one student described compassionate caring:

> [The supervisor] spent the night working and she couldn't work for crying because this other nurse was taking care of a patient who was dying and they knew he was going to die that night. And she [the "other" nurse] had the wife get in bed with him and hold him and talk; just hold him and talk with him and tell him you love him. She [the supervisor] spent the whole night in tears but she admired her [the "other" nurse] so much because it gave them [the husband and wife] something. I [the student] wasn't even there, but that's what I'd like to do . . . there's no big pain medication or anything given . . . but being very in tune with the emotional aspect of it.

Connecting/Putting Oneself in the Family's Shoes

During the time his father was dying, a student shared that his mother:

> . . . kept saying "why?" I was asking the same question. I guess you have to look somewhere else, depending on your religious background, and that may have a bearing on how you handle it. That there was a reason . . .

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> maybe it gives me something I can carry out there in dealing with families cause I've been there. It's hard to do till you've been there. Now I know where they're coming from and . . . it's a hard thing to handle.

This account depicted the essence of the subtheme of connecting/putting oneself in the family's shoes. Participants provided many examples of how they felt they connected with the family of a person who was suffering. Because the majority of participants had suffered personally, they believed they were able to put themselves in the family's shoes.

One student stated:

> I think in general we have been taught throughout our courses from day one that when you treat the client, you treat the family. But I think it's something that I realized that I didn't grasp the concept before I was in the situation of being a family member taking care of somebody.

A student, who was also a licensed practical nurse, shared that she had a child who was born prematurely and had to be placed in a special care unit. As a licensed practical nurse, she now works in a unit for premature infants. "Having been there" was an important element in connecting with parents. She described:

> The parents were very concerned, very scared, and I tried to answer the questions as much as possible and . . . with the answers be realistic. And not, "Oh, it's gonna be fine." The mother believed the baby had become worse because of her breast milk and she started on this big guilt trip. I tried to make her understand that there was no way this was her fault. The child went to surgery. There was no way to save the baby and they just sewed him back up and brought him back up to the unit to die. The physician talked with the parents. I wanted them to be in control and help assist in the baby's death. I told the doctor the parents would like to bathe their baby before he dies. The physician agreed. There was no pressure, no time, no nothing. It was the mother, the father, and me. So we were able to talk while she was bathing and there was some laughing too. It made her feel good and I let her do everything. I mean . . . I was treating the child like gold . . . making sure I was real gentle with the skin

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> and the body. I let her wash the baby . . . and put his clothes on. She didn't watch the tube being pulled, but the father did and the father wanted to carry the baby to the conference room . . . to the doctor. I at least allowed the mother and the father to be in some type of control over their baby's death. I think it helped them make their suffering a little bit easier.

Several authors posited beliefs which were in accord with the data presented by these participants. Hinds (1992) believed the family of persons who are suffering may themselves experience intense suffering. She advised that nurses must be willing to listen and observe for cues that indicate suffering. Also, nurses should assist families to understand and deal constructively with immobilizing emotions which contribute to suffering. Brallier (1992) provided support for the findings of this doctoral research, when she stated "those who deeply love a person who is suffering . . . are likely to be very vulnerable while caring for that person" (p. 219). She believed health care providers must be aware of the vulnerability of the family of the sufferer and offer comfort and support to them. According to Hill (1992), "persons burdened with the physical and psychological stress of caring for these individuals over long periods are also considered sufferers" (p. 71). The suffering of significant others can be just as severe as, if not more so, than the sufferer, because of the perception of having even less control than the sufferer feels (Brallier, 1992).

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Synthesized Description of the Lived Experience of Nursing Students Caring for Individuals Who Were Suffering

The foregoing findings provided a basis for creating the structure of the lived experience of nursing students as they cared for individuals who were suffering. Participants richly, albeit with some difficulty, described the experience and its far reaching effects. Adhering to Giorgi's (1985) method of data analysis, the five themes of remembering/knowing, listening/voicing, attending, standing inside/standing outside, and being with were synthesized into a statement regarding the structure of the experience. The statement is:

To nursing students, the experience of caring for individuals who were suffering was a paradoxical coalescence of thoughts, feelings, and emotions. Suffering was perceived as being distinct from pain but frequently equated with pain. Emotional suffering was thought to be more all-consuming than physical suffering. The experience of caring for suffering individuals was remembered as being emotionally challenging while at the same time emotionally draining. As students, they were often frustrated and angry because they believed they were powerless to adequately alleviate the suffering of patients and also believed they were dealing with nonresponsive, uncaring nursing staff. The profound experience of caring for someone who was suffering stimulated their desire to "make a difference" in the nursing profession. Empirical, personal, ethical, and esthetical ways of knowing were utilized by students to know and explain the total experience. Students were physically, psychologically, and spiritually

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affected by the suffering they witnessed. Emulating role models was a primary avenue for becoming educated. Compassion, caring, technically skilled, well educated, and a positive attitude were characteristics of faculty and nursing staff whom students sought to emulate. Students attended to physical and psychological needs by nurturing the personhood of the suffering individual as well as managing pain, individualizing care, and showing compassion and respect. Highly valued was the ability to "put oneself in the shoes" of suffering individuals and their families. Students believed strongly the family should hold a preeminent position in nursing care planning and implementation. An additional paradoxical coalescence resulted from students wanting to care for persons who were suffering, while sensing the need to distance themselves to protect their vulnerability. Current nursing curricula prepare students to care for those who are in pain but fail to address caring for those who are suffering.

Theoretical Connectedness of Findings

The purpose of this study was to illuminate the lived experience of nursing students when they cared for individuals who were suffering. A phenomenological approach was utilized because as Burch (1989) said:

> Phenomenology does not simply iterate what is already given and understood. It seeks a transcending theoretical understanding that goes beyond the lived experience to situate it, to judge it, to comprehend it, endowing lived experience with new meaning. (p. 192)

Another advantage of using phenomenology for this research was it allowed us "to 'borrow' other people's experiences in order to better come to an

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understanding of the deeper significance of an aspect of human experience in the context of the whole human experience" (Ray, 1987, p. 169).

The theoretical connectedness of the findings is summarized in the following analysis of the assumptions which influenced me and were foundational for this research. Some assumptions are related to and are derived from nursing and other disciplines that guided the research; other assumptions are from my lived experiences.

The classical causal model of empirical science is inappropriate as an approach to study the lived experience of nursing students while caring for those who were suffering. The phenomenological philosophy and method is warranted for my research in order to describe the world-as-experienced by nursing students; thus enabling me to discover the common meanings underlying students' experiences in caring for individuals who were suffering. The findings from my study are in agreement with the assumptions that persons are beings who are engaged in and are constituted by their interpretive understanding and that "meaning in life is never predetermined. It is discovered by each person in his/her own living" (Kreidler, 1984, p. 175).

The theoretical research conducted as a part of my doctoral study confirmed suffering has been studied relatively well in the disciplines of religion and philosophy but studies are virtually non-existent in the health care professions, particularly nursing. Several authors cited in previous chapters agreed with my assumption that a more comprehensive understanding of the lived experience of caring for suffering individuals is needed.

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Other authors and participants in the study concurred with me that pain and suffering are not mutually exclusive concepts but may be studied separately in order to understand them more comprehensively. The data supported the assumption that there is no single entity called "pain" nor is there a single entity called "suffering." Research findings support the assumption that pain and suffering are pervasive, multifaceted, subjective phenomena. In the words of one student, suffering has "multiple, multidimensions." Kahn and Steeves (1986) stated that human suffering is a lived experience of the total person. Participants in my research substantiated this claim as they described how suffering affected all aspects of the sufferer's personhood.

Affirming the assumption that suffering may have multiple meanings for a person, students recounted myriad meanings for suffering from their perspective and from the view of sufferers. An assumption similar to the preceding one stated individuals who are suffering and health care workers who care for those who are suffering are confronted with existential concerns such as the meaning and purpose of suffering, as well as the meaning and purpose of life, living, dying, and death. All participants detailed existential concerns as they described the experiences of caring for those who were suffering. In the words of one student, her experience was a "reality check; it gets too close to dying. You're thinking about your own mortality. It's kind of like going through a little death of yourself."

Through the voices of the sufferers and through their own voices, students affirmed the validity of the assumption that the meaning(s) and purpose(s)

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attributed to suffering by an individual (both the one who is suffering and the one who is caring for that person) profoundly affect their physical, psychological, social, and spiritual reactions to the experience of suffering.

One of the most significant findings in this research supports the assumption that individuals who are suffering often need someone to help, understand, be with, truly be present, be authentic, and exhibit compassion for them.

Students were the embodiment of the assumptions derived from Paterson and Zderad (1988) which stated that nursing is a lived dialogue that incorporates an intersubjective transaction between a nurse and a patient and that nursing is the ability to struggle with others through peak experiences related to health and suffering.

An assumption partially substantiated was that nurses, on a daily basis, are confronted with many facets and forms of suffering and are challenged to understand it and be successful in its relief. All participants recounted that they saw many forms of suffering every day they were in a clinical area but there was strong evidence that all nurses are not challenged to understand it and be successful in its relief. Numerous examples were given depicting some nurses as being nonresponsive and uncaring toward patients who were suffering. Furthermore, several of these nurses were supercilious toward students as they attempted to relieve suffering.

Significant affirmation was obtained from participants that nursing lacks adequate descriptions of caring for those who are experiencing suffering or of

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those who are caring for individuals who are suffering. It was unanimous among participants that they had no formal educational preparation in caring for those who are suffering, nor had they experienced course work which prepared them for their personal reactions to the suffering of others.

The premise for my research was the assumption that insights into students' experiences in caring for suffering individuals can be learned through their accounts of the lived experience. Building upon that premise was the assumption that to understand nursing students' responses to caring for suffering individuals, one must study the responses in context. Students provided significant insights into their experiences and I always considered the contexts of their responses.

Integral to my research was the confirmation that nursing students can learn how to care for those who are suffering by utilizing the four patterns of knowing delineated by Carper (1978). Students described in depth the use of empirical, ethical, personal, and esthetical knowing.

One of the most significant findings of the study paralleled the assumption that nursing faculty can influence the manner in which nursing students care for suffering individuals. Students voiced many examples where faculty were outstanding role models. Often faculty made the critical difference to these students in demonstrating how a nurse should care for those who are suffering. Emulating role models was very strong within the voices of these students.

Another facet to the educational preparation of students involved the preparation of faculty to teach students how to care for those who were suffering.

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Despite the strong influence of faculty as role models, all students shared they had no formal "teaching" by faculty about the care of those who were suffering. Classroom teaching which they felt prepared them for relieving suffering was primarily in the pharmacological management of pain. Some students pointed out that a sociology elective on death, dying, and bereavement had been informative in teaching them how to care for a person who was suffering. Two students noted they felt very qualified to perform skills such as catheterizations and dressing changes but did not feel they had been taught how to alleviate suffering. One student stated it in this manner: "I think sometimes we learn to be good technicians, but we aren't always in tune with the emotional side. When you talk with people later about their experiences, they say 'the nurse held my hand.'"

The final assumption that I made prior to conducting this research is an explanatory statement for what I experienced listening to the voices of these students. It was "the more fully engaged we are, the more we can look through others' eyes, the more richly individualized we become" (Greene, 1978, p. 3). I had a rich experience as a result of sharing these narratives with the students.

Summary

Included in this chapter were the findings and discussion of the study. Five themes emerged as descriptive of the lived experience of nursing students in caring for individuals who were suffering. These five themes were remembering/knowing, listening/voicing, attending, standing inside/standing outside, and being with. Participants richly, albeit with some difficulty,

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described the experience and its far reaching effects. The findings of the study were presented and discussed in the context of the literary and theoretical contexts presented in Chapter II. Adhering to Giorgi's (1985) method of data analysis, the five themes were synthesized into a statement regarding the structure of the experience.

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CHAPTER VI

CONCLUSIONS AND RECOMMENDATIONS

The purpose of this study was to illuminate the lived experience of nursing students when they cared for individuals who were suffering. In the preceding chapters, the experiences of 12 nursing students were presented and analyzed. Through the use of the phenomenological method, I unveiled five common themes embedded in the experiences of these students. The five themes were: remembering/knowing, listening/voicing, attending, standing inside/standing outside, and being with. Subthemes were identified in four themes. A synthesized statement was developed to explain the structure of the experience.

This chapter includes the final conclusions or, in other words, the working hypotheses generated by the inquiry. According to Lincoln and Guba (1985), working hypotheses are tentative conclusions about the research findings. These working hypotheses are tentative both for the situation in which they are first uncovered and for other situations; there are always differences in context from situation to situation (Lincoln & Guba, 1985). I am in agreement with these statements by Lincoln and Guba.

Glaser and Straus (1967) believed that in qualitative research methods, conclusions are often discussed in terms of working hypotheses. Working

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hypotheses enable the researcher to develop additional pertinent questions about the data.

Working Hypotheses

Considering the study findings and comparing them to extant literary and theoretical contexts, the major working hypothesis of this inquiry is: Insight into nursing students' experiences in caring for suffering individuals is gained through their narratives of the lived experience. Several additional working hypotheses were developed from the data supporting the primary working hypothesis. The additional working hypotheses are:

1. Descriptions of the lived experiences of nursing students in caring for suffering individuals have five major aspects: remembering/knowing, listening/voicing, attending, standing inside/standing outside, and being with.

2. Personal experience with suffering alters the manner in which nursing students care for individuals who are suffering.

3. Suffering has multiple meanings for a nursing student.

4. The four ways of knowing (empirical, personal, ethical, and esthetical) delineated by Carper (1978) provide a framework for how a student comes to know and explain the experience of caring for a suffering individual.

5. A paradoxical coalescence occurs with students wanting to care for persons who are suffering while needing or wanting to distance themselves to protect their vulnerability.

6. The family of a suffering individual holds a preeminent position for nursing students.

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7. Nursing students believe that pain and suffering are different but pain is a primary element of suffering.

8. Nursing students believe that caring for those who are suffering is a way to "make a difference" in nursing.

9. Nursing students perceive a primary avenue for becoming educated to care for suffering individuals is through emulating role models.

10. Compassion is the main characteristic of a role model which students wish to emulate.

11. The meaning(s) and purpose(s) attributed to suffering by nursing students affect their physical, psychological, social, and spiritual reactions to the experience of suffering.

12. Nursing faculty and nursing staff influence the manner in which nursing students care for suffering individuals.

13. Nursing students often feel frustrated, angry, and powerless when confronted with nursing staff who do not adequately alleviate the suffering of patients.

14. Highly valued by nursing students is the ability to "put oneself in the shoes" of suffering individuals and their families.

15. Current nursing curricula prepare students to care for those who are in pain but fail to address caring for those who are suffering.

Recommendations

The rich data which emerged from this phenomenological study have implications for the nursing profession in the education, practice, and research

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arenas. Recommendations will be presented together in order to view them holistically and in context.

The idea for this doctoral inquiry was derived from my 20 years of teaching nursing students about the concept of pain and from extensive research in this particular area. Based on this experience and from the findings of the current study, I concluded that nursing students are not adequately prepared to care for individuals who are suffering. The recommendation is made that educational content be developed relating to the care of those who are suffering. The content should then be included in undergraduate nursing curricula.

No other research of this type was found in nursing or nursing education. Therefore, it is recommended that similar studies be repeated with other students to determine if their experiences with suffering individuals cause them to identify the themes (remembering/knowing, listening/voicing, attending, standing inside/standing outside, and being with) described by participants in this research. If other students identify similar themes, nurse educators should determine how to teach students to care for suffering individuals in varied contexts. Also, students could be taught effective coping strategies to deal with personal experiences in caring for those who are suffering.

Further investigation is needed in nursing education to determine how personal experiences with suffering alter the manner in which nursing students care for individuals who are suffering. The majority of participants in my doctoral research stated that "having been there" (meaning they had suffered) influenced how they knew a person was suffering and the actions they used to

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care for the person. "Having been there" also influenced some students' choice of nursing as a career. I question whether early, "profound or intense" experiences with suffering (either before a person begins nursing courses or early in the nursing courses) influence students more than similar experiences that occur at the end of their nursing curricula. Further examination of this question is recommended in order to determine if curricular content or planned clinical experiences related to caring for those who are suffering need to be situated early in the curriculum. This could enable students to assimilate their personal experiences and develop nursing care plans to care for suffering individuals.

Research is needed regarding whether the inclusion of undergraduate, registered nurse students in the sample would change the themes which emerged from the data in this study. Also, the voices of graduate students have not been heard regarding their experiences with suffering individuals. Owing to the fact that generic nursing students are placed in classes with registered nurse students in many nursing programs, studies are needed to determine whether the experiences of the registered nurse students differ significantly from those of generic undergraduate students.

It is recommended that nursing faculty utilize the phenomenological method in order to illuminate other aspects related to the experience of nursing students in caring for those who are suffering. Nelms (1988) believed nursing educators:

> . . . must begin systematically to illuminate the internalized personal meaning or "lived experience" of the nursing student as they experience the planned curriculum and the learning environment in order to make the

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> nursing education more personally relevant for nursing students and faculty and ultimately to make the nursing profession more sensitive and personally relevant to the public it serves. (pp. 4-5)

Another recommendation focuses on the need for nursing faculty to study how they influence the manner in which nursing students care for suffering individuals. It is recommended a study be made of the influence of nursing staffs' attitudes and actions toward suffering individuals upon nursing students caring for those individuals. A significant finding in my doctoral research was the tremendous effect that faculty and nursing staff have on nursing students. That effect was both positive and negative. Students provided descriptive stories about compassionate, highly skilled, and well educated faculty and nursing staff whom they wished to emulate. Conversely, they graphically depicted their perceptions of nonresponsive and uncaring nursing staff. Because pain and suffering are the most frequent complaints of most patients for whom nursing students care, it would seem logical that further research in this area is critical.

Paralleling research by Ferrell, McGuire, and Donovan (1993) on the academic deficits of pain education, it is recommended that nurse educators examine their own knowledge and beliefs related to suffering. It is my contention that education must begin with educators. Furthermore, faculty need to acknowledge that only through adequate undergraduate education on suffering will students become skilled clinicians equipped to contribute significantly to the relief of suffering.

A significant finding of this research was the frequency with which participants used intuition to know "when" and "how" a person was suffering. It

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is recommended that future research focus on the use of intuition by nursing students to "know" the suffering experience. Additionally, because the majority of nursing curricula focus on the empirical way of knowing and based on the findings of my study that substantiate that other ways of knowing are warranted in caring for those who are suffering, it is suggested that research be focused on how students use the other ways of knowing (Carper, 1978) to "know" about the experience of suffering.

Summary

The conclusions and recommendations generated by this inquiry were presented in this chapter. My assumption before I started this research, that insight into nursing students' experiences in caring for suffering individuals is gained through their accounts of the lived experience, was substantiated by findings and became the major conclusion of my study. Fifteen working hypotheses were presented. The chapter concluded with recommendations for future research.

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APPENDIX A

INFORMED CONSENT FOR A STUDY INVESTIGATING THE EXPERIENCE OF NURSING STUDENTS CARING FOR INDIVIDUALS WHO WERE SUFFERING

Researcher: Susan Sweat Gunby, R.N., M.N.

Academic Chair/Dissertation Chair: Jo Jones, R.N., Ph.D.

Purpose and Benefits

A tremendous void exists in knowledge and research pertaining to the lived experience of nursing students when they care for individuals who are suffering. Curricula in most nursing schools focus upon teaching students to alleviate the physical pain experienced by patients/clients and include little or no discussion of the experience of caring for individuals who are suffering.

The purpose of this study is to understand the lived experience of nursing students when they cared for individuals who were suffering.

Participation in this research could lead to an enhancement of self-knowledge through the process of self-reflection as a part of the interview conducted. The information you share with me could increase awareness of the need for further research on teaching students to care for individuals who are suffering. Also, this study could lead to an increased level of knowledge related to the ways nursing students learn to care for individuals who are suffering. An

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improvement in the quality of patient/client care could result from the research conducted.

Procedures

Your participation in this study will involve participation in an interview about your experience in caring for an individual who was suffering. The interview will be audiotaped. During the interview, the researcher may take notes.

Questions will be asked such as, "What is it like to care for an individual who is suffering?" and "What were your thoughts, perceptions, and feelings about this experience?" You will be asked to recount the experience in as much detail as you can remember.

During the study you will be free to choose not to answer or respond to any question or statement. You may stop the interview at any time.

Other Information

All information you share will remain confidential. Your name, or the name of the individual who was suffering, will not be recorded on any notes or transcripts from the interviews. Any inadvertent identifying information will be deleted in all records.

Your signed consent form will be kept separate from the remainder of the study data and will not be matched by code name or number.

Only the researcher and her dissertation committee will have access to the data during the study. Audiotaped recordings will be destroyed upon completion

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of this research. Confidential notes and interview transcripts may be kept by the researcher indefinitely.

There is no monetary compensation for participating in this study.

The completed study will be written as a dissertation and placed in the Georgia State University Library. The results of this study will be used to prepare scholarly writings or presentations in which you will never be individually identified.

Please feel free to ask about this study now or at any time.

_____

Signature of Investigator

_____

Date

Participant's Consent

The purpose of this study has been explained to me and I consent to participate. I give permission to the researcher to use audiotaping during the interview. I realize that I have the right to withdraw at any time. I understand I have the right to refuse to answer or respond to any question or statement. I understand that I can ask questions at any time. Furthermore, I understand this form will be kept separate from researcher notes and tape transcripts. I realize that the transcripts of the recordings will be edited to obscure inadvertent identifying information and will be confidential. I understand that the actual recordings will be destroyed or erased upon completion of this study.

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Signature of Participant

Date

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