Advances in Nursing Science
Issue: Volume 24(1), September 2001, pp 47-59

Publication Type: [Nursing Models of Care]
ISSN: 0161-9268
Accession: 00012272-200109000-00007
Keywords: enduring, pain, suffering, theory

Toward a Praxis Theory of Suffering

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The assistance of many colleagues is recognized. Special thanks go to Barbara Carter, Barbara Doberneck, Judith Hupcey, Maria Mayan, Karin Olson, Janice Penrod, Charlotte Pooler, and Maritza Tason. This research was funded by NIH NINR RO1 NR02130-08, MRC #MT14490, and MRC Scientist and AHFMR Health Scholar Award awarded to Dr J Morse.

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Abstract

This article revises and summarizes the major findings from a research program exploring the behavioral-experiential nature of suffering. Suffering is perceived as comprising two major behavioral states: *enduring* (in which emotions are suppressed; it is manifested as an emotionless state) and *emotional suffering* (an overt state of distress in which emotions are released). Individuals who are suffering move back and forth between these two states according to their own needs, their recognition/acknowledgment/acceptance of events, the context, and the needs and responses of others. Implications for the provision of comfort during suffering states are presented.

Understanding the experience of suffering and knowing how to assist those who are suffering are important goals. Yet, despite the vast amount of literature on suffering, little research has been conducted from a behavioral-experiential perspective. In short, although many have conducted interviews, written about the plight of the sufferer,[1] and the ethical-moral implications of suffering,[2] few have conducted research that observed those who were suffering, linking their emotional responses with their behaviors—and the responses of others to the sufferer—over the course of suffering. Until such research is conducted, we cannot understand fully the behavioral cues of the sufferer and how best to assist those who are suffering.

Nurses are the caretakers of suffering.[3] Understanding suffering, and the responses and needs of those who are suffering, rests squarely on the shoulders of nurses, and easing and alleviating suffering are the heart of nursing.[4,5] Nurses are at the bedside throughout the course of illness, and they are often the only

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support for those suffering, both patients and their families.[6,7] Although nursing has given voice to patients' "stories" of suffering,[8] the literature does not contain an accurate behavioral description of suffering. Links between these stories and patients' behavioral responses are lacking. More seriously, there is no connection between these stories of suffering, behavioral cues, and the responses of caregivers. Nursing texts contain recommendations for interacting with the sufferer that are not research based, and they promote caregiver responses, such as empathy, that are possibly inaccurate and may even be harmful.[9] There is an urgent need to explore suffering from a number of research perspectives, examine suffering within the clinical context, and evaluate nurse-patient interactions with patients who are suffering.

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LITERATURE REVIEW

Medicine has played a dominant role in examining suffering, considering suffering to be inextricably linked to pain [10,11] and other unpleasant symptoms, such as nausea and vomiting.[12] From this perspective, suffering is a behavioral/emotional pain response. The primary effort in medical research on suffering, therefore, has been to alleviate pain. Cassell [13] notes that this perspective of suffering is simplistic: to remove pain is to remove the suffering.

For many decades, social scientists have noted that suffering also occurs in response to the meaning of the symptoms to the sufferer (see, for instance, the classic work of Zborowski [14]). Despite this, medicine has been slow to recognize that suffering "goes beyond the physical."[13] Cassell [13] defines suffering in physical terms, but states it results in an emotional response of the whole person. He writes: "Suffering occurs when an impending destruction of the person is perceived; it continues until the threat of destruction has passed or until the integrity of the person can be restored in some other manner."[13(p33)]

The final major perspective on suffering is the ethical and theological-moral perspective, which considers the purpose of suffering and its redemptive qualities. The ethical perspective considers the relationship between treatment and the value of suffering in human life.[15] It also considers the moral responsibility of preventing and relieving suffering,[16] and the problem of causing suffering in the process of providing treatments. These and other authors explore the process of suffering and the transformative processes that occur when the meaning of suffering is realized [17] and suffering is relinquished.[18]

Kleinman's [19] early work explored the cultural representations of suffering within an ecologic framework and the cultural variation in normative behavioral responses. With Veena Das, Margaret Lock, and others, he later developed the notion of *social suffering;* in other words, the suffering resulting from "political, economic, and institutional power" and reciprocally "how these forms of power themselves influence responses of social problems."[20(p ix)] Such human suffering occurs as the result of war,[21,22] famine,[20-22] or violence [23] and occurs at the societal (national/populations) level [24] or within ethnic/cultural groups.[25]

Suffering has been linked with nurses' imperative to care.[26] The suffering of caregivers resulting from viewing or assisting those who are suffering has been a professional concern for many decades, and it is often linked to burnout. However, inherent in the process of providing care is the sharing of the suffering experience [27] and the moral obligation to speak of this suffering.[6] Recent caring theorists expanded beyond empathy to discussions of authenticity,[28] or genuineness, which Ray defines as "unconcealment of affect to self and others."[29(p115)] Our previous research [30] indicated that such genuineness may not be always present—nurses apparently either "matched" or "countered" the patient's affect, depending on their perception of the patient's needs. The interaction is apparently patient led, with nurses taking their cues from the patient. In order to provide optimally effective care, there is an urgent need to explore this phenomenon further.

Despite the vast amount of research into suffering, inquiry into the *nature* of suffering has rarely been approached considering it as an emotional response and using a behavioral-experiential approach. Suffering has been viewed as a response to losses: the loss of a pain-free existence,[10] the loss of health,[31] the loss of dignity, the loss of movement, the loss of an anticipated future, the loss of another, the loss of self.[32-34]

What is suffering? Many synonyms illustrate the affective nature of suffering: discomfort, anguish, distress, torment, pain, heartache, misery, anxiety, and affliction. Interestingly, "endure" is not listed under suffering, but under "endure" we find support, survive, brave, hold out against, withstand, and suffer. From our interviews, lay people speak about "enduringandsuffering" under the rubric of suffering, as though both concepts were one word (and therefore one concept), or different manifestations of one concept (that is, two parts or states within one concept), or as two separate, but inextricably linked, concepts ("enduring-and-suffering"). The perceived relationship between enduring and suffering has important ramifications for exploring suffering, because it determines *how* the studies are conducted methodologically, *how* the resulting theory is conceived and diagrammed, and ultimately *how* therapeutic interactions and therapeutic outcomes are established for those who are suffering. It also raises significant research questions. For instance, if suffering and enduring are separate states, can a person emerge from enduring without releasing the emotions? And, is it possible to experience emotional release and resolve suffering, without at some point enduring?

It also is important to note that some researchers consider enduring an integral part of suffering, but have not labeled it as enduring. For instance, Frankl [22] writes about keeping "suffering privately contained"; Reich [35,36] has a stage labeled "mute suffering." Is "mute suffering" another label for enduring? The literature is certainly conceptually confusing.

In this research program, we are exploring suffering using narrative accounts or stories of suffering and linking these with behavioral observations of those who are suffering. Our research program is divided into discrete research projects, each exploring various aspects of suffering. This research began as a part of an 8-year National Institutes of Health (NIH) grant delineating comfort for the improvement of nursing care. Then we realized that we could not understand comforting unless we first understood what was being comforted. We interviewed trauma and burn patients, patients with chronic conditions, and observed (including videotaping) in the trauma room. We continued to study enduring and suffering directly with a 3-year grant from the Medical Research Council of Canada (MRC), exploring suffering in oncology and palliative care populations. (A number of projects were funded by these grants. Refer to the original publications for methodological details.) We developed a model of suffering that consisted of two states: enduring and suffering.[37,38] This model has been revised considerably as our understanding of the second phase (releasing) developed: we relabeled this suffering as *emotional suffering,* identified the consequences of failing to endure, identified escapes from enduring and emotional suffering, and finally described the relationship between states of enduring or emotional suffering and caregiver response. This article presents the revised and expanded theory.

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A PRAXIS THEORY OF SUFFERING

We have identified two broad and divergent behavioral states of suffering: emotional suppression or *enduring* and *emotional suffering*.[38] These states are not only distinct, but also diametrically opposite; each demands that the person be treated in a distinctly different way.

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Enduring

Enduring occurs as a response to a threat to integrity of self. It results in a shutting down of emotional responses while the person "comes to grips" with a situation. Enduring is the blocking of the emotional response; emotions are suppressed, squelched, sealed off. Enduring is a strategy that enables the person to "go through the motions," doing what must be done. It is therefore a natural and necessary behavior that permits the person to continue day-to-day functioning, but the internalizing of emotions does not bring relief.[38] The individual *must* experience an emotional release *if* healing (ie, healing that is not of the physical body) is to occur.[39]

Enduring occurs at various levels of intensity, depending on the severity of the threat.[38] In its most extreme form, the person appears emotionless, with a mask-like expression. The person has an erect posture, with shoulders back and head up, and mechanical "chunky" movements. Walking is characterized by a robot-like gait, swaying from side to side. There is little facial expression, and little movement of the mouth and lips when speaking; the person speaks with an expressionless monotone, using short sentences and sighing often. Eyes appear dull and unfocused, the person shows little interest in life,[38] and he or she appears vague. In its most severe form, emotional suppression disconnects the person from life, such that later he or she may have no memory of the funeral or other stressful event.

Persons who are enduring focus on the present, and it is this focus that enables them to keep going, minute by minute. By focusing on the present, one blocks out the past and the future. If whatever is being endured is a physical threat, then individuals develop strategies for physically holding on to the present, such as counting something, breathing in and out, or watching the clock.[38]

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Escapes from enduring

The suppressed energy must go somewhere, and persons who are enduring often erupt emotionally, expressing anger at some trivial and tangential concern. For example, we see relatives in the trauma room furious with the staff over some minor matter. These *emotional outbursts* provide an escape for pent-up energy and escape from that which is being endured; they are usually episodes of short duration, with the person quickly returning to enduring.[40] Escapes used are *mind-absenting* behaviors that require purposeful concentration—tasks that distract and remove one's mind from that which is being suffered (eg, doing puzzles), concentrated cognitive work, hard physical exercise, or laughing hysterically. In its most extreme form, participants tell us they count—count the tiles on the ceiling or the leaves on the tree.[38]

We argue that enduring behaviors are instinctive and helpful because they are a normal response that enables preserving the self. According to the context and circumstances, we have identified three types of enduring.[38] *Enduring to survive* occurs in instances of serious physiologic threat. It enables the person to focus on vital physiologic functions such as breathing in order to control intractable pain, to focus on the self. It enables the trauma patient to remain in control, not to fight caregivers, so that care is provided more quickly and efficiently, and not to scream. It conserves the patient's energy and enables the provision of safe care. *Enduring to live* occurs in untenable life situations. It enables the person to focus on getting through each moment and thus getting through day by day, thereby getting through the untenable situation. *Enduring to die* occurs at the end of life. It enables the person to prioritize, conserve energy, maintain control, and remain focused on the present in order to bear the unbearable. Although enduring requires energy, it requires much less energy than emotional releasing. As the person's condition deteriorates, fatigue overwhelms and the person slips from enduring and relinquishes to death.

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Emotional suffering

On the other hand, emotional suffering is a very distressed state in which emotions are released. (Previously Morse and Carter 37,38 labeled this state as suffering, but it was confusing to label the model suffering, as well as one of the states within the model. We have revised the model to call this "emotional suffering.") The person who is emotionally suffering is filled with sadness. The person may cry, sob, moan, or weep constantly. The person talks to whomever will listen, repeating the story of the loss over and over, as if to convince himself or herself that the nightmare is real ("When I tell you it makes it true"). The person's posture is stooped, with head down and looking as if he or she is "falling apart." The face is lined, and facial expression is described as drooping.

When one is emotionally suffering, one can recognize the meaning or significance to one's life of whatever is lost; there is recognition too that the future is changed and irrevocably altered. Gradually, when one has "suffered enough," hope begins to seep in,41,42 and possible alternative futures are envisioned, realistic goals are established, and strategies to work toward achieving these goals are made. It is the work of hope that brings the person from despair to the reformulated self. Once suffering has been worked through, people report that they revalue their lives; they live life more deeply.

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Escapes from emotional suffering

Escapes from releasing are *mind-numbing* strategies. The person may sleep, drink, or eat excessively or try to remove himself or herself from the situation by mindlessly watching television. Note that while physical escapes used when enduring are actions that use excessive energy, emotional suffering itself uses energy. Those who have emotionally suffered report feeling drained. Therefore escapes from emotional suffering tend to conserve physical energy.38

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The trajectory of suffering

When a catastrophe occurs, the initial response of the individual is shock. The person's senses are acute, they are trying to absorb and make sense of what is happening. If it is an accident, then the person "checks out" himself or herself to see if his or her body is intact and how seriously it is injured. The immediate response may be denial, "No, *NO!*" There may be a failure to endure, as a loss of control or screaming. As soon as the person recognizes what has happened and recognizes that he or she must function in order to survive or to get through the situation, then the person "pulls himself or herself together" and begins enduring.

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Failure to endure

Through our observations of patients receiving trauma care, we identified six behavioral states. With the first four (unconscious, relaxed/normal, scared, afraid) some degree of relinquishment for care and enduring was evident. The last two, terrified and out of control, may be classified as a *failure to enter enduring*. Nurses' comforting actions using the *Comfort Talk Register,*43 and eye contact and touch 44 with patients who are terrified, facilitate the patient's ability hold on, prevent the loss of control, and move the patient toward enduring. Comforting strategies are not attempted with those who have lost control. Loss of control is a dangerous state for trauma patients: they are screaming and unable to hear or hold still, may fight caregivers, are restrained, and are usually pharmaceutically paralyzed as soon as possible so that care may proceed.

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Entering emotional suffering

Those who are enduring do not move from enduring to emotional suffering until they are tentatively ready to accept their loss. People may move slightly beyond enduring and "taste" emotional suffering, then sense the possibility of psychologically disintegrating and instantly move back into enduring. They also may flip back and forth between enduring and emotional suffering according to energy level, context, and available supports. In this way, progression through the model is not a linear movement from enduring to suffering. The person may move back and forth quickly between enduring and emotional suffering, and emotional suffering may suddenly, and at any time, overwhelm a person who is enduring. Furthermore, within each state, the emotional levels change in intensity. Sometimes, when enduring, it may take a great deal of energy to contain the emotion; other times the emotional suppression will occur without the sufferer being aware. Sometimes when emotionally suffering, the sadness will be intense; at other times, it will be manifest as an all-encompassing sadness resembling depression.

Individuals move back into enduring in two ways. First, the taste of releasing with its overwhelming emotions may cause the person to fear loss of control, fear that they may disintegrate, and fear not being able to regain control. Second, emotional suffering requires energy: After a period of sobbing, the individual is depleted of energy, and it is this depletion that enables the person to move back into enduring.

What moves individuals from one state to another, from enduring to emotional suffering and vice versa? We have identified two factors: (1) cultural and behavioral norms and context, contributing to the individual's ability to withstand the loss and (2) levels of understanding/acceptance about the event that is causing the response.

First, whether one endures or emotionally suffers is a process of *appropriate behavioral norms*. For example, one may endure in public and emotionally suffer in private; one may express emotional suffering in front of some family members and hide the emotional suffering from others. Family members suffering in the waiting room may "pull themselves together" as they walk toward the patient's room, ceasing to exhibit suffering, quenching their emotions. They endure as they enter the patient's room, for to reveal the extent of their suffering by revealing emotional suffering, is to reveal the seriousness of their anticipated loss, which might place a burden on the patient. It is paradoxical that at the same time patients are concealing their emotions from the family by enduring for the same reasons, and sometimes at great effort, suppressing their emotions and returning to enduring. This enduring behavior sometimes causes much distress to caregivers who have been taught that crying is normal, and who therefore try to encourage emotional releasing, particularly in families in which someone is dying. Thus, first it is the *appropriate situation* and *context* that, in part, determines whether a person endures or releases emotions.

Second, as previously mentioned, it is *recognition* that the event has happened that moves people into enduring; *acknowledgment* that it really occurred moves them into emotional releasing; and *acceptance* of the lost past and the altered future that moves them beyond suffering. Once the loss is accepted, hope seeps in; it is the work of hope that enables the person to move on to the reformulated future. We argue that suffering is a necessary means to recovery. In other words, emotional suffering is a "healing agent."[39]

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Outcome of suffering

People who have suffered reconstitute their lives, and they describe themselves as becoming much richer for the experience of suffering. They have an urge to "give back," to help those who are suffering get through the experience. They volunteer to help with support groups and become involved in the lives of

those who are suffering, and they are prepared to speak publicly of their experience, their loss, and their own suffering.38


Fig 1

To reiterate, the process is not linear. Note that enduring and releasing in Fig 1 are drawn with shaky circles, indicating the nature and intensity of the experience vary over time, sometimes from minute to minute, sometimes more slowly. People switch back and forth between enduring and emotional releasing, using the escapes when they can no longer endure or tolerate releasing.

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THE ROLE OF SUFFERING

We live within a social world of mutuality—of interaction, of dependence, of community. As such, behavioral cues of suffering communicate distress. From this perspective, we consider suffering behaviors, such as the signs of overt distress of emotional releasing (weeping, sighing, stooped posture, verbal expressions of distress, and so forth), as *signals that motivate others* to comfort those who are suffering.45

Enduring is a natural response that enables the individual to function. Enduring gives signals to others that imply dignity, capability, strength, and coping. It sends a message: "Don't touch; I'm fine, thank you." When enduring, individuals have an erect posture; their arms lie impassively at their sides, or they may be crossed as though they are literally holding themselves together. Family groups who are enduring stand apart. When one person is more distressed than others, family members may stand on either side of the one who is most enduring. There are spaces, gaps between each individual. They do not touch, maintain eye contact, or talk to the person who is enduring; they may "talk for" him or her, when approached by others.

When sufferers are releasing suffering, their posture is stooped; the extreme is to collapse on the floor. Those observing the sufferer to some extent share the emotional response or are moved to compassion, compelled to console, commiserate, sympathize, and pity. People step forward to touch, support, hold or hug, give reassurances, and so forth. They may encapsulate the sufferer with their body, as if to hold the sufferer together. This response in others to alleviate suffering is probably innate, although we recognize that those with certain relationships to the sufferer or those with certain roles or professional preparation have priority access to comfort the sufferer. That is, one is less likely to offer comfort to a stranger than a family member or a friend, but comforting a stranger is not taboo if the signals of distress are acute, or the circumstances are extraordinary.

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Paradoxes of suffering behavior

Because of the response of others to suffering (ie, suffering signals distress, which motivates others to assist), we describe emotional suffering as an external or public state. The nature of the distress and the type of behavioral signals present communicate the severity of the distress and place the responsibility onto others to intervene, to try to alleviate the distress by comforting, by *being there* for the sufferer.

A *paradox* occurs because emotional suffering is a state that is communicated, can be instinctively evaluated, and motivates others to alleviate the distress. It also can result in the distress of the other. Such is the basis of empathic response. Further, the sufferer is aware that *if* the reason for the suffering was caused by another, *if* it will distress the other person to see the suffering, *if* the very act of seeing the suffering will make the other suffer as well, or *if* the suffering is considered a sign of personal weakness, inappropriate in the context, then the

emotional release of suffering will be concealed. The paradox is that whereas its public nature enables others to assist in alleviating the suffering, its public nature also demands that emotional suffering be *a private behavior*. In our data, we have records of sufferers concealing their suffering, crying in secluded places (in a car on the way home from work 46), by retreating to the bathroom, or by simply turning away from others. Some people prefer to be consoled by counselors and clergy rather than family members and close friends in order to remove the responsibility and the burden of comforting from others who also may be suffering. The person also may conceal the suffering by moving from emotional releasing to enduring.

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Enduring behaviors

The suppression of emotions in the person who is enduring demands a distant respect from others. This makes enduring a private state in which the person's emotions are concealed. The upright posture and controlled emotions do not invite others to console—quite the converse. Those who are enduring send a signal to others not to touch or to hug, not to console or to comfort; rather, the message ranges from "leave me alone" to "stand back, I'm OK." The suppression of emotions and the focus on the present enable the enduring person to "get through" the immediate untenable situations beyond comprehension: the funeral, medical treatments, and so forth. It enables them to continue to care for children rather than to "fall apart," emotionally disintegrate, and be unable to function in day-to-day events. However, it is interesting to note that although enduring people consider themselves to be functioning quite well, in retrospect they may rate their level of functioning as poor. Because emotions are suppressed and not communicated to others, we have classified enduring as a private state. Again note an interesting paradox: The encapsulating or blocking of the emotions when enduring (hence making it a private state) enables *public behavior/public functioning*.

Returning to Fig 1, note that individuals may move back and forth between enduring and emotional releasing. It also is important to note that both concepts vary in intensity, depending on what is being endured, the distractions present, and the overall context. As their state alters, so do the others' styles of interaction with those who are suffering. From silent support and being there when they are enduring, to moving in and comforting when they are releasing.

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The synchrony of suffering

Day-to-day events demand that responsibilities be met, children be cared for, and one spouse "be there" for another. Thus one spouse may endure to keep "things going," while his or her partner suffers; sometime later, they may switch these roles. In this way there is a certain synchrony or pacing of enduring and suffering states that depends on the responses of others and on context. As previously mentioned, people may suffer in the family waiting room, walk down the corridor to visit with relatives, pull themselves together, move to enduring, and enter the room concealing emotional distress from the sick person. Later, when leaving the room, they may "break down" and return to the waiting room to suffer. Therefore, whether one endures or suffers depends on the context and the support available.

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IMPLICATIONS

Earlier I made the argument that "nurses are the caretakers of suffering."3 This means that the primary responsibility for the care, and the comforting, of those who are suffering is the professional responsibility of nursing and rests squarely on the shoulders of nurses. From the above, what can we ascertain that will help nurses achieve this goal?

First and foremost, we see that *care must be patient led (or sufferer led)*. Nurses are experts at reading the nonverbal behavioral cues of patients. Perhaps it is experience, intuition, or simply a part of human interaction that enables this "reading" of the patient. Nevertheless, being able to recognize the behavioral patterns that patients exhibit as they suffer—and use them to guide therapeutic interventions—is an advanced nursing skill. Nurses must be able to recognize and articulate behaviors related to suffering, to differentiate between those who are enduring and those who are emotionally releasing, and to recognize that they need to be treated differently. Those who are *enduring* should have their enduring behaviors supported. They should not be touched. Verbal statements should be used that support their enduring: "You're holding up well" is appropriate. Being with the person in silence—not saying anything—also is helpful, although it may appear that the person is unaware of your presence. Support must be present focused, making no reference to the future ramifications of the event.

When persons are enduring, empathy should *not* be used. These people are not "emotionally available" as they attempt to come to grips with their situation. Empathetic statements, consolation, commiseration, condolences, and expressions of sympathy and pity "break through" the enduring, so that the person will move unwillingly to emotional releasing. We call empathetic expressions that are unanticipated and cause the individual to "break down" *side swiping,* and nurses must recognize that helping a patient to cry or face the reality of the situation is not necessarily therapeutic.[45] Our value on tears as a therapeutic sign—a notion perhaps adopted from counseling—must be reexamined, for releasing may not be appropriate during a crisis. Individuals intuitively sense that during the crisis they must be "strong" or they will not be able to support others and do what needs to be done. Empathetic statements and the use of touch with those who are enduring give them something else to resist if they are going to maintain control—another thing to resist and to be endured. Thus empathy, when used with persons who are enduring, is not helpful and may even be harmful.[9]

On the other hand, when people are *emotionally suffering,* others encase them with an embrace, as if to give them a new body boundary, a support on which to lean. Touch is firm. These people are held and stroked, and the voices of caregivers console. When emotionally suffering, sufferers need to talk; listening is important, and empathy is appropriate. If they seek reassurances, these must be realistic ("I'll be here for you," rather than "Things will work out"). These people do not cry constantly—sobbing comes and goes, increasing and decreasing in intensity—but these people may continue to tear easily. Assistance with daily tasks, comfort food, and emotional warmth are important at this time.

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DISCUSSION

Nursing is beginning to recognize the significance of suffering in the provision of care, and expanding its conception of suffering. However, much of our research on suffering still focuses on pain [47] and other unpleasant symptoms.[48] There is a failure to recognize that not all pain, in particular chronic pain, the immediate pain of trauma, or the transient (but sometimes severe) procedural pain, can be eliminated; neither is it appropriate to always anesthetize these patients. Apart from the naturalistic childbirth movement that actively resisted analgesics and replaced them with coping strategies, we have done little to investigate ways to enhance enduring or foster stoicism, preferring instead to use restraints of one type of another, including simply holding patients down. There is an urgent need to investigate nonpharmaceutical measures that enhance patients' ability to endure, such as the *Comfort Talk Register,*[43] patterns of touch, and the most effective and kindest ways to conduct distressing procedures such as nasogastric tube insertion.[49,50]

While the focus on clinical pain continues, some authors are beginning to recognize enduring as a legitimate coping style [51] or aspect of hardiness,[52] more

often associated with psychosocial distress (such as homelessness 53), imprisonment,54 and catastrophes (such as tornadoes 55 or war 56). Nurse-authors are beginning to attend to suffering as the basis of patient needs,57,58 caring,26 and comforting,59 to interpret and to follow patient cues in our efforts to provide patient-centered care.44 Nevertheless, we still have an immense amount of research to do in learning to understand the behavioral cues of enduring and emotional releasing. Researchers continue to prefer to rely on the perspectives of professionals and patient reports of their needs and the nurse-patient relationship, rather than using video technologies and observation methods that will enable actually identifying those cues. We still have an immense amount to learn about appropriate modes of comforting those who are suffering.

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Key words: enduring; pain; suffering; theory

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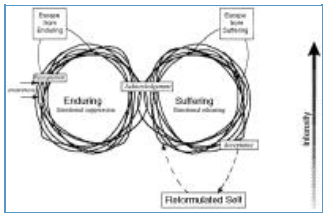

☑ Fig 1

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