A STUDY OF
HEALTH CARE PROFESSIONALS’ EXPERIENCES
OF WITNESSED SUFFERING

by

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Abstract

The purpose of the study was to investigate the day to day experiences of health care professionals who witness suffering in their work. The existing literature largely focuses on the negative consequences of experiencing difficult life situations involving suffering. There is less existing literature that focuses on the experiences other than vicarious trauma. Acknowledging the quantity of the existing research, the methodology chosen for this research that best addresses these issues was an exploratory phenomenological methodology. The general conclusions of this study highlight key aspects of the participants' experiences of witnessing suffering. This study identified four major themes which are; the impact of witnessing suffering, meaning making and the connection with something larger, holding a sense of duality and finally the participants' evolution over time. The first theme is the impact of witnessing suffering, which describes what these participants experienced as they look back over the many experiences of witnessing suffering. The next theme focuses on the meaning made by each participant as they witnessed suffering which includes their personal connection with something larger. This discovery highlights the pivotal role the participants' personal spiritual perspective plays throughout their work. The next theme describes the participants' experience of holding a sense of duality or holding opposing forces simultaneously as they encountered the day to day experiences of witnessing suffering. They noted how essential the holding a sense of duality is for continued engagement in their work. The final theme describes these participants evolution over time in relation to the frequent experiences of witnessing suffering day to day in their work. The changes noted include change/growth in their sense of self, physical responses, emotions,
expectations, and their spiritual development. It is clear that further research is indicated to further define the factors involved and seek a greater understanding of the paradox of witnessing suffering and experiencing growth. The importance of this greater understanding has numerous implications for professional training and could also assist in reducing professional burnout and increase opportunities for professional growth and development in the future.
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CHAPTER I

INTRODUCTION

I begin with this recollection of an experience in my work that planted the seeds for this inquiry.

On the bed, lies a ten year old boy, unconscious, dressings surrounding his eyes, nose and mouth in an attempt to absorb the seemingly endless slow oozing of blood. The bleeding announces his body's surrender to the leukemia he and so many close to him have fought against over the last nine years of his life. The room is still, filled with the uneven, persistent sound of the death rattle. Beyond the death rattle can be heard his mother's periodic wails, the gentle sounds of his father in attempts to comfort and the muffled voices of the health care team working to support this child and his family in the transition from life to death. Then in just a moment the room is silent, the wail becomes constant and over takes the room and beyond... The pain and suffering fill each person touched by the sounds and the presence of suffering so near. The parents receive support from family and health care team members. The team members each touched in their own way support each other as best they can. The team works to create closure on this relationship, this experience and then go on to another similar yet unique relationship and experience over and over again...

As a health care professional with twenty years experience, I have been exposed to pain, suffering and death in numbers of adults and children. I have at times felt unprepared for the experience of these complex and intense situations. I have been struck repeatedly by the intimate and personal nature of my reactions resulting from the multiple and persistent exposures to these experiences as part of my chosen professional field.

This experience is not unique in the work of professionals in the health care fields, particularly those who have chosen to work in palliative care or in areas where the reality of death can be as regular as disease management and cure. Experiences like this have fostered a process of transition for me as I moved from a novice health care professional to a position of more experience. I have noted changes in myself and in members of the interdisciplinary teams with whom I have worked. My own exposures and what I have seen in my colleagues has fuelled my interest in this research.
Statement of the Problem

The question that guides and is the foundation for my research work is: what is the experience—other than vicarious traumatization—of health care professionals who have witnessed suffering? This question includes the need to explore, clarify and understand the process(es) and influences of this phenomenon.

Rationale for the Study

Researching the literature, one finds works related to witnessed suffering (Arvay & Uhleman, 1996; Cerney, 1995; Charney & Pearlman, 1998; Collins, Taylor & Skokan, 1990; Dearing, 1985; Figley, 1995; Frank, 1995; Janoff-Bulman, 1992; McCann & Pearlman, 1990b; Schauben & Frazier, 1995; and Valent, 1995) which focuses primarily on the negative effects of exposure to trauma and suffering. Less work has been done regarding the possible positive effects of such exposure. The work that has been done in this area is early in the development of knowledge and is primarily at a theoretical level or focused on a very specific aspect of life circumstances (Affleck & Tennen, 1996; Calhoun & Tedeschi 1980-1990; Calhoun & Tedeschi, 1991; Calhoun & Tedeschi, 1998; Folkman, 1997, McCann & Pearlman, 1990a; O'Leary, Alday & Ickovics, 1998; Park, Cohen & Murch, 1996; Pearlman, 1995, Schaefer & Moos, 1998; Tedeschi & Calhoun, 1995; Tedeschi, Park, & Calhoun, 1998; Tennen & Affleck, 1998; Tennen, Affleck, Urrows, Higgins & Mendola, 1992).

The literature supports that health care professionals working with individuals enduring pain and suffering may vicariously experience a form of trauma as a result of their work experiences (Figley, 1995). There is a need to further explore the complexities of the “cost of caring” (Kleber, Figley & Gersons, 1995). It has been my personal experience, supported in the literature (Figley, 1995; Janoff-Bulman, 1992), that health care professionals may
experience secondary trauma as a result of vicariously experiencing the suffering of individuals with whom they work. Secondary trauma has been defined by Figley (1995) as, the natural consequent behaviours and emotions resulting from and knowing about a traumatizing event experienced by a significant other—the stress resulting from helping or wanting to help a traumatized or suffering person (p.7).

Other terms used in reference to this phenomenon include secondary victimization (Figley, 1995) compassion fatigue (Figley, 1995) and vicarious traumatization (McCann & Pearlman, 1989).

It is also my experience that the effects from work of this nature are not limited to secondary trauma and compassion fatigue. I noted gaps in the literature in relation to any positive consequences that may develop, despite the inherent risks of the work itself. Those who have written on the positive consequences have highlighted the significance of meaning attached to the experience and the impact of that meaning for the individual involved (Kleinman, 1988; Lavelle, 1963; Moulyn, 1982; Watson, 1986). In addition work by Tedeschi and Calhoun (1995) suggests a model of growth in relation to traumatic life experiences. In myself, there seems to be a range of other experiences that have included personal growth, psychological exploration, healing, spiritual questioning and growth. This research will expand the level of understanding of potential positive consequences of these experiences.

Assumptions

My evolution, noted previously, has included the development of understanding and insights resulting from these experiences and their impact on me as a professional and as a
person. The impact has touched the psychological, spiritual and physical levels of my being. I have witnessed changes in other health care professionals in a variety of ways. I have also noticed there appears to be a progression of change over time. It seems to me there may exist two extremes in the progression; one extreme including personal and professional growth after the multiple work-related exposures to pain and suffering. The other extreme includes the experiences of vicarious traumatization. I also understand that there maybe a whole variety of experiences and reactions within the progression between these extremes.

As a result of these experiences—personally and professionally—I am left questioning my understanding of these experiences and their impact for others and myself at a variety of levels. What can I do to further support those of us working in the helping professions as we endeavour to provide care and maintain personal and professional growth? I struggle to understand how and what is necessary to support the needs of professionals like myself in the day to day work. Ram Dass and Paul Goram (1985) have found words that fit for me:

> It's so...poignant. You feel ten dozen things at once.... It's unbearable and beautiful at the same time. It's just the part of you that's with them is getting ripped up. But the part of you that's like trying to understand it all... well, that's beautiful because you see that you can be, we all can be in the presence of great pain, but still appreciate life, even in its last moments. Especially then (p. 71).

**Definition of Terms**

**Suffering**

What is suffering? The Latin source for the word is *ferre* to bear. A commonly used definition is to "undergo, endure" (Oxford English Dictionary Online, 2002). Suffering has
over time been defined relying on definitions consistent within particular disciplines. Many traditions, and perspectives that have contributed in defining suffering over the years. A critical analysis of these is beyond the scope of the thesis.

For the purposes of this study, given the interdisciplinary nature of my work, I want to create an understanding of suffering that goes beyond the definitions provided specifically within one discipline but crosses a variety of disciplines, since the experience of suffering is a universal experience. The literature demonstrates a number of definitions of suffering. In creating an interdisciplinary perspective and acknowledging the universality of this experience I will organize the defining information in two categories in relation to self and other.

Suffering in relation to self is:

- when some crucial aspects of one’s own self, being, integrity or existence is threatened (Cassell, 1982, 1992; Chapman & Garvin, 1993; Gregory, 1994; Kahn and Steeves, 1986).
- inherently emotional, unpleasant and psychologically complex (Chapman & Garvin, 1993).
- described by the term “total pain” which includes physical, psychological, social, emotional and spiritual elements (Saunders, 1958)
- an enduring psychological state (Chapman & Garvin, 1993) that can range from a simple transitory feeling of displeasure to a final phase of apathetic indifference (Gregory, 1994).
- a possibility for self-conscious being (Dearing, 1985) and a consequence of person hood (Gregory, 1994).
• transformative (accumulation of wisdom) growth or healing that can enrich the lives of caregivers and sufferers through caring moments (Cassell, 1982; Gregory, 1994; Mulder & Gregory, 2000).

• connected within the spiritual/religious realm and explained by some Christian perspectives as the price God pays for participating in the creation of a full and holy life. Another Christian spiritually based explanation notes suffering is accounted for by sin or punishment of sin (Dearing, 1985).

• often used interchangeably in the medical literature with pain. Pain is not a sufficient condition for suffering; since experiencing pain does not always constitute suffering.

Suffering in relation to other is:

• part of our lives entering through many doors (Dearing, 1985) in relation to any aspect of the person- i.e. physical, psychological, social, economic and spiritual (Cassell, 1982; Chapman & Garvin, 1993).

• is considered by the helping professionals as their job to control and it is assumed to be controllable (Gregory, 1994).

• the mutual acknowledgement of the sufferer’s plight. It is our own experience of suffering that enables us to be compassionate and to share in the plight of another (Gregory, 1994).

• those who suffer, however, are always pained in some way (Gregory, 1994). Some pain will never subside; there exists unfixable suffering (Lehman, Wortman & Williams, 1987; Plomp, 1998; Tedeschi & Calhoun, 1995).
**Witnessing**

As we explore this question further, it seems necessary to clarify the meaning of the notion of being a “witness”. The Canadian Oxford dictionary (1998) describes an Old English source and defines witness “as a person present at some event or occurrence able to give information about it from observation”. What is it to be a witness? It may be a way to find calm/peace even in the midst of trauma. What is needed to bear witness? The role of witness (Dass & Gorman, 1985) allows us to acknowledge our feelings/reactions and then let them go allowing for compassion to move in. The role of witness gives us some room/space. This role acknowledges our feelings, encourages awareness of the actions and reaction of others. It is not committed to a particular result but open to all and its presence actually seems to bring about change. Being present, fully attending to the moment allows for the process of bringing “what is” into awareness. This awareness is the universe’s way of providing us with clues to understanding the experience of suffering, what is being asked of us, what fears are affecting us and what might really help us. This information is all available to us if we can listen—really listen (Dass & Gorman, 1985). The role of witness carries the expectation and responsibility to provide testimony, “the witness offers testimony to a truth that is generally unrecognized or suppressed” (Frank, 1995, p. 137). During the process of providing testimony the witness makes witnesses of others and with each telling and re-telling the cycle continues. Kleinman’s work (1988) includes the use of the term empathic witness, which describes an individual providing care with a purpose, whether that is in the form of a specific intervention or in their presence designed to provide comfort.
Health Care Professionals

Who is included when we use the term health professionals? Depending on whom you ask, I suspect you might get different answers. It seems necessary to begin with assumptions within some of the primary professions commonly considered health care professions. Historically the physician and the nurse are commonly associated with the health professions. Their roles and responsibilities have evolved over time as the health professions developed. Today the roles and responsibilities of the broader team of health care professionals have expanded beyond the historically established roles and responsibilities of those previously identified within the health professions.

In terms of the roles of physician and nurse an historical perspective is useful in the process of defining who is a part of the health care professions. The modern Greek word for physician is the noun “iatros” which originally meant “extractor of arrow” in ancient Greek (Karger, Sudhues, Kneubuehl, & Brinkman, 1998). Sir William Osler’s (1919) Essay on Vocation outlines the foundations of modern medicine while highlighting the distinction from priestcraft and the notion of the art of medicine as the science of observation of man and nature. In addition, Osler (1919) describes medicine as the profession of cultivated gentlemen with high moral ideals. Osler’s writing defines the work of medicine “to prevent disease, to relieve suffering and to heal the sick”. The physician is expected to undertake these tasks as well as,

while calling forth the highest powers of the mind, brings you into such warm personal contact with your fellow men that the heart and sympathies of the coldest nature must needs be enlarged thereby. Will not your whole energies be spent in befriending the sick and suffering? (Osler, 1919, p. 9).
While the word nurse derived from Middle English and Old French (norice) and Latin (nutriere) means to nourish (Canadian Oxford Dictionary, 1998). In Osler’s (1919) essay he also coments on the profession of nursing “there is no higher mission in this life than nursing God’s poor” (p. 11). Osler (1919) notes that the majority of applicants for nursing school are women and this fact remains unchanged even today. He places the trained nurse as a blessing beside the physician and priest while maintaining equal status regarding her chosen mission. Regarding the work of nursing Osler (1919) notes,

Kindly heads have always been ready to devise means for allaying suffering; tender hearts, surcharged with the miseries of this “battered caravanserai”, have ever been ready to speak to the sufferer of a way of peace, and loving hands have ever ministered to those in sorrow, need, and sickness (p. 10).

Today the term health care professional could be the doctor, for others it could be the nurse, physiotherapist, pharmacist, occupational therapist, social worker, clinical psychologist, chaplain and others or some combination thereof. For the purposes of this study all those associated in the present sphere of patient care as noted above are considered health care professionals.

Purpose of the Study

This study is designed to reveal the essences and meanings of the health care professionals’ experiences other than vicarious traumatization (Moustakas, 1994) of witnessed suffering. The focus other than vicarious traumatization narrows the study perspective and selects a phenomenon that is not well researched. The purpose of the study is to discover the psychological, spiritual and physical factors within these experiences. I have
examined data that creates a comprehensive, vivid and accurate description of the experience which includes meaning making and understanding of the experience (van Manen, 1997). The selection of a qualitative approach allows for the opportunity, in a small population, to have an intense and in-depth look at the experience. When this description is created it will resonate for those who have had such experiences while simultaneously attempting to describe experiences to those readers who have not had these experiences themselves.

The intent of this study is to expand the existing theoretical knowledge-base regarding the consequences of consistent and persistent exposure to suffering on health care professionals, particularly related to those experiences that arise which are not as well explored and documented as vicarious traumatization. The outcomes from this study have created opportunities to further increase positive outcomes rather than increase the negative outcomes for health care professionals. This research has contributed further to existing research in the specialized area related to reactions/responses to witnessed suffering. The findings also provide confirmation of what is presently known regarding secondary trauma and compassion fatigue while expanding the knowledge regarding the positive consequences.
CHAPTER II
REVIEW OF THE LITERATURE

Call the world. 'The vale of Soulmaking'...Do you not see how necessary a World of Pains and troubles are to school Intelligence and make it a soul? A Place where the heart must feel and suffer in a thousand diverse ways. Not merely is the Heart a Hornbook, it is the Mind's Bible, it is the Mind's experience.

John Keats, Letter to George and Georgiana Keats

The phenomenon of witnessing human suffering is not unique to health care professionals. Being a witness to human suffering is a part of the experience of being human. It is inevitable and unavoidable, especially in this age of rapid information sharing. Each individual has a unique personal experience(s) of suffering. Each individual’s experiences of suffering are influenced by personal experience, meanings, cultural values, norms and specific levels and types of suffering (Duffy, 1992). Some experiences of suffering will be agonisingly intense and others may be painful and somehow less intense. The experience of suffering has been represented historically in a variety of forms including religious materials, literature, music, drama, and a variety of artistic forms. Suffering has been represented in cultural traditions in the form of stories reflecting the impact of suffering and the possibility of positive change passed from one generation to another.

As stated in Chapter One, this study will focus on health care professionals’ experiences, other than vicarious traumatization, of witnessed suffering in patients during the course of their work. This chapter begins with a review of the literature related to the general notion of suffering and then moves to the health care professionals’ vicarious experience of it. The chapter concludes with an identification of existing gaps in the literature related to the experience of witnessed suffering.
The Notion of Suffering

It is difficult given the many approaches and contexts within which suffering are explained to know where to begin. I will begin with some explanations within the religious and spiritual realm since those areas are often ignored, are the least understood and researched.

Religious/Spiritual Perspectives

The religions of the world have a deep affiliation with the frequently painful nature of the human condition. Each of the major religions has its own way of acknowledging the fact that life can be perilous. Buddhists believed that existence is first experienced as suffering (Dukkha) which is universal and inescapable. Dukkha encompasses physical pain and mental anguish, negative changes, and lack of freedom (Gard, 1962). One illustration of the ability to hold the tensions associated with suffering is illustrated in an old Chinese story quoted by Roshi Philip Kapleau (1989) in the *Wheel of Life and Death: A Practical Spiritual Guide to Death, Dying and Beyond*, is the following story:

One day a farmer lost his horse because it ran off and his neighbours came to console him, saying “Too bad, too bad”. The farmer responded, “Maybe”. The next day the horse returned, bring with him seven wild horses “Oh, how lucky you are!” his neighbours exclaimed. “Maybe,” the farmer answered. On the following day, when the farmer’s son tried to ride one of new horses, he was thrown and broke his leg. “How awful!” cried the neighbours? “Maybe,” the farmer answered. The next day soldiers came to conscript the young men of the village, but the farmer’s son wasn’t taken because his leg was broken. “How wonderful for you!” said the neighbours, “Maybe,” said the farmer (p. 247).

In Buddhism the Four Noble Truths are expressed often as the existence of suffering, the causes of suffering, the cessation of suffering, and the path that leads to the cessation of suffering (Bowker, 1970). The Noble Truth of suffering is contained within the Noble Eightfold Path to the cessation of suffering which is stated as; “birth is suffering, aging is
suffering, sickness is suffering, death is suffering, sorrow and lamentation, pain, grief and despair are suffering. Association with the unpleasant is suffering, dissociation from the pleasant is suffering, not to get what one wants is suffering” (Bowker, 1970, p. 239). In summary, the five areas of attachment (matter, sensation, perception, mental formulation and consciousness) are sources of suffering (Bowker, 1970). In fact, living is suffering.

In Judaism and some elements of the Islamic tradition, God chooses those who suffer. Some are chosen to be tested by God and in some way are special for being chosen. Some Islamic sects believe there exists a salutary welcoming of suffering. From a Judaic perspective, understanding of suffering includes the belief that suffering purges and leads to life, and it can be made redemptive, and become the foundation of better things, collectively if not individually a way of atonement (Bowker, 1970).

Christianity uses an interpretation of suffering in the world through the crucifixion of Jesus Christ. Inbody (1997) provides four Christian interpretations of suffering which are: “Punishment: we deserve what we get, pedagogy: our suffering is education for our growth and maturity, eschatology: all’s well that ends well, mystery: all is finally consumed in mystery” (p. 59-63).

In the Hindu tradition one’s suffering in life is related to one’s fate, based on how well one has lived in previous lives prior to one’s current incarnation. It is essential that each individual act with integrity, and to live true to themselves on whatever level that maybe (Bowker, 1970).

Geertz (1966) notes any religion must consider “how to suffer, how to make physical pain, personal loss, worldly defeat, or the helpless contemplation of others’ agony something bearable, supportable-something, as we say, sufferable” (p. 19).
Philosophical Perspectives

Existential philosophers have made a significant contribution in the understanding of the human experience of suffering. The development of existential psychology offers several notable perspectives. In Yalom’s (1980) writing each individual is essentially alone in the universe and each person has responsibility for “creating one’s own self, [and] destiny” (p. 218). In May’s writing (1981) destiny is the “givens” in life that must be accepted which influence our freedom to choose a life path. Kierkegaard (1983) and Nietzsche (1955) note opportunities for growth in trauma and suffering. In addition to opportunities for growth Frankl (1963) notes each individual maintains a central focus on the notion of the quest for meaning and purpose in life and the capacity to transcend environmental influences. Baltes and Smith (1990) comment in addition to the previously noted growth opportunities, that the possibility exists for increased life wisdom as a result of existential issues. Fromm (1947) contributes the inevitability of existential anxieties as part of the human condition and the freedom of choice. These philosophical perspectives include recognition of our isolation and mortality and ways we seek to allay our fears of these.

Psychological Perspectives

Psychology contributes significantly to the existing knowledge regarding the experience of suffering and witnessing suffering. The psychological literature itself covers a wide range of research territory. There has been research on the effects of difficult life events on person’s physical, emotional and spiritual well-being (Epstein, 1990; Janoff-Bulman, 1989; 1992; Pennebaker, 1990; Vash, 1981). There has also been research demonstrating the negative effects of suffering and vicarious suffering in relation to trauma (Herman, 1992; Figley, 1983, 1995; Figley & Kleber, 1995), adult survivors of trauma (McCann & Pearlman,
1990) and trauma counsellors (Arvay & Uhlemann, 1996; Cerney, 1995; Charney & Pearlman, 1998; McCann & Pearlman, 1991; Pearlman & Saakvitne, 1995; and Valent, 1995) which offers some insight into the cost of caring and the provision of supportive services in situations of suffering. Many of these studies cite the negative effects on health care professionals as witnesses to suffering that include alcohol and drug abuse, depression, sexual misconduct or burnout (Farber, 1985; Kahill, 1988; Lalotis & Grayson, 1985) and disruption in spirituality (Pargament, 1997).

Individuals and clinicians often anticipate that the outcomes of difficult times/trauma are limited to negative effects. There recently has been a small and growing research base to support the notion that paradoxically negative life challenges have a positive effect on the lives of those affected (Calhoun & Tedeschi, 1998).

Health Care Professionals' Experience

Each professional brings a variety of unique experiences with them into their work life. In addition to these uniquely disciplinary experiences each individual brings professional perspectives and their own personal qualities as well. This section will explore some professional roles, influences on roles, and personal qualities.

Professional Roles

In an attempt to understand the impact on health care providers of their regular exposure to suffering in-patients they care for, it is necessary to understand and appreciate some of the features of their professional identity. For example:

- What is their professional purpose?
- How were these professionals prepared or not prepared for the experience of witnessing suffering so regularly?
• What expectations do these professionals have for themselves?
• What does their professional discipline expect in terms of their role?
• What does society see as their responsibility regarding their role and the witnessing of suffering?

Physician Role

Let's begin with medicine and the role of the physician, who is often the first contact for any individual experiencing illness. The medical profession as we know it existed only since the nineteenth century. Prior to that society was cared for by a variety of healers, only a small number of whom were physicians. During this time period most physicians were general practitioners. In the early 1900's there was the increasing development of specialization which emphasized rapid technological advancement and specialized training. Early in this time period a significant shift occurred following a report on Medical Education in the United States and Canada (1910) conducted by Abraham Flexner. Flexner strongly believed that the promise of medical progress and education was based in science and dreamed of scientific medicine (Flexner, 1910; Porter, 1997). He suggested a plan for medical education that had it's foundation in the natural sciences and encouraged research, teaching and maintained good scientific facilities. Recommendations from this report and funding from John D. Rockefeller and other financial support changed the face of medical education at the time, raising the standards for entry and a reducing the number of colleges (Flexner, 1910; Porter, 1997). This trend toward specialization focused on laboratory science, technological aspects and research. The development of these areas of specialization contributed to a decline in the number of general practitioners and created a fragmentation within the profession which affected the quality of physician-patient relationships (McWhinney, 1997).
In addition, the next most important influences to general practitioners were the influence of new developments in behavioural and social science (McWhinney, 1997).

Today medicine has an identity as a science whose purpose is to diagnose and treat disease. In addition, physicians must recognize and respond to all forms of suffering. Physician’s tasks include understanding illness and understanding people (McWhinney, 1997). At present one of contemporary medicine’s central purposes relevant to this study is to relieve pain and suffering (Campbell, 1997). Cassell (1982) also notes that the twin obligations of medicine are to relieve suffering and cure disease. Some pain is accepted as a necessary part of the certain procedures but the relative tolerance for pain is considered reasonable in the broader context of achieving a pain-free existence for patients and to enhance patient control and quality of life (Campbell, 1997).

Suffering, not death, is the ultimate or absolute ‘enemy’ of modern medicine, while death is a relative or qualified enemy which may be transformed into a dignified ‘exit’ under appropriate circumstances (Campbell, 1997, p. 247).

Cassell (1982) notes the obligation and expectation of physicians to relieve suffering goes back into antiquity (Osler, 1919). He further notes,

the dominance and success of science in our time has led to the widely held and crippling prejudice that no knowledge is real unless it is scientific-objective and measurable. From this perspective, suffering and its dominion in the sick person are themselves unreal (p. xi).
The pain and suffering that may be unintentionally inflicted as a result of physician recommended intervention is described by Kuhl (2002) as “iatrogenic suffering”.

MacLeod (2001) notes that training of physicians strives to help them feel in control of situations by therapeutic interventions dealing with symptoms or disease. They have often been told “don’t get involved: keep your distance” (MacLeod, 2001) while working with people who are vulnerable, helpless and powerless while the physicians are unable to control what they have been prepared to believe they can control. However the ability to put oneself in the place of another or to demonstrate empathy, is an essential aspect of caring. The practice of empathy in relation to suffering includes paying genuine attention to and accepting the individual’s concerns (MacLeod, 2001). In the day to day reality however, patients experience suffering, and physicians are not always able to eliminate the suffering. So they may experience their own suffering as a result of feelings of helplessness and vulnerability (MacLeod, 2001) as professionals in their roles, in relation to their failure to eliminate the patient’s suffering. McWhinney (1997) notes, “the most intense form of suffering is vicarious suffering” (p. 91). In these moments of helplessness if the physician or any health care professional experiences sympathy (shares in the feelings of suffering) and/or experiences feelings of pity which may involve feelings of contempt and rejection this may result in increased feelings of separation/distance for the individual and the health care professional. The presence of feelings of sympathy and/or pity can have a detrimental effect on the caring relationship and again add to the suffering of those involved (MacLeod, 2001). It appears there maybe an inter-relationship between witnessing suffering and the experience of suffering for those in the role of the witness.
It is only very recently that the implications of witnessing pain and suffering for physicians and other care providers who witness suffering has been a consideration. Also, it has only been with the recent developments in behavioural sciences that a new body of knowledge regarding behavioural and social factors has demanded integration within medicine and the broader health professions in relation to patients, and it is just beginning to expand in relation to those providing care.

McWhinney (1997) notes the task of understanding the illness is indivisible from understanding the person who is ill. This definition certainly highlights the evolution of medicine’s focus over a period of time. Some of the difficulty in looking at the impact of the experience of witnessing suffering for care providers may stem from their own training in relation to illness. McWhinney (1997) notes physicians are not trained to understand illness as a human experience. Physicians can come to understand both their own experience of witnessing suffering and the patient’s experience of suffering by paying attention, listening, reading the appropriate literature and reflecting on their own experience. Medicine has historically been pre-occupied with some essential physiological understandings so that only now when these have been more extensively investigated has there been the opportunity for other areas to be explored more fully.

Both physicians and nurses care for patients and one of the shared realities for these professions and others in health care is that care is provided to patients. In examining the etymological root of the word, “patient” this word includes “pati” which means “to suffer”, so not only are health care professionals prepared in their training to address suffering, the role of the patients they care for is expected to include suffering as well.
Nurses' Role

In considering other key roles within the health professions the nursing role is significant. Much like the development of the role of the physician, the role of the nurse has evolved over time. The role of the nurse certainly was more strictly formalised during the Crimean War. The profession of nursing has historically been primarily female dominated and remains so at present. Until that time, in combat situations, those providing care were either the physician or other military personnel. Around this time Florence Nightingale, with a reputation as an authority on hospital sanitation and function was involved in taking charge of the hospital in Crimea. She hired a group of young women to go with her and serve as nurses, establishing the role of nurse within the military (Wicks, 1998).

Traditionally nurses felt their areas of active involvement in healing were pain relief, wound management and care of the dying patient. The practice of pain relief is an area in which a high proportion of nurses consider themselves expert in their judgement and practice. Nurses today regard the focus of their profession to be the patient’s comfort and pleasure, and to promote healing through caring involvement in the patient’s internal and external environment (Wicks, 1998). The contemporary role of the nurse continues to evolve, and while maintaining some features from early in this profession’s development nursing continues to add new dimensions and perspectives regarding patient care, advocacy, education and research. An extensive analysis of the ongoing evolution of the profession is beyond the scope of this study.

Health Care Professional Role Influences

The roles of physicians and nurses have been influenced recently by feminism, particularly in relation to the division of labour, by sociological theory, health care policy and
the structure of the health care workforce. In addition, there is the conflict of professional focus between medicine and nursing, with medicine focusing on “cure” and nursing focusing on “care” (Wicks, 1998). This conflict arises when physician initiated interventions that focus on cure impact on the nurses’ focus to provide care.

As a result of the historical development of the roles of physician and nurse, their professional conditions and the impact of societal influences over time have played a significant role in their experiences of witnessing suffering in those they care for. For physicians who have focused on “cure”, the witnessing of suffering can be framed as one aspect of what is considered the “healing” process, not an end but a means to an end. This specifically refers to the use of more and more complex and at times invasive treatment alternatives. For nurses their desire to “care” has been repeatedly challenged as the focus of their work has shifted to increasingly demanding treatment procedures designed to “cure” which have fewer aspects which are consistent with the historically based understandings of “caring” behaviours.

The notion of the connection between psychological states, spiritual influences and physical states was not historically part of the notion of traditional Western “healing”. The interconnection of these various influences was more common in what has become considered complementary approaches or non-conventional treatment. The history of the traditional medical approach has focused primarily on the physical aspects, which left little or no room to consider the influence of other factors like the psychological and spiritual in relation to illness (McWhinney, 1997). This separation of the physical, psychological and spiritual has remained to some degree over time. Today, this same struggle is demonstrated as a part of the interdisciplinary dissonance when health care professionals are involved in
providing what is called “healing”, and each discipline brings its own specific perspective or behavioural objectives to define what healing is.

**Personal Qualities**

One inescapable aspect of the health care professionals’ experience in relation to their work is what each individual brings with him or her to the experience. Research intent on explorations of the many aspects of personality cross a variety of areas including the life cycle (McAdams, 1994), and in relation to trauma work (Hermans & Hermans-Jansen, 1995). They include work on psychotherapeutic change (Landman, 1993), affective experience (Harvey, Orbuch, Chawalisz & Garwood, 1991), and personal crisis (Herman, 1992; Pearlman & Saakvitne, 1995). Personality has strong support as a potential moderator of outcomes during and after a trauma. The literature suggests that personal growth following a trauma may be more common than previously thought (Affleck, Tennen, Croog & Levine, 1987; Affleck, Tennen & Row, 1991; Wallerstein, 1986; Yaron, 1983), but has not been presently demonstrated as so frequent that it supersedes individual differences in personality traits. Previously, authors studying in the area of personality and transformation have cited links between crisis related benefit-finding and personal growth to internal locus of control (Wollman & Felton, 1983). Others have noted the effect of a persistent belief in a just world (Kiecolt-Glaser & Williams, 1987), dispositional optimism (Park et al. 1996; Thompson, 1985; Tennen et al. 1992), extraversion and openness to experience (Tedeschi & Calhoun, 1996). The present research on the idea of growth/transcendence has supported and grown from earlier theories of psychotherapy (Frankl, 1963), as well as models of preventive psychiatry (Caplan, 1964), and systems theory (Maruyama, 1963). The research has continued to expand to cover a variety of areas described earlier as well as “physiological
toughness” (Dienstbier, 1992), and resilience (Rutter, 1987), which had not been previously mentioned. In examining the evolution of this research what is apparent is the awareness of the significance of a variety of personal qualities that play an important role in the process of growth/transcendence.

In considering the health care professionals’ work, some research has explored the area of coping (Folkman, 1992; Schaefer & Moos, 1992, 1998). Studies by Bloom (1998), Norris and Murrell (1987), Rush, Chandler and Harter (1980), and Rutter (1987), deal with interpersonal and social forces and prior life experiences that promote adaptation during and after a personal crisis. When considering these ideas and what health care professionals bring in terms of professional “personality” and their previous life experience, there are specific features that require description. Individuals who choose the helping professions have made a contract to “help” those that they serve. They may be providing help in relation to different aspects of the individual (physical, psychological, social, spiritual, practical etc.), but their overriding understanding of their presence within any specific relationship with an individual in their work settings is to provide help. Professional codes of ethics and standards of practice within each profession are designed to confirm and articulate the intention helping professionals accept within their profession.

Schumacher (1979) in his book Good Work describes work as “one of the most decisive influences on (a person’s) character and personality” (p. 3). Yet, he writes, “The question of what the work does to the worker is hardly ever asked” (p. 3). Susanne Langer (1979) wrote...“any man who loves his calling loves it for more than its use; he loves it because it seems to have ‘meaning’” (p. 288). It is clear that choice of work, the meaning made of it, and the personal qualities that influence the choice of work are complexly linked.
Suffering and Growth

Having previously provided a definition of suffering, it is necessary to provide a working definition of growth. Growth refers to a process that result in an increase in size or value (Oxford English Dictionary, 1998). In relation to experiences of suffering, other authors using a variety of terms have described the term growth. Some examples of these terms include: positive psychological change (Yalom & Lieberman, 1991); perceived benefits or construing benefits (Calhoun & Tedeschi, 1991; McMillen, Zuravin and Rideout, 1995; Tennen et al. 1992); stress related growth (Park et al. 1996), thriving (O’Leary & Ickovics, 1995), positive illusions (Taylor & Brown, 1988) positive reinterpretation (Scheier, Weintraub & Carver, 1986) and drawing strength from adversity (McCrae, 1984). The phenomenon described by these terms has also been described and explained in religion and literature over the years as the way human suffering brings individuals closer to wisdom, truth and God (Tedeschi, Park & Calhoun, 1998).

The research in the area of suffering initially focused on the consequences of exposure to difficult or challenging experiences. The early work in this area noted primarily negative effects of a variety of life experiences like life threatening illness and chronic illness and disability, natural disaster/accidents and bereavement. The features identified in these areas that contribute to negative consequences are the sudden and unexpected nature of events that increase the risk of threat to psychological well being (McCann & Pearlman, 1990; Weiss & Parkes, 1983). Another feature of these events is the lack of control experienced by those affected (Slaby, 1989; Tennen & Affleck, 1990). In all these events there is additional risk of negative impact given that these events are out of the ordinary and there is no previous experience to help manage the circumstances (McCann & Pearlman, 1990).
The results or outcomes of these events influence the degree of negative consequences, so that those events that are highly disruptive or that result in permanent significant life changes are most likely to have a greater negative impact. In these kinds of negative life situations, current research (Downey, Silver, & Wortman, 1990; Tennen & Affleck, 1990) indicates those individuals who blame others for their circumstances are at greater risk for difficulties than those who don’t. The impact of any of these kinds of difficult life events will have different negative consequences at different times and in different ways in relation to the individual affected (Tedeschi & Calhoun, 1995). In reviewing the literature on these specific events what is most often documented are the negative effects. The majority of other studies related to additional types of posttraumatic experiences demonstrate negative effects (Armsworth & Holada, 1993; Berlinsky & Biller, 1982; Furman, 1974; Roesler & McKenzie, 1994). The potential for positive impact of specific events is less frequently discussed.

Research in the area of suffering, however has recently shifted from a focus on negative effects to exploring for the possibility of growth for individuals. The preliminary research began with the development of the concept known as “posttraumatic growth” (Tedeschi & Calhoun, 1995). The initial research in the 1980’s began with the exploration of the processes involved when growth developed. Most of the studies at that time acknowledged posttraumatic growth and focused on coping with specific events. Posttraumatic growth was discussed as a coping strategy.

**Areas of Positive Change**

As I explored the area of personal growth following a traumatic event the findings seemed to include changes in three areas. The three areas include the perception of self, changes in interpersonal relationships, and change in philosophy of life (Tedeschi & Calhoun, 1995).
Self

In the work related to self, some of the words used to express the experiences of growth are increased self-reliance and personal strength, recognition and appreciation of vulnerability. Research in related areas includes work done regarding resilience (Beardslee & Podorefsy 1988; Green, 1986; Rutter, 1987; Werner 1984), sense of coherence (Antonovsky, 1987), hardiness (Kobasa, 1979), stress inoculation, and toughening (Dienstbier, 1992). In addition, findings regarding the personality elements of internal locus of control, (Rotter, 1966) self-efficacy, (Bandura, 1977, 1982) self-confidence, (Schaefer & Moos, 1992) optimism, (Scheier & Carver, 1985) hardiness, creativity (Strickland, 1989), increased coping skills, increased self-confidence, self-esteem (Affleck et al. 1985), changes in perspective and increase in self-knowledge (Aldwin, 1992, 1994; Lechner, 2001; Turner & Cox, 2004) are also associated with growth. For adults there is research to support growth over time simply through experience which results in increased coping skills (Folkman & Lazarus, 1980) and increased self-knowledge (Aldwin, 1994; Epstein, 1990). Also noted in the literature related to adults are increases in self-esteem and self-confidence (Aldwin, Sutton & Lachman, 1996; Cook, Novaco & Sarason, 1982). Schaefer and Moos (1992) developed categories that included improved coping skills “social resources,” and “personal resources”. In terms of personality the findings (Costa & McCrae, 1985) note that growth is associated with two of the five major factors (neuroticism, extroversion, openness, agreeableness and conscientiousness) of personality. The factors of personality that appear to be related to growth most often seem to be the trait of extroversion and the tendency to be open to internal experience (Tedeschi & Calhoun, 1995).
**Relationship**

In examining a changed sense of relationship in response to difficult or challenging life circumstances, descriptors used include increased self-disclosure and emotional expressiveness, specifically in relation to compassion, empathy, and investment in relationships (MacLeod, 2001; Veronen & Kilpatrick, 1983). Difficult life experiences may foster an awareness of the inherent vulnerability of all relationships and a sense of who is available in life for support. Experiences of this nature may also foster closer relationships, emotional growth and appreciation for the significance of strong relationships in their lives (Calhoun & Tedeschi, 1995).

**Life**

In looking at the idea of a changed philosophy of life, in response to an unexpected challenging life circumstance, this has been described in terms of increased appreciation of one’s own existence (Affleck et al., 1985) and in relation to how and on what individuals use their time (Tedeschi & Calhoun, 1996). Also noted was the exploration of life’s existential questions (Sodergren, Hyland, Crawford & Partridge, 2004; Yalom & Lieberman, 1991), spiritual development (Cadell, 2003, Cadell, Regehr & Hemsworth, 2003; Pargament, 1997) and acquisition of wisdom (Lehman et. al, 1993; Linley, 2003).

There is also research that demonstrates positive growth, resilience and enhanced functioning in later life related to phenomena like war, poverty or family mental illness, and parental loss (Albert, 1983; Anthony, 1987a, 1987b; Eisenstadt, 1978; Felsman & Vailant, 1987; Gamezy, 1983; Murphy & Moriarty, 1976; Simonton, 1984; Werner & Smith, 1982, 1992). It is not apparent from the existing research that any specific clear contextual factors can be described as necessary for growth or transcendence to occur. One of the most
common findings in the literature on posttraumatic growth is a change in perspective. This change in perspective includes view of life, values and/or in the perceptions of situations (Aldwin, 1994). Changes such as these are reported regularly despite the contextual and intrapersonal pressures against personal change (Baumeister, 1994). Even though many people who face adversity report growth, the experience of growth is difficult to verify (Affleck & Tennen, 1996). It has been documented that subjective pain and growth may coexist for many individuals (Yalom & Liberman, 1991) and that the positive and negative effects are separate dimensions (Bradburn, 1969; McIntosh, Silver & Wortman, 1993). What is clear is that any specific life experience must include what Janoff-Bulman (1992) describes as a “shake to the foundations” of the individual’s assumptions and view of the world. Mahoney (1997) describes it as “psychological disequilibrium”, O’Leary and Ickovics (1995) call it “thriving”, Aldwin (1994) calls it “transformational coping” and Tedeschi and Calhoun (1995), call it “posttraumatic growth” (PTG).

Vicarious Positive Effects

Calhoun and Tedeschi (1999) note there is a gap in the body of inquiry related to the potential vicarious positive effects of working with clients in crisis. Some initial work supporting the positive effects of the impact of trauma work comes from Schuben and Frazier (1995). There has been anecdotal and theoretical recognition of the positive effects of trauma (Caplan, 1964, Linley & Joseph, 2004; Lipowsi, 1970, Taylor, 1977). There has also been more solid data related to illness (Cadell, 2003; Hamer & Shontz, 1978) disaster and stress (Houston, Boom, Burish & Cummings, 1978; Kramer, Patt, & Brown, 2004;) and bereavement (Polatinsky & Esprey, 2000).
As in the on-going development of research in areas like the area of posttraumatic stress disorder, the research into positive effects began first with those affected directly by traumatic stress. It then moved to exploring the experiences of those individuals who experienced secondary or vicarious posttraumatic stress disorder. In the study of posttraumatic growth, the process of expanded exploration beyond the immediate individual to include those who work in fields like health care –where witnessing of suffering may result in the possibility of growth– is certainly the next logical step.

The work completed regarding the development of vicarious posttraumatic growth suggests that what clinicians may experience contributes to the development of growth. Pearlman and Saakvitne (1995) note the influence of hearing/witnessing the heroic struggle and survival of others, on the awareness gained from such a story on our own vulnerability and potential strength. The opportunity for clinicians to experience positive changes in their worldviews and general philosophies of life is another factor. Opportunities for re-evaluation and shift of life priorities, including a new appreciation of each day and an enhanced awareness to maintain and nurture connections with others are also factors (Calhoun & Tedeschi, 1999). In addition, individuals may experience an empathetic connection to all human beings who suffer (Pearlman & Saakvitne, 1995). These experiences provide the clinician a controlled shaking of his/her foundation without the high cost of the direct experience of suffering the client’s experience (Calhoun & Tedeschi, 1999). This recent research has begun to systematically try to understand, assess, and investigate the notion of posttraumatic growth under various circumstances (Cadell, 2003; O’Leary & Ickovics, 1995; Polatinsky & Esprey, 2000; Tedeschi et al., 1998).
Tedeschi and Calhoun (1996) have noted that posttraumatic growth can occur in any of the five domains of growth. These include: enhanced relationships, a greater appreciation of life, the opening up of new possibilities for living, spiritual development and a greater sense of personal strength. The process of growth in each of these domains is described as complex and multifaceted and requires further study to be better understood. None of these domains has yet to be fully explored regarding the process of growth. Research to date regarding posttraumatic growth for individuals suggests similarities may exist between how those directly affected by trauma and those who witness traumatic events may be affected by difficult life circumstances. Similarities of this nature are noted in relation to the negative impacts of trauma and vicarious trauma, therefore it seems reasonable to entertain this possibility in relation to posttraumatic and vicarious posttraumatic growth as well.

Gaps in the Literature

In the review of existing research to date what is noticeably missing is a deeper exploration of difficult/traumatic events in relation to individual experiences, which are difficult to explain or describe; those that are experienced more like a sense or feeling rather than events or activities. Gomes (1996) has described these kinds of experiences using the metaphor of the “thin places”. In Celtic mythology, the “thin places” represent locations where it is easier to experience what some might call the supernatural. This would be described by those with more traditional religious views as situations where individuals have an increased chance of experiencing God, something transcendent, or something like the divine other (Calhoun & Tedeschi, 1999). This experience, referred to as “transcendence”, is described by O’Leary et al. (1998) as,
the final mechanism for change. Transcendence is used to explain
the experience of those who attribute their change to some external
source, such as a higher power (i.e., God) (p. 139).

James (1985) notes “the feelings, acts, and experiences of individual men in their solitude,
so far as they apprehend themselves to stand in relation to whatever they consider the divine”
(p. 31). He also notes “a sense of reality, a feeling of objective presence, a perception of...
‘something there’… of the special and particular ‘sense’ ” (p. 58). O’Leary et al. (1998) note
no research has been done to date to “explore individual difference in the process used to
stimulate profound change or in the circumstances in which one or another mechanism is
effective or preferred” (p. 138).

The process of growth in relation to experiences with trauma comes out of work done to
explain the coping in general (Lazarus & Folkman, 1984) and the search for meaning
(Baumeister, 1991; Frankl, 1963). Tedeschi & Calhoun (1995) have developed a model
outlining a process of posttraumatic growth. The model includes seven principles in relation
to growth. These principles describe changes or resistance in schemas, some positive
evaluation in relation to the events, variable influences with different events, positive
influence when the event has a central place in the life story and results in the development
of wisdom.

Tedeschi and Calhoun (1995) note that psychological growth is perceived when some
change has taken place in the view of self and/or world, when the change is perceived to have
resulted in a more profound understanding of the self and world. This understanding allows
for changes in behaviour that effectively ward off future distress while engaging in
previously unconsidered or untried activities, or providing rewards previously unattained.
The loss is transformed into more value in the present and future and appears only to be possible because of the struggle, the challenges presented by trauma and perhaps only because of the trauma.

In describing their model of the growth process, Tedeschi and Calhoun (1995) believe the best description sees the process as a part of a self-regulatory system of feedback loops, similar in manner articulated earlier by Schaefer & Moos (1992). This way of understanding the process adds complexity to the explanation but seems one way to make sense out of the experience of perceiving benefits from situations that are dreaded, avoided and distressing. An example of these loops is,

...there is likely a reciprocal relationship between wisdom and meaningfulness as well. The meaningfulness of life is deepened when the preciousness of what remains is enhanced by the losses (Tedeschi & Calhoun, 1995, p. 91).

It seems that there is a sense that coping with difficult circumstances and the process of struggle to get through these difficulties may be the only route to acquiring wisdom (Calhoun & Tedeschi, 1995).

When looking at the existing research on personal growth post-trauma experiences some unanswered questions arise. These questions include the influences of personal variables (such as gender, age and developmental stage), the interactive nature of trauma, complexity of belief systems, and influence of religious beliefs. Other unanswered questions are related to situational variables like how contact with others affects the process of growth, the degree of benefits that may accumulate vicariously, understanding the non-unitary nature of the phenomenon, and the potential effect of the historical and cultural milieu. It will be necessary
in the future to establish the practical significance of the benefits perceived by survivors. The final question involves the possibility of cognitive bias in self-perceptions of growth and whether these benefits and the self-perception of growth are truly present, or just another representation of bias (Tedeschi & Calhoun, 1995).

At present the relationship between the experience of distress and growth is not well understood. Calhoun and Tedeschi (1999) cite the following limitations in regard to present research in this area: it is not clear to what degree distress could be necessary for growth to occur and to be maintained; to what extent does posttraumatic growth involve more than the individual’s sense of change when observable change is minimal or absent?; there is not enough information about posttraumatic growth to clearly discern what the observable changes are and how an individual act of change occurs; there is also not enough evidence to demonstrate that if growth occurs there is a reduction in distress; finally there has not been a full exploration of the experience of those who witness suffering and their experiences of vicarious posttraumatic growth. These undetermined areas provide support for the need for further research in this area.

Summary

This chapter explored the literature regarding the notion of suffering, religious, spiritual, and psychological perspectives, experiences of health care professionals, professionals roles, physicians role, nurses role, influences to health care professionals, suffering and growth and vicarious positive effects in response to traumatic events. The gaps of knowledge identified in the literature supports the continuation of research in this area. In addition, the complexity of the relationships and other influential factors in previous research also supports the need
for further research in this area. The existence of some "hard to reach" or "hard to describe" aspects related to this topic offers further confirmation of the need for further research.

In summary, an exploration of the literature demonstrates a need for further exploration of the experience of witnessing suffering by health care professionals. The existing gaps in the literature highlight the complexity of factors that may account for and influence one's experience. This study is proposed to explore some of this complexity in examining the health care professional's experiences of witnessed suffering other than vicarious traumatization. The study is designed to illuminate previously unexplored aspects of the process, meaning, and experience of the individuals involved in witnessing the suffering of those they care for in their role as health care professionals. It is expected that the research will expand the knowledge of what is understood and experienced by individuals in this study, while encouraging and inspiring further investigations in this area in the future.
CHAPTER III
METHODOLOGY

In this chapter I will provide the details regarding the choice and plan for data collection related to the focus of this inquiry, beyond the existing research on vicarious trauma, which is the health care professionals’ experience(s) as a consequence of witnessing suffering in their work. This chapter includes a discussion related to the selection and implementation of a qualitative methodological approach and the specific qualitative method, phenomenology, chosen for this study.

Qualitative Methods

In the research regarding the experiences of suffering and vicarious traumatization, some of what has been explored includes behaviour, motivation, attitudes, belief systems, social and personal values, mental and psychological constructs, and individual actions. A similar full exploration of the areas noted previously remains lacking in relation to the experiences other than vicarious traumatization. My specific research interests are those aspects described in the literature as growth. In studying notions of this type there was a shift in my interest to a more phenomenological perspective (Guba & Lincoln, 1989; Lincoln & Guba, 1985). My shift of focus grew from a combination of my own interest and curiosity regarding some long held unanswered clinical questions and what was left unanswered in the literature to date. Relying on the phenomenological perspective, my research question explores reality, which from this perspective exists actually as realities, with multiple mental constructions that are socially and experientially based, local and specific in nature, and rely for their form and content on those who hold them and on the groups to which these individuals belong (Lincoln, 1992).
In exploring the methodologies employed in the literature on the experience of health care professionals who witness patients' and/or families' suffering, it is important to note that research specific to this topic was not discovered. This lack or limit of research in this area is one feature that supports the selection of a qualitative method. When there is a dearth of research in a particular area, what is required in the next phase of research is the collection of deep, rich, and descriptive data necessary to understand the phenomenon to be explored (Denzin & Lincoln, 1994). Qualitative methods are inherently multi-method in focus involving interpretive and naturalistic approaches to the data. Qualitative research is interdisciplinary and transdisciplinary and crosses the humanities as well as the social and physical sciences. These methods allow me to broadly explore and understand a phenomenon which has not previously been deeply researched in its context, meaning or some combination of all of these (Denzin & Lincoln, 1994). The qualitative approach maintains its strength and rigor by its courage and resolve to stand up for uniqueness as a part of life (van Manen, 1990). van Manen (1990) notes, “research is a caring action: we want to know that which is most essential to being” (p. 5). The result of research of this type is this strong, rich, deep text that invites action sensitive to the knowledge and dialogical response from the reader.

Phenomenology

Phenomenology is derived from the Greek word phenomenon, which means, “to show itself, to put into light or manifest something that can be visible itself” (Heidegger, 1962, p. 57). Husserl (1970) considered phenomenology a combination of a philosophy, an approach and a method. van Manen (1990) said “the method of phenomenology and hermeneutics is that there is no method” (p. 30). Phenomenology is seen as more of an orientation than a
specific method (Osborne, 1990). There is no one phenomenological method of inquiry; (Colaizzi, 1978; Polkinghorne, 1989; van Manen, 1997) there are numerous phenomenological methods. Phenomenology does not test a hypothesis but aims to understand a phenomenon by allowing the data to speak while one attempts to put aside as much as possible any preconceptions.

One aim of phenomenology described by van Manen (1990) is the “lived experience”. Another aim is deep understanding that allows for the reconstruction of previously held constructions. An additional aim is to make explicit and seek a broader or more universal meaning for life experiences. Research of this type strives to explore the secrets and intimacies that are part of being in the world. This approach applies a structural analysis to what is most common, most familiar, and most self-evident. Phenomenology aims to construct animating, evocative description of human actions, behaviours, intentions, and experiences that are part of life (van Manen, 1990). Phenomenology accepts the difficulty of representing human experience through language (Osborne, 1990) and allows for the use of other forms of data. The variety of possible data sources extends beyond interviews, to experiential anecdotes, literary experiential descriptions like poetry and movies, art and other phenomenological literature. This may also include what is labelled as “epistemological silence” by van Manen (1990) and what Polanyi (1969) describes as the sense of knowing “that we know more than we can tell” (p.159). Phenomenology asks the question, “What is this or that kind of experience like?” (van Manen, 1997, p. 9). Given the continuous and ongoing nature of the creation of meaning such questions can never be closed.
The question “what is the meaning of this?” remains a part of day to day life and as such is part of conversations by individuals related to these experiences used in their own unique way in the hope of expanding their insight related to these experiences. So at some level, phenomenology is to attempt to accomplish the impossible: to construct a full interpretive description of some aspect of the life world, and yet remain aware that lived life is always more complex than any explication of meaning can reveal. The use of phenomenological reduction teaches us that complete reduction is impossible, that full or final descriptions are unattainable. But rather than therefore giving up on human science altogether, we need to pursue its project with extra vigour (van Manen, 1990, p. 18).

A good phenomenological description “is collected by lived experience and recollects lived experience, is validated by lived experience and it validates lived experience” (van Manen, 1990, p. 27). This process creates what van Manen (1990) labels the “validating circle of inquiry”. This sense of resonance with lived life is referred to by Buytendijk (1962) as the “phenomenological nod”.

When considering the outcome of research, or the answers concerning the questions about a particular phenomenon, it is important to examine the knowledge gained. The knowledge gained using this approach includes the constructions I have developed that have some consensus—or at least some movement toward consensus—and which remain open to reconstruction with the addition of new input.

All research findings using any method of inquiry are subject to examination of their rigor; the phenomenological method is no exception. Lincoln (1992) suggests two different
paradigms of appropriate criteria judgements. They are trustworthiness and authenticity judgements. The trustworthiness criteria are consistent with conventional rigor criteria like credibility, transferability, dependability and confirmability. Authenticity criteria are connected with the concerns about the paradigm that Lincoln (1992) refers to as indigenous criteria like fairness, ontological authenticity, educative authenticity, catalytic authenticity and tactical authenticity. Osborne (1990) notes,

Descriptive research methodologies are neither more nor less rigorous
or interpretive than statistically based research methods.
Phenomenological research is no less empirical than traditional
‘empirical’ research methodologies unless the term ‘empirical’ is to be
defined as meaning experimental rather than experiential (p. 90).

When considering “goodness of fit” in relation to the choice of method, it is important to consider the question being asked and type of knowledge to be gained. Given the existing gaps in research focused on experiences other than vicarious traumatization—particularly those which could include the potential for growth, or other experiences—the choice of phenomenology is well suited. This choice provides the opportunity to get a deeper understanding of a complex multifaceted phenomenon that has not previously been deeply researched.

In exploring the phenomenological approach another consideration is the role of values and ethics within this inquiry process. In more conventional scientific inquiry there is an acceptance that the inquiry should be neutral/objective or “value free” (Lincoln, 1992). The phenomenological approach recognizes that values play a significant role in shaping the inquiry process. These factors may have a significant role within the phenomenon being
explored and so any outcome would be “less than” if values were not represented. Other considerations include the need for continuous attention to the ethics of data collection in the research process. Using this approach requires maintaining an awareness of my role as a facilitator, interpreter and co-participant in the inquiry process.

Procedures for the Study

van Manen’s (1997) style of phenomenology provides a loose methodological structure, which requires a dynamic interplay among the six research activities. The six research activities include: studying a phenomenon which seriously interests and commits us to the world, investigating experience as we live it, reflecting on essential themes which characterize the phenomenon, describing the phenomenon through the art of writing and rewriting, maintaining a strong orientation to the art of teaching in relation to the phenomenon, and finally balancing the research context by considering the parts and the whole (van Manen, 1997).

van Manen (1990) suggests a full review of the literature to identify what is known and what is not known regarding the phenomenon, examination of the researcher’s experience and assumptions combined with the researcher striving to be “presuppositionless”. To be “presuppositionless” requires that I bring a sense of openness and a suspension of judgment to the process (Husserl, 1970; Katz, 1987; Moustakas, 1994). In van Manen’s approach he suggests it is,

better to explicate our understanding, beliefs, biases, assumptions, presuppositions and theories. We try to come to terms with our assumptions, not in order to forget them again, but rather to hold them deliberately at bay and even to turn this knowledge against itself, as it
were, thereby exposing its shallow or concealing character (van Manen, 1990, p. 47).

This “phenomenological attitude shift” reinforces the rigor of the research process. It is necessary to maintain this shift throughout the research process to reduce the risk of premature judgment or imposing of meaning (Mason, 2002). It is my responsibility in the research to articulate what is known about this phenomenon and to hold this knowing while seeking what is known by others about this phenomenon.

To be aware of the structure of one’s own experience of a phenomenon may provide the researcher with clues for orienting oneself to the phenomenon and thus to all the other stages of phenomenological research... It is that my experience could be our experiences that the phenomenologist wants to be reflectively aware of certain experiential meanings (van Manen, 1990, p. 57).

Holding this awareness contributes to the interpretation of the meaning of the experiences (Heidegger, 1962). The use of personal experience, review of existing work and maintenance of a presuppositionless stance combined with the deep, rich, and descriptive data obtained in the participant interviews strengthen this kind of research and foster trustworthiness in the findings. Phenomenology addresses any phenomenon as a possible human experience and in this way descriptions obtained have a universal character. As van Manen (1990) notes, “...the author recognizes both one’s own experiences are possible experiences of others and also that others experiences are possible experiences of oneself” (p. 58). Trustworthiness in studies of this nature is also confirmed in the reading of others and the confirmation of the “phenomenological nod” (van Manen, 1990).
Data collection

Selection of Participants

The sampling process (Mason, 2002) used began by selecting health care work environments in which there were a variety of health care professionals from a variety of disciplines, at a range of experience levels. A number of disciplinary programs were contacted via letter and e-mail inviting the staff to voluntarily participate in this study while ensuring compliance with university guidelines and ethical practices (see Appendixes A and C). The health care professionals chosen expressed an interest in participating in the research and work in areas that regularly and persistently expose them to the experience of witnessing suffering. Patton (2002) refers to this as purposeful sampling, which allows for the selection of information-rich participants. The rationale for this approach is to ensure that within the sample there is sufficient information to describe experiences other than vicarious traumatization that represents the phenomenon of interest (Patton, 2002).

The final size of the sample size was twelve participants. In general, in relation to phenomenological research, Creswell (1998) suggests approximately ten interviews for a study of this type. I conducted thirteen initial interviews, and one participant withdrew. The nature of inquiry, the quality of informants and quality of the data influence sample size. The two guiding principles that were considered in relation to sample size were: that the sample should be enough to understand the process and be evolving (Mason, 2002). The investigating process and the point of "saturation" will dictate the sample size. Saturation is achieved when there is a sense of having heard or seen it all, when events do not remain a single incident but are replicated in several cases and with that replication comes verification.
(Morse & Richards, 2002). In this study, saturation was noted in two ways. First, within each interview when participants reported they had nothing more to add. Again when after conducting a number of interviews when it was apparent I was starting to hear the same things repeated in subsequent interviews.

**Interview Process**

"Storytelling is for another just as much as it is for oneself" (Frank, 1995, p. 17.)

The collection of the data was completed with two interviews, using broad open-ended questions, designed to foster the participants' process of "bringing to speech" (van Manen, p. 32) to their experience. This process provides the participant adequate time and opportunity to fully express his or her viewpoint. Patton (1990) suggested this rationale for interviews in research:

> The purpose of interviewing is to find out what is in and on someone else's mind...we interview people to find out from them those things we cannot directly observe...we cannot observe feeling, thoughts and intentions...we cannot observe the meanings they attach to what goes on in the world. The purpose of interviewing, then, is to allow us to enter into the other person's perspective (p. 278).

van Manen (1990) notes the interview serves very specific purposes:

- it may be used as a means for exploring and gathering experiential narrative material that may serve as a resource for developing a richer and deeper understanding of a human phenomenon and it may be used as a vehicle to develop a conversational relation with a partner (interviewee) about the meaning of an experience (p. 66).
In this process, I am seeking detailed descriptions of the experiences, actions, thoughts, feelings, sensations, beliefs, values and mental and psychological constructs.

The purpose of the interviewing process was to facilitate the opportunity for each participant to comment on his or her experience in relation to a variety of areas. I asked each participant to tell his or her “story”. The beginning probe used was:

"Given the purpose of the research is to explore the day to day experiences of health care professionals who have witnessed suffering I would like you to talk about your experiences of witnessing suffering at work. We can discuss your experiences in any way you like. We might begin with your general experience first of what you experience in relation to events of witnessing suffering other than vicarious traumatization? How would you like to proceed?"

I listened for the essences and meanings of the experiences. I listened and explored using probes regarding the psychological, spiritual and physical factors of the participants’ experiences. I used the participants’ own words to probe for deeper exploration, for example, “tell me more about what you mean by ‘soul’” (the participant’s chosen word). I encouraged each participant to provide as vivid and as accurate a description of their experience as possible. The questions I used in the interview were intended to illicit additional information touched on within the story. The probes (see Appendix B) may have touched on any of the five domains of growth (Tedeschi & Calhoun, 1995) if the participants’ comments included any of these aspects of the model: enhanced relationships, greater appreciation of life, opening of new possibilities for living, spiritual development, and greater sense of personal strength. I asked and listened for changes in relation to these five domains of growth. I noted
their perception of it, description of it, their feelings about it, their judgment of it, their remembering of it, the sense they make of it and how they talk about it to others (Patton, 2002). The use of probes related to but was not limited to these areas, and was used in eliciting a description of the “story” of their experience.

Data Analysis

**Phenomenological Reflection**

The process of analysis in phenomenology begins with explication of researcher’s assumptions and pre-understandings provided in the researcher’s narrative later in this chapter. A global sense is necessary to begin the process of accessing the data. In trying to maintain the overall perspective of phenomenology the basic divisions are in relation to discrimination of meaning. The process of discrimination begins by mining for meaning; “the meaning or essence of a phenomenon is never simple or one-dimensional” (van Manen, 1990, p. 78). This means going through repeatedly and reflecting on the descriptions seeking parts that are described as “meaning units, structures of meaning or themes”, considered structures of experience (van Manen, 1990, p.78).

The data was reviewed repeatedly to allow for the discovery of themes and then a thematic analysis was completed. A theme is at best a simplification (van Manen, 1990) of what has been said. Themes are also described as:

- the sense we are able to make of something, the openness to something, the process of insightful invention, discovery, disclosure, a means to get at the notion, gives shape to the shapeless describes the content of the notion and is always a reduction of a notion (p. 88).
These themes may be understood as the “structures of experience”, something telling, meaningful, or thematic. These themes point to, or hint at some aspect of the phenomenon but do not do justice to the fullness of the life of the phenomenon being studied. These elements may be consistent with specific knowledge associated within the interdisciplinary perspective.

The opportunity to look for themes provides a greater ease in getting at the notion of what the experience is and gives some degree of control and order to the research and writing (van Manen, 1990):

making something of a theme or of a lived experience by interpreting its meaning is more accurately a process of insightful invention, discover or disclosure-grasping and formulating a thematic understanding is not a rule-bound process but a free act of ‘seeing’ meaning. Ultimately the concept of theme is rather irrelevant and may be considered simply as a means to get at the notion we are addressing (van Manen, 1990, p. 79).

The process of seeking themes holds me engaged in looking or seeking the “discovery-oriented” process (van Manen, 1990). This seeking provides and promotes the opportunity for openness which allows space for unexpected meanings to emerge.

The data will be fully explored maintaining several perspectives. The perspectives to be maintained include wholistic, selective and detailed. When using the wholistic process we attend to the text or data as a whole. In using this perspective, I held the question “what sententious phrase may capture the fundamental meaning or main significance of the text as a whole?” (van Manen, 1990, p. 93). The selective process seeks statement(s) or paragraphs(s)
that seem essential or revealing regarding the phenomenon or experience. I looked for “what statement(s) or phrase(s) seem particularly essential or revealing about the phenomenon or experience being described?” (van Manen, 1990, p. 93). In the detailed process I looked at each sentence or cluster of sentences to see what is revealed about the phenomenon or experience. I looked for “what does this sentence or sentence cluster reveal about the phenomenon or experience being described?” (van Manen, 1990, p. 93).

Once the thematic descriptions were completed, I went back to the participants (co-researchers) to collaborate and interpret the significance of the preliminary themes in relation to understanding the lived experience. In the process of collaborative reflection van Manen (1990) suggests consideration of the use of “life world existential guides” which include lived space (spatiality) the experience of felt space, lived body (corporeality) the physical or bodily presence felt, lived time (temporality) the experience of how time is lived and lived human relation (relationality or communality, experience is felt in relation to others). In reviewing the material with the participants, the essential question at this point was, “does this fit, is this what you experienced?” The analysis then moves to a determination of incidental and essential themes described earlier. With this task completed, the process of the creation of the phenomenological text begins. The process of pulling together the identified themes requires the art of sensitivity and attunement to the subtleties of language (van Manen, 1990). The writer strives to “make some aspect of our lived world, of our lived experience, reflectively understandable and intelligible” (van Manen, 1990, p. 126-127). With this comes the expression of what has been learned in this research from those involved about their experiences other than vicarious traumatization that is now in a form to be shared with others. Phenomenological text succeeds when,
...the words are not the thing. And yet, it is to our words, language, that we must apply all our phenomenological skill and talents, because it is in and through the words that the shining through (the invisible) becomes visible (van Manen, 1990, p. 130).

Organizing and Expression of the Data

Following the collection of the data it is first reviewed with the intention of identifying themes or recurring features (van Manen, 1990). In seeking themes I used the wholistic, selective or detailed approaches in the discovery process (described in the previous section).

Once the “themes” have been identified and this information has been collected, my work was to interpret the meaning of these themes as an informed reader. I examined these meanings to discover the essential, recurring features of the phenomenon being studied.

Once this is completed the data are organized in meaningful clusters, each having equal weight. These themes and thematic sentences are used in composing linguistic transformations that are taken back to participants for collaboration with the interviewee. The purpose of this collaboration is to provide yet another opportunity for interpretive insight from those involved.

The interviewee and I tried to interpret the significance of these preliminary themes in relation to the original phenomenological question, asking “Is this what the experience is really like” (van Manen, 1990, p. 99). The conversation goes back and forth until the conversation, gradually diminishes into a series of more and more pauses, and finally to silence, something has been fulfilled. It is the same fulfillment that marks
the triumph of an effective human science text: to be silenced by the stillness of reflection (van Manen, 1990, p. 99).

Bollnow (1982) describes it this way:

And the conversation finally does sink into silence, it is not empty silence, but a fulfilled silence. The truth, not only the insight that as been acquired, but the truth of life, the state of being in truth that has been achieved in the conversation, continues to make itself felt, indeed becomes deeper, in the course of this silence. There is nothing more to add (p. 46).

From this place of silence the challenge that faces me is determining what is incidental and what is essential in the themes collected to this point. To do this, clarifying the themes it is necessary to perform a delimiting process, removing irrelevant, repetitive, or overlapping data. The next work is to identify the invariant themes and perform "imaginative variation" which Douglass (1985) describes as "moving around the statue" to see these themes from differing perspectives. This process of seeing the invariant themes from different perspectives offers the opportunity for enhanced or expanded versions of these themes. This process of free imaginative variation is used to determine if a theme belongs to a phenomenon as essential or incidental, and examines the question, "Is this phenomenon still the same if we imaginatively change or delete this theme from the phenomenon? Does the phenomenon without this theme lose its fundamental meaning?" (van Manen, 1990, p. 107). Once the essential themes have been discovered, the opportunity to begin creating elaborations of the lived meaning of the experiences discovered other than vicarious traumatization began.
Phenomenological Writing

The next step in the process is the writing; and using the van Manen approach, writing is the method in phenomenology. The process of writing and re-writing acts as a mediating feature in relation to reflection and action. It seeks to make external what is internal van Manen (1990) notes,

writing involves a textual reflection in the sense of separating and confronting ourselves with what we know, distancing ourselves from the life world, decontextualizes our thoughtful preoccupations from immediate action, abstracting and objectifying our lived understandings from our concrete involvement, and all this for the sake of now reuniting us with what we know, drawing us more closely to living relations and situations of the life world, turning thought to a more tactful praxis, and concretizes and subjectifies our deepened understanding in practical action (p. 129).

This writing up is the final step in the analysis and presenting process.

To write phenomenologically is the untiring effort to author a sensitive grasp of being itself-of that which authors us, of that which makes it possible for us to be and speak…(van Manen, 1990, p. 132).

Summary

In this chapter I have provided a rationale for the use of the qualitative approach of phenomenology for this research inquiry. I have demonstrated the fit between the gaps in existing data and a qualitative approach early in the evolution of the research process in this area. I have also explored the fit between this approach and the knowledge sought in this research. Focusing specifically on the need for this work to seek strong, deep, rich
descriptive text that recollects and validates lived experience. I have identified the procedures for the study. This information includes how the data is collected, from whom, in what way and how the data is organized and presented to others.

This work attempts to describe experiencing something other than vicarious traumatization in the face of witnessed suffering that somehow leaves the individuals involved feeling positively changed in the process. It is my hope the results of this research will contribute to the existing knowledge, that further exploration of the complex issues around positive outcomes, arising from this research examined in this way will provide some expansion of understanding in this area. This research work is another step along the path of discovery and understanding in the on-going challenge to better understand what to some maybe a mysterious experience.
CHAPTER IV

COMPREHENSIVE NARRATIVE—PULLING IT ALL TOGETHER

The pain of the world will sear and break out hearts because we can no longer keep them closed. We’ve seen too much now. To some degree or other, we have Surrendered into service and are willing to pay the price of Compassion. But with it comes the joy of a single caring act. With it comes the honor of participating in a generous process in which one rises each day and does what one can. With it comes the simple, singular grace of being an instrument of Love, to whatever end.

Ram Dass

In pulling the research participants’ descriptions of witnessing suffering together it is first necessary to introduce the participants. The study included twelve health care professionals who presented with varied professional health care experiences from a variety of professions. The health care professionals included; Pastoral Care (2), Social Worker (1), Speech and Language Pathologist (1), Nurse/Counsellor (1), Psychologist (1), Counsellor (1), Nurse (2) and Physician (3). The participant group includes 10 females and 2 males. The range in age of participants was from 29–54 years with an average age of 45 years. The participants’ length of work ranged from 4–29 years with the average being 15 years. One participant withdrew after the initial interview for personal reasons. The results from that initial interview are not included. All participants agreed to provide a loss history. Each participant has had personal experience with loss in their life; none of the participants had a loss experience in the six months prior to their participation in the study.

In creating this comprehensive narrative regarding these health care professionals’ experience of witnessed suffering, the details have been arranged in sections designed to create a whole or comprehensive perspective of the phenomenon of witnessing suffering for
this group of individuals. The sections within the narrative created focus on the process of collecting the data, the data itself, the participants' descriptions of their experiences of witnessed suffering and the researcher's experience of collecting and organizing the data.

Process of Collecting the Data

The process began with an invitation to participate in the study (see Appendix A). The invitation was distributed by mail and e-mail to major local hospitals and other care facilities to the departments' of medicine, nursing, allied health and chaplain/pastoral care services where these existed. Once individuals voluntarily self selected for participation initial interviews were arranged. As the participants spoke of their experiences of witnessed suffering the interviews were tape-recorded and I kept a journal of initial reactions following each interview.

It was clear very early in the interviewing that in their descriptions the participants were unable to retell their experiences in isolation, but could only recall their experiences in relation to the suffering they have witnessed in their work. It was also necessary for many of the participants to provide a context for the experiences of suffering they spoke about; describing what was for them the day-to-day experience of their work. In addition, they each spoke compellingly about the extreme examples, likely experiences of vicarious trauma, even given the extremely intense and demanding environments in which they worked. The participants' sense of their experience appeared inseparable from the experiences of those they witnessed suffering. This sense of interconnectedness raises the awareness that these professionals maintained a dual role of witnessing and co-participating in the experiences of suffering at work.
The description of the experiences began with what they witnessed and then moved to what they experienced when they witnessed suffering. The form of these descriptions of their experiences of witnessed suffering varied within the interview and within participants. The variations included some atypical extreme examples and the more day-to-day experience and described as typical. The typical for this group of individuals they found highly intense and are what they and others would likely describe as traumatic. Some examples of their descriptions;

Nurse
One child with dreadful seizures...

Physician
people going through...real changes in their lives, real adjustments, real loss, real suffering...some where it’s been exquisite, excruciating physical suffering...some it’s been exquisite, um, spiritual suffering...others where it’s been kind of a restlessness...

Chaplain
When a chaplain is called they’ve gotten bad news...

Physician
Like children having to have pokes, having to have their chemotherapy, having to have procedures...and I think that is, there’s no doubt that that’s suffering.

Nurse
You know in the form of physical pain, people who can’t breathe, delirium can cause suffering, nausea; vomiting...and then we get our spiritual crises...and psycho-social problems

Psychologist
Children in their process of moving through their own pain and suffering not as intense or immediate (as in hospital) more prolonged

Counsellor
a bereavement client. Her sister just died by suicide...I’ve only met her a couple of times...there is this...incredible anger
Social worker
...dealing with what I call flirting with life and flirting with death, a 39 yr old, and “I just want to know if I’m going to live or if I’m going to die, I just want to know if I’m going to be here for my children’s graduation...?”

A 14 year old who has ovarian cancer...

Speech and Language Pathologist
Many of the people I work with are experiencing total loss of control in terms of their bodies not doing what it’s supposed to do...You have to be really very sick to be in hospital...they are very vulnerable...They are often cognitively intact and have severe communication impairments and suffering the madness of essentially being locked in

Nurse
There were certainly very difficult experiences, especially including those where people are asking to die and wanting your help in dying...that’s not uncommon...

Physician
I don’t think there is any time in a family’s life that is more crucial than when you are telling somebody that their child is going to die and to be able to do that in a way that is going to allow them to keep living...

Once the initial interviews were completed using the descriptions of their experiences (stories) and a phenomenological methodology I worked to explore the details of these experiences to discover their essence. The essences of these experiences include some major and minor themes. The combination of the major and minor themes attempts to capture the essence of these individual health care professionals’ experiences of witnessed suffering. See Table 1.

Description of the Experiences of Witnessed Suffering

The introductory comments of each interview focused on my invitation to each participant to talk about their experience of witnessing suffering in any way they were comfortable, noting any thoughts, emotions, beliefs, values and physical sensation, focusing on what happens for the participant in those experiences. The participants’ descriptions of experiences
<table>
<thead>
<tr>
<th>Overarching Themes</th>
<th>Descriptive themes</th>
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<td>The impact of witnessing suffering</td>
<td>Description of the experiences of witnessed suffering</td>
<td>Telling their story</td>
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</tbody>
</table>
| Meaning making and the connection with something larger | What Drew me?  
To make a difference  
Intensity  
Drawn without clear explanation | Advice for other health care professionals |
| Physical sensation  
Practices related to sense of connection | In the Experiences of Witnessing Suffering  
Physical Changes  
Emotional  
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| The sense of duality  
Mind/body and examples in many of the other areas | Impact of the work  
Emotional impact  
Physical impact  
Relationship impact  
Impact on thoughts on life perspectives  
Impact on life  
Costs, challenges and difficulties  
Systemic/administrative difficulties  
Personal issues  
Recognition, professional respect  
notion of personal strength | |
| Evolution over time  
In relation to others  
In relation to self  
Expectations  
Physical evolution | How they manage the impact  
Beyond actions; the search for meaning  
Representations | |

Table 1. Summary of Themes
of witnessed suffering include major and minor themes. In attempting to organize and summarize the large volume of data collected and remain true to the phenomenological approach the broadest overarching themes within each individual’s experiences were identified and grouped together.

The four overarching themes are: the impact of witnessing suffering, meaning make and the connection with something larger, the sense of maintaining multiple dualities and the evolution over time. The initial overarching theme, the need to describe what they have seen, was consistent and unanimous for all the participants. Only when this had been done could they move on to speaking about their own experience in relation to those experiences. Descriptive themes include what drew them to the work, descriptions of what the participants experienced in moments of witnessing suffering, the impact of these experiences on the individuals, and how the participants’ process their exposure to suffering. It is important to note each of the overarching themes includes a sense of maintaining a duality, holding opposing forces simultaneously within each of the aspects of these experiences. It is also important to highlight in the all the layers of themes that the sense of duality was consistently and deeply integrated in the descriptions. The sense of duality commonly appeared as a mind/body duality but was not limited to any specific duality. The sense of duality was represented in multiple examples (thoughts, beliefs, values, emotions, sensations etc.). The connections, linkages and other relevant information about the mind/body connections will be discussed further in the discussion section of the dissertation.

Now that we know who the participants are and what they have witnessed, the story continues with the participants sense of how they were drawn to the work they have chosen.
What Drew Me?

In describing their experience of moving into their work, they spoke about the work as a process, filled with an intensity that attracted them, provided a meaning for their involvement, a purpose for their actions and a sense of satisfaction regarding their impact on their work. They also noted their affinity to work was not necessarily linked to a clear understanding or specific explanation of what drew them to the work.

To Make a Difference

Pastoral Care
Wow. Well, I feel, I feel drawn to people... who are suffering as one who can hopefully help. I, I don’t feel a sense of helplessness usually, because I don’t approach, I don’t approach suffering as a problem to be solved usually. More like an experience to get through.

Physician
I do think that, that the overall context of believing that there is some purpose that I may never understand and that, that’s okay is very helpful and it keeps me being able to do this work.

Social Worker
I don’t know what gets me in the door. I love the work I do I absolutely love it. I know that just hearing people’s stories with a compassionate heart and ear somehow I’m affecting somebody's life. I know I’m positively colouring clients’ lives through a very difficult time.

Physician
I think that what brings you back is knowing that you can make a difference.

Counsellor
I think purpose is actually what drives me...that I actually think that I have a purpose here. I think that I have a reason...there’s a belief that I have, that there’s a reason that I do the work that I do that there’s a purpose for it. I actually don’t think it’s about me, which is different than how I would have thought of it before. It’s not about anything other than our own humanity, so it’s really about connecting.

Speech and Language Pathologist
I notice the draw for me in this work is my need for meaning, a desire to make a difference and a little bit of carpe diem. From my experience I know that anything can happen in life.
Intensity

Speech and Language Pathologist
There's something really attractive about ah, raw...piece that I was very drawn to so I take my risks in a different way and find something worthwhile there so, it's really different shades of the same thing. So it's interesting.

Counsellor
Um, there's something about me I know, which ...is why I'm doing this work, that I'm drawn to the edge, I don't think I'd be doing it otherwise.

Drawn Without Clear Explanation

Physician
So once I found this work it was like a big light went on for me. And um, it just feels like this is what I am meant to be doing. And I never understood you know when ministers say they'd had a calling and that's the only time I'd ever heard it referred to as the calling, but I got that when I found this (work).

Counsellor
I believe I was drawn to do this work for whatever reason. I mean that's actually beyond my, realm of understanding. When I first started it, I was more caught up in the, in the theory of it. It's not like I've been kicking around for years but I am a human being of fifty-one so there are those experiences which I bring to it. So...you know, I...I'm beginning to appreciate that part in a different way.

In the Experiences of Witnessing Suffering

All the participants described what happens for them in those moments of being in the experience witnessing another suffer. They speak about quite a variety of reactions including physical, emotional, a sense of connection in relation to the other, energetic and cognitive reactions.

Physical changes

They noted physical changes like accelerated breathing, sweaty palms, butterflies in the stomach, a kind of "lurch in the gut", tightness in my chest, uncomfortable, find myself shifting and a pulling back.
Pastoral Care
I find it, I find it affecting me physically...Um I guess, probably sweaty palms, I would get a tightness in my chest, I'd notice my breathing would accelerate, I'd feel uncomfortable...I'd find myself physically pulling back from the person.

Speech and Language Pathologist
My physical sensations in these intense moments range the full gamut. From a numbness in which I realize an hour later what a terrible situation the person is in and that I just wasn’t connecting. To the other extreme, not in front of the patient...I am in tears, need someone else to know, want a hug or some physical support and it takes a few minutes to pull myself together.

Pastoral Care
In the moment, in my body I sometimes feel butterflies, “oh, shit, this is not going to be fun” and you experience all the fight, fright and flight kind of syndrome, the clammy hands, the tingling fingers, the butterflies in the stomach a kind of lurch in your gut.

Physician
You actually have to get bigger inside, to hold all that diversity and balance yourself...in those moments of awe or Wow...two sort of feelings, physical feelings...they’re hard to describe...one is sort of the chest wall or the whole upper body, kind of feeling...that things...expand...slightly, loosen, move and I don’t think this is true in space but they seem to move back just a notch and down...well it moves open, but shifts back...and physically similarly there is also facially, tingling and almost this backward and down feeling, I sometimes feel like I moved abruptly.

Nurse
Really, feel...it’s a really kind of expansive feeling inside, almost a softening or expanding or feeling of love somehow.

Emotional
At an emotional level the participants noted a range of feelings from feeling depressed, incredible sadness and “brought to tears” as well as feeling incredible joy. These contrasts are another illustration of touching the notion of duality.

Nurse
So it’s always that...trying to wind your way through that feeling, you’re really feeling love for those people at that time and yet, being able to let them go into their own lives and getting on with what you have to do.
Speech and Language Pathologist
In the intense moments with patients I feel a real range of feelings particularly in those situations that breach every expectation and I have about life. I feel a strong sense of sadness. The sadness comes I think from empathy.

Pastoral Care
If their pain and their suffering has touched me to the point that I might shed tears, there's nothing wrong with that it's an authentic genuine response to pain....All these feelings of injustice and anger, and rage and fear and sadness and dry mouth is another one I get, sweaty palms, I can feel kind of shaky...

Nurse
So I think for me there's times of feeling teary...there's times for me of feeling incredible joy. Some times feeling incredible sorrow, um...feeling often kind of very much drawn to kind of spiritual, feelings of, you know the hugeness of all of our lives. I don't know that sounds corny or whatever, but just kind of how it all fits in with this huge picture too.

Sense of Connection

It was noted these experiences do not occur in isolation, and as a result, the participants note the opportunity to share in the unique quality of interaction that is a part of that relating. The sense of the depth of these connections and the speed with which they develop seems to add to the sense of connection within the experiences. There is a sense of heightened intensity, feeling focused and clear, being drawn to those suffering, almost joining with the suffering person, feeling an almost palpable connectedness, accepting their feelings, their fears, the pain and their suffering and yet remaining separate the duality of holding opposing forces again.

Physician
This kind of connection which doesn’t always happen with strangers, seemingly strangers so it’s like... touching into the spirit which is beyond personality and history and how I know someone and all that kind of thing...that you can actually feel that with somebody brand new you've just met because of the nature of what you are talking about...and that's very powerful.

Pastoral Care
It's a, um identifying with the person that's suffering, sort of saying, it's more than not even saying 'that could be me' almost there is a sense “that is me”.
Nurse
I think it’s really important to keep ourselves... out of the other person’s suffering, and at the same time I don’t mean isolated from it. What I mean is, is that it’s more like... the suffering will wash over me or can even flow through me, but it’s not allowed to stop. It must keep moving, cause it’s not mine; I’m there to witness; to be part of it.

Pastoral Care
Where you just think “oh, my gosh” fighting back tears because you realize, right away I connect...

Nurse
You know, you’re just going right down to talking about whatever it is...whether it’s pain or whether it’s...but often invited into this place of intimacy and getting to know people.

Nurse
There are times that I can totally connect with this patient, and it almost becomes, it almost takes on another dynamic, dimension, it’s almost a spiritual dimension.

Nurse
And the connection that we had, it, it almost made me cry, it was just so beautiful.

Physician
My eyes fill up...and more often not out of sadness necessarily. Sometimes it is and often it’s just out of connectedness and just feeling like what a blessing it is to be doing this.

Physician
It is often sort of a sacred family, important connecting time; you know as a stranger in this family, I am getting this kind of connection which doesn’t always happen with strangers...

Energy

The participants entered each experience with an awareness of entering the unknown, knowing the experience has its own energy. The energy of each experience uniquely touches each person and is affected by what each participant brings in addition to what the suffering individual brings. Participants described a variety of energetic experiences, feelings of being energized, a physical rush, being open (right down to experiencing a physical opening of the
heart), to being present for what is happening in the moment by providing time and availability.

Nurse
It felt like chaos...

Physician
My heart rate goes up like unbelievable, and it’s just right here, sort of the solar plexus I think it’s sort of like energy, literally just there, under the rib cage.

Physician
Because it’s, I mean, I feel it’s connecting with, that place of presence that does energize us and gives us the answers that we need or desire and then it comes back to the magic.

Nurse
You know when you are feeling connected with somebody and you know when you’re not. There are times at the bedside with somebody who’s close to dying when I feel very connected with them...there’s just such an intimacy with it. You’ve got that intensity and that intimacy so you make this connection with the person... it’s a very profound feeling.

The maintenance of that sense of connection and openness requires enormous energy that varies in its availability. The limitations of energy are managed individually, or shared with others on the team. There are moments of tentativeness, not knowing what to do, not knowing what to say while still remaining engaged.

Nurse
I can feel myself actually close...

Physician
Knowing there is a network, so there are other people involved in the care.

Nurse
I can feel myself put up a shield around myself that I am consciously aware of and let down, and that’s in that process...

Physician
I can’t think about it beforehand, can’t think about what I’m going to say...but I take time alone, and you just have to trust that you’re going to do the right thing, and the words just come...you know you’re just there and you just sometimes don’t say anything, sometimes you have to go back and back and back many times...
Personal reflection

Participants noted a sense of honour, reverence and respect, a sense that what they are a part of is beyond description.

Pastoral care
I feel a reverence and a respect for the pain and for the suffering and for the meaning that can be taken from it. So, instead of shrinking away from it in the way that I used to, being able to open myself to it...

Counsellor
I actually can’t put words to, because there aren’t words for it

Nurse
I just feel incredibly, incredibly grateful.

Nurse
There are times that I’m speechless. And, you know, when I say speechless, I mean that, I actually mean that, I’m trying, I would like to say something or I think that something profound would be appropriate, but there’s nothing profound to be said.

Nurse
I have experienced awe that is so beautiful I almost can’t, describe it...

Pastoral Care
People I’ve been called to accompany have impacted me with their courage and with their strength with their story. It’s very humbling. I can never get over how humbling it is what an honour that it is, to be invited into their story and into their life.

Pastoral care
I lose my multitasking abilities...in a sense time stands still...

Impact of the Work

The participants indicated the work has had an impact on them in a variety of ways. Some of the common ways the impact was described from their experiences of witnessing suffering and came together in six areas. These areas are 1) emotions, 2) physical changes, 3) relationship on others, 4) reflection, 5) impact on life generally which includes increased awareness of their personal strength and 6) level of awareness in relation to the broader
human condition. The participants spoke not only of the impact but also their own experience of how they managed the impact. An additional area where participants felt influence was in relation to each individual’s personal spirituality. This will be discussed later in more detail in relation to the broader major theme of connection with something larger. An overall perspective of the data reveals a mixture of influences that foster a variety of impressions. The participants described at times their impressions of their experiences as falling along a positive/negative continuum. They noted the impact of these experiences may range from a single specific impact to simultaneous multiple or complex impact experiences. These experiences of witnessing suffering trigger a continuous process of moving in and out of this variety of influences moment to moment day to day over their years of work. The descriptions highlight the transitory and ever changing nature of these kinds of experiences and yet although the experiences do not last the impressions left behind do.

*Emotional Impact*

In relation to the emotional impact of witnessing suffering, the participants’ most commonly noted their feelings of sadness. In addition these participants spoke of their feelings of fear. The emotional impact of the feelings of sadness and fear raised concern about how these emotions bleed into themselves and their life beyond the work setting. They noted in the moments of witnessed suffering how they felt the challenge of managing the emotions within themselves and in relation to the patients and families. The participants noted that part of the impact of the work is holding in a particular moment what may appear to be simultaneously conflicting emotions. Each opportunity of this nature described by participants provides another example of a sense of duality. This sense of duality appears to be fully integrated into the sense of what these kinds of experiences are for these participants.
Nurse
I've worried if the sadness has infused into my life in any way. And yet on a conscious level, my, my umm equation at this point has definitely been that, the positives have definitely out weighed the negatives, that the experiences have enriched me, and enriched my life. I have laughed at work as much as I've cried.

Nurse
I often think...I probably think of death a lot. I don't know whether that comes from early death in my family or all the palliative care. But I do, I often think about death, I think about my own death...I think how I'd want that to be...I guess there are some things that I witness that make me fearful...because there are situations that people in palliative care can't relieve, so I have seen some awful situations...that does make you fearful.

Physician
I try not to show it (my sadness) in everything I do, because you go to other patients and you’ve got to be upbeat and very positive and hopeful. Being rah rah, and so that's often hard, because you've got to switch from one mode to the next...

Physician
From the Buddhist perspective, every day I can think on death, I can appreciate my life. I can be in the presence of suffering which makes again me be thankful for my present health, my present breath...you know. So it's that gratitude.

Physical Impact
There is also a physical impact from these experiences. As with the other themes, within the stories of these participants' experiences they describe again opposing forces, this sense of duality. In the participants comments on the physical manifestations of the work they noted physical pain in the chest, neck, shoulders and back as well as a total body reaction. The description of the physical impact is not restricted to descriptions of any specific type of reaction but to a variety of reactions that might be considered opposite in nature.

Speech and Language Pathologist
When things are going well...I feel I get energy, I feel happy, uplifted, I feel like I have more energy and feel very, very positive.

Psychologist
I want to say almost a weariness. Um, there are times that there's no question that I don't carry, or have it impact me, I don't have the option with that. It's the way I work, the way I'm constructed. I think some clinicians may separate themselves more from it, I don't. Therefore I get weary...I think the weariness is cyclical stuff.
Counsellor
I'll carry something...because I realize that sometimes I can carry that, actually in my body. You know, and then I may not sleep well, and I'll be thinking about it a lot... and then actually... So, carrying it around in my body actually does, it does impact, how I sleep, how I think, what kind of crowds into my mind around that.

Physician
So, some of it (the work) is just exhausting and so, me needing to make sure to find time for just me...it's difficult to come from work where there's such... pain and suffering, I'm tired, physically, emotionally.

Social Worker
It can be difficult for me because at the end of the day, I just don't want to listen to anyone else, I just don't want to, because I'm tired.

Physician
I find that sometimes I dream about work and I normally don't ever dream about work, so... the time I'll dream about work is if I am sort of more overloaded.

Nurse
Usually in my arms, you know, down my arms, and in my thighs, I, ahh, I feel, it's like a tingling heaviness. That's slightly uncomfortable; it makes me want to move.

In addition to these actual physical manifestations the health care professionals describe the influence of these experiences on their thoughts about their own physical well being,

Physician
You do get slightly over-panicked about medical symptoms because you are living in this skewed world... and so you know you think that every symptom is cancer and you hear stories and you know it could have been you and you have similar symptoms. So in some ways I think you are a little hypochondriac, but I think I can balance that out actually and I think that knowing that you could have cancer anytime and kind of, rather than being a scary place, is an okay place to be.

Social Worker
I have so deeply ingrained that I am absolutely going to have cancer young, or that I even have cancer now...its just such a part of me a lot of my actions and thought processes are actually dictated around this notion that I have...that I have cancer, it's quite odd.

Speech and Language Pathologist
I feel a sense of appreciation that I made it home, I'm safe this is my sanctuary, my family's all here with me, healthy and I try to focus a bit more on the present while
realizing, I could stroke tomorrow, I don't know what's lurking inside my body and it could go either way.

In relation to the impact of the work all participants commented that this kind of work is best suited for them on a part time basis or balanced with either other life pursuits or different work demands. The participants provided a clear message that some sort of balance was required to sustain the work.

**Relationship Impact**

The participants noted the impact of their work was not restricted to what they themselves experienced as a result of their work experiences but also influenced their relationships with others beyond the individuals they work with. In their other life relationships they noted specific desires and expectations for total honesty, openness, reciprocity, receptive shared perspectives and closer relationships with little or no time for “trivial” relationships. In addition they noted a willingness to take chances in their relationships. These relationship expectations seemed to include partners, friends and in some cases colleagues and acquaintances. Along with this perspective was the concern these desires and expectations may be arrogant, that there is an awkwardness, in relation to this desire to relate with others beyond the “fluff and trite”.

**Physician**

I think what it does do is makes one, want, and have total honesty. I don’t know, I just have this whole thing about, being totally honest ... even in my relationships with my, with my friends, it’s on a, on a, very, I have a much closer relationship. Things are much more open, honest relationship that I have with my friends, than perhaps when I look back twenty years ago but again, whether that’s maturity or not. You just don’t have time to have trivial, now this sounds weird, but you just don’t have time to have trivial relationships. You can’t, you know, life is way to short to spend time with people that are going to be negative and um, and so, it’s almost, I suppose it’s almost an arrogance that comes with it, because you are saying, “here I am dealing with death and suffering and children having cancer, I’m not going to spend my time on someone who’s worried about their car breaking down all the time, the minutiae of life” because you just can’t, I just can’t give myself to those kind of people.
Pastoral Care
I find it much harder, to party with a bunch of people where they’re sitting around and discussing something. Which for them is vitally important and, you know, the end of the world, and all this. And, compared to the stuff I deal with at work, excuse me? This is just fluff and trite. But, so I find that awkward. Because I know I’m the odd one out in that room. And I have no right to, not pee on their parade, but to downgrade their perceptions of suffering um, in other relationships.

Nurse
The impact for me on relationships I think...is that willingness to take some chances and not have to be so safe. To appreciate more just that sense of impermanence and the fact that these (relationships) are all going to change, there’s going to be change all the way along. And there’s going to be endings, everybody, everybody that I know now, at some point will be gone and it’s just the mind can’t conceive of that.

Impact on Thoughts on Life Perspectives
The participants noted the experience of witnessing suffering reflects only a part of life’s experiences for themselves, “a piece of the picture” and for those who are suffering. The participants used words like richer, deepened, appreciation, admiration, intense, profound and learning in relation to their life perspectives as a result of their experiences.

Nurse
So, so I’ve really come to also see that for most of us the suffering (witnessed) is only a piece of the picture, it’s not the entire picture. And I’ve come to see incredible wisdom, incredible beauty and incredible coming together in the face of that suffering.

Counsellor
Certainly feel richer, my own experience as being human in this world is, is deepened, and I value life in such a different way now... Certainly don’t take anything for granted... Um, and there really isn’t a day that goes by that there isn’t an appreciation that I don’t have, for whether it’s those birds that are chirping or something.

Psychologist
...and felt ironically enriched by the process because I came to um, appreciate the dimensions of life. And I come home to my healthy children and hug them and uh, and have a greater tolerance for um, for them, given the acute awareness that life is transitory...I really think that one of the secrets... not often spoken is that you develop toler...the capacity to deal with this, it, um, enriches your own life. So, the,
um, the costs that exist are less. The benefits far outweigh. The benefits, personally, socially, um, interpersonally, intra-psychically, and also, with myself and developing spiritual growth...

Social Worker
I feel like I could write a whole novel, just on the benefits of...this (the work). And you know, just say that, just how I personally live within the world has changed drastically because of it (the work)...I'm more open...but it's almost in an insidious way, it's almost difficult to put words to. It's like trying to describe air. You know, it's just, it's just there....No; I feel the gains outweigh the costs.

Nurse
And also just really I often would feel, admire, admire what I was seeing in people...and take that away with you too and learn from it, it becomes part of your story, things you use and think up for yourself too, some very beautiful situations and families a lot. I mean just being part of that...leaves you on kind of a high, in fact there's a real intensity...it's very intense. I think there's something almost...I don't know, addictive...really like that intensity that ability to really get to the core right there as part of something really profound. That intensity, its...there's something, very, very satisfying about that too.

Social Worker
...I kind of feel like a freeloader. To all these, like, people, I feel like a freeloader to all, that I'm reaping all the lessons of people suffering. That I have not suffered the way that they have... It's like; I'm a freeloader to suffering. You know those benefits that can come out of it? I guess the clinical term, posttraumatic growth that comes out of that, I'm reaping all of that, because of the role that I'm in.

Physician
There's no doubt, I just can't leave it behind, it's not something that I do, and leave...it does influence...the way you view the world.

Impact on Life
An impact of witnessing suffering is the sense of enrichment that accompanies this work. This enrichment comes in relation to the value of others, one's relationships, one's life, and promotes an increased awareness of the tentative and fragile nature of life. The witnessing of experiences promotes an attitudinal shift away from "sweating the small stuff" to embracing the beauty of today.

Physician
I think it enriches one's relationships. I think it enriches one's life. Where you can be so, you know, what we do is, we're so privileged in being able to have such intimate
relationships with people. You know, they come in one day and don’t know you, and the next day, you know everything about them, just about because you are somehow privileged with that information. Um, and I don’t think there’s any time when you see sort of raw suffering, and there’s no question that you become intimately involved with that family. And I think to have, to see that, can only positively impact the way you value, people, other people’s lives and relationships. Because you, you know, it is so tentative. You realize when you see, I suppose when you see death, or you face death that you realize how tentative and how fragile life is and that you’ve got to believe in what you have. Um, no, I mean, I think that it does just make you, it makes you step back and just really, um, take stock of where you’re at, and to not necessarily sweat the small stuff.

Physician
Being a witness to suffering makes it much easier to recognize the joy and the blessings that are in my life...so I feel gratitude to...suffering in that it’s a reminder to the non-suffering.

Speech and Language Pathologist
Suffering is a way to learn, and experience personal growth; I’m a lot kinder. I have a sense of my own privilege. I have an understanding that we each come with their own different bag of goodies and...we all do different things with what we have. This sense of knowing I think has made me a better therapist and a better mother.

The participants were aware that these kinds of experiences were limited to what has been gained, how life has been enriched, or what goes well and enhances their sense of life. There are other forms of impact of the witnessed events; the participants used words like costs, challenges and difficulties to describe these forms of impact in relation to the work.

**Costs, Challenges and Difficulties**

In addition to the costs, challenges, difficulties or negative effects of witnessing suffering some participants spoke of a sense of isolation or aloneness with all the suffering. This sense of isolation was described when for whatever reasons those involved feel unable to speak about the suffering to the patient, family or even their colleagues. Some spoke of difficulties relating to team dynamics. Others spoke about the impact of systemic organizational complexities related to their work in systems with restraints and limitations in addition to the impact of the direct work. Some of these examples include administrative demands that add
to the ever-expanding list of clinical work demands, as well as the struggle to create and maintain an atmosphere of professional respect.

Systemic/Administrative Issues

Speech and Language Pathologist
There’s something sort of called the burden of confidentiality and that the things you experience in a day, you’ve not really allowed to come home and tell your husband, guess what, I assessed someone today and this is what happened. So you don’t always feel there’s someone you can share your experience of it just in case you give away some confidential information. I had an experience (a breach of confidentiality)... I thought was in a confidential and... who breached... I just realized like, oh my god, like I really can’t talk to anybody about this stuff. So that can be a burden sometimes. You don’t always, you sometimes need to be able to talk or work through the stuff to stay healthy...

Physician
Um, but there certainly have been times when we haven’t been able to alleviate suffering like we would like to and I think for me what makes that suffering worse is when there is less ability to talk about it, either with the family of the patient, and if the patient is really uncomfortable, you can't talk to them. The other part that makes the suffering worse is when our staff doesn't communicate well and support each other and for the most part I think we do that pretty well. But there are times especially on the very difficult situations very stressful situations, lots of suffering, where the group...sometimes what happens with the nursing group is that they almost turn on us, the physicians and question what we are doing or expect us to manage the whole system and change the family dynamic and have the outcome that they want.

Physician
Then in terms of the negative things I take away. Actually the complexities of working in a large system because I don't ever think bigger is better, so it's this big system where you've got all these layers of administrators and decision-makers and so much of what we do is out of our hands in some way, um and you can't control a lot of things about the care, um. So, the sort of system stress is a huge part of it.

Some of the other stresses around staff’s ability to communicate directly and respectfully.... and just when you hear things kind of put out in the ethers or you hear someone said something...that just wasn’t helpful or respectful, kind, you know, professional, um just wanting to be in that atmosphere.

Pastoral Care
Maybe I am projecting the negativity I’m picking up from the suffering on to the negativity I naturally feel towards administration and stuff in the hospital...and paperwork and blame that instead. Um, there’s times where I know I feel driven. But
I don’t think that’s the suffering so much as the workload and that’s when I fear for myself...

Personal Issues

Physician
You know, there’s a few times where I really wonder if we’ve sped up someone’s death. I don’t spend a lot of time on that and even if that’s happened I think it’s okay because I’m really clear that my goal was comfort and symptom-management.

Physician
There’s no doubt that there are costs...there’s days I’d like to work at Safeway, where the biggest deal is the eggs break, ...because we joke about that...it would be nice if you didn’t have to worry, and have the burden of all the enormity of what you are doing...but first and foremost, I am a physician and that is what I do.

Psychologist
and to be truly honest, I’ve been more aware in the last few years that I will carry...that person’s story, the pain, suffering... in my consciousness, unconsciousness, I’m more than ever, I’ve been aware that it’s a responsibility, a big responsibility...

Recognition, Professional Respect and Notion of Personal Strength

Another perspective on the impact of the work is in relation to the influence of recognition, professional respect and the public perception in relation to personal strength necessary for this kind of work. In addition that sense of being a part of a team or a larger professional community that recognises the work itself.

Nurse
I work on a team that’s quite well respected amongst the community. And so when I call and I put in an assessment...then I often suggest what it is that we need, I usually get what I want. If my voice wasn’t heard, I wouldn’t be here, I think that’s one thing that’s crucial for me here.

Physician
So part of the reason this work is fulfilling is because I feel like I have the time and the support within a team. I don’t feel like I’m doing this individual thing there, I really don’t. I feel like there’s a group of us working together and that makes a huge difference. If I thought if I did get overwhelmed and I needed someone to help, I know another doctor, one of my colleagues would...come in on a weekend and they’d work for me. I’ve not had to do that but knowing that really helps. So having this amazing team that follows through, you can actually talk about when you are
struggling and it is not seen as a negative. It's amazingly helpful and so, and also within the work itself it is way more satisfying...

Physician
I would never underestimate the power that team and communication, does to help be able to do this work...that being in and around suffering that it’s not, it’s not my sole responsibility to deal with that if something is happening within myself, around that suffering that there are people to talk to about it whether that be at, within my team or outside the team. Walking in a place of suffering really requires I use the word team, but it’s more than team, its people and that there are other connections...

In each interview at some point in the discussion each participant commented on the outside perception of the work and the difference between that and their own. The language associated with these discussions seems to connect with the health care professionals sense of their own personal strength in relation to the work versus the more commonly expressed perspective provided when they disclosed the nature of their work beyond the work setting. Each of the participants interviewed have heard frequently over their career statements like, “I don’t know how you do that work, it must be so hard, you must have to be really good at detaching (and other comments of that nature)...” The participants’ perspective on this is different from others not involved in the work.

Pastoral Care
I’m not sure it’s so much personal strength as, being... willing to be weak enough, to be vulnerable enough, to go into that kind of stuff, to let go enough and maybe that’s a strength in itself.

Physician
Some people you talk with about your work, they just sort of wither up...you feel strong when you see others sort of shocked by what you do...in those difficult moments I feel pretty darn strong...I am very present and care very deeply but I’m able to let go...I think that I am more human for doing this work, and it’s so often the opposite of what people think.

Nurse
You know people think palliative care is such a depressing job and yet it’s funny cause I really find myself a very optimistic person in the sense that somehow I believe that I’ll be okay.
The impact of what occurs in the moments together with the individual who is suffering continues to impact these professionals as it trickles down into their lives shifting their thoughts, beliefs, values, expectations and relationships in recurring cycles following such experiences.

How They Manage the Impact

The participants named and described the general impact of their chosen work. Also, they each spoke about their individual methods of managing the impact of the work, or their own answer to the rhetorical question raised by one participant, “What do you do with it?” The processing of these witnessed experiences included feeling the emotions of the moment, getting caught up in the existence of being, and that feeling that “life goes on” despite what they see. There is also an awareness of the sense that not only is the health care professional witnessing suffering; they are a part of the experience of suffering themselves, another example of duality. Participants spoke of a number of different ways they process what they have witnessed. The range of ways of processing used by these participants includes some physical actions and reactions in the form of thoughts and perspectives that provide an explanation or meaning for what they have witnessed.

In additional to processing what has been witnessed some participants rely on “black” humour, physical contact with others, physical activities and anything to change the subject, pampering themselves and consciously monitor whether they are having trouble. Some of the activities they rely on include journaling in the chart and privately, creating and maintaining personal rituals (such as playing a bowl bell) seeking professional support, and light reading that distracts. Journaling using these different focuses provides the health care professional the opportunity to reflect on the impact of their most recent interaction and may
guide future involvement. The chart or journal can become the method for telling the official story (Frank, 1995). The practice of personal rituals provides a method and structure that encourages conscious processing of experiences.

**Physician**
I keep in contact with my families (after a death or in medical follow up) so that’s important for me. And it’s nice to see families heal, in their own ways, but there is always healing, there’s no doubt. So it’s nice to know that suffering is a time frame and that they’re on their own trajectory but there is healing and it’s nice to see the healing to help, in whatever way that healing, to take in their experience of healing not only the experience of witnessing their suffering.

**Physician**
I like to run, to think about things and to kind of, I use it positively and I find running is a really good way of, releasing some of that, and just really, having time to ones self and again just putting it into a, a universal perspective if you know what I mean?

**Pastoral Care**
Black humour is a classic, a really good way of trying to get some distance between the painful experiences and you need to still function in it. Black humour is a big one for me...I will stop and talk with other staff...they will know the patient as well but sort of unload that, in a feeling sort of sense. Um, humour, sometimes really, really, really, dark hospital humour. But...I’m a big believer in laughter and sometimes it’s humour that’s really pushing the edges of what you would call it, it’s almost, too, the kind of humour that if I was to say it publicly as a priest...which I am, I would get in trouble, you know?

**Social Worker**
Talk about it, but I don’t talk about it with a lot of people. I tend to seek support from a few people that I talk with in an attempt to make sense of it, to find a meaning for it...

**Pastoral Care**
If I’m opening the bottle of wine a little bit quicker in the evening or having a few more glasses than I should or overeating or... what I notice if I’m getting into trouble is I isolate.

**Pastoral Care**
For this stuff, it’s a hug that works to relieve some of that heaviness, a hug, a shoulder hug, a human contact. And I guess that’s what I do with patients too in the sense of the touch, um; it seems to make such a difference.
Pastoral Care
I might stop and do some sort of fluff reading... it’s short, pithy, something that I can read for two minutes, it’s almost like bathroom reading... it changes the subject...

One participant relies on her skills and training in art therapy to process what is witnessed.

She begins by drawing a mandala (see Figure 1). “I actually need the visuals to articulate it (what I see) afterwards”.

![Figure 1. Drawing of a mandala.](image)

Figure 2 depicts her response to the questions, “What do you know? What do I wish for them (those suffering)?”

![Figure 2. Picture of her sense after further processing.](image)
This way of consciously processing allows this individual to work through the impact of what has been witnessed using her skills as an art therapist as the tools to access the processing.

_Beyond actions: the search for meaning_

As participants’ spoke about their experiences of witnessing suffering at some point they moved beyond describing the experiences and moved to making meaning of the experiences. The descriptions of their processing in these situations focused on their thoughts and beliefs in relation to these experiences of witnessed suffering. One of the key methods participants described regarding what to do with what is witnessed relates directly to the professionals’ desire and struggle to explain to themselves or in other words to make some sense of what they see. Victor Frankl’s (1963) work describes this challenge as “meaning making,” the process in which an individual comes to terms with life events in such a way they have an understanding of the meaning and significance of these events in their life. There are times for some of these health care professionals when they are confronted with the existence of “unfixable suffering” and awareness that suffering of this nature may be survivable. Based on their previous exposures they know it is possible the human spirit can thrive in times of hardship, struggle and sorrow. The participants held a perspective that suffering witnessed is not without meaning for the individual suffering or for the witness. Some meaning making related concepts that arose from the interviews were captured in words like “hope to relieve the suffering” or “even with the dark there is a pin point of light somewhere”. They spoke of acceptance that “there’s really nothing you can do...that’s beyond your control” that in “explaining it (suffering) is recognizing that you can’t explain it all”. For some participants meaning was made of the experience by explaining what the experience is not.
Finding meaning may mean an act of surrender, which is not just giving in, but being present with the suffering. This surrendering is about not “fighting it (suffering) causes more suffering” and “a degree of comfort living with the unknown and the humanness in all of us” while concentrating on being there. It can also be the understanding that “suffering is necessary, it’s not pathological…it’s a place of growth”. One nurse noted, “There are these pearls that people find in packages that are wrapped quite grotesquely”. The search for meaning may be to “ask the questions of life, of God” or “looking at one’s own mortality”.

Nurse
I have felt like, we’ve wanted, to take away some of the sting, I wanted to play God, I'm not just there to witness, I want to help support, I want so much to make it feel better, intervene in some way, physiologically, psychologically or spiritually. Maintaining the hope to somehow relieve the suffering that is witnessed knowing it’s not always possible and have this experience happen repeatedly.

Pastoral Care
We often have to look for the meaning...or build it sometimes but there is more than pain and suffering.

Physician
Part of explaining it (suffering) is, recognizing that you can’t explain it all...there’s no sense to that, recognizing that there is suffering and it sounds negative, but it’s not, that there will always be suffering.

Counsellor
Even with the dark there is a pin point of light, somewhere and we may not even know it’s there, we can’t even see it, there’s something.

Pastoral Care
I would say that suffering is necessary. It’s not pathological. It’s a place of growth and ...that was new for me.

Physician
I’ve taken away ...a degree of comfort living with the unknown and the humanness in all of us. And a deeper trust, that there’s a larger, connectedness about us all...a sense of a better understanding...of the world and of us as human beings...and just a real comfort, like a real calmness in the face of pain...I think that’s a good gift to have. There’s a lot, a lot we can’t change. But we can just be with it and in that being with it can change. But that is different than going in there thinking that you’re there to change it. That's very important.
Physician
Just sort of surrendering to the fact that there is suffering...and again, using that word but being present with that suffering. That, that the suffering itself isn't evil, there's nothing necessarily evil, about it, but it's a part of what we experience as spiritual beings, human beings. And sometimes, fighting it causes more suffering...which sounds some ways very...I'm not finding the words easily...but talking about surrender, it's not about just laying down and letting it all happen, not being sort of walked over by suffering, not curling up into a little ball and rocking back and forth with the suffering. But the surrender, just to the fact that it's there, and it's a piece of what's in the room it's a piece of what's in the heart and in the mind. And recognizing that...staying with it, because it will hopefully open up, that there'll be more space in...in and amongst the piece of suffering.

Nurse
I think the ability to truly witness suffering...has a lot to do with the rest of my humanity and acceptance of our humanity and mortality...I think it has a lot to do with strength and even possibly has a lot to do with values...that are not very western. I think we prefer to think in our scientific minds that there is no need for suffering that it can be abolished, can be fixed and yet suffering often has an outcome that is kind of amazing. There are these pearls that people find in these packages that are wrapped quite grotesquely.

Psychologist
I realize that I've developed a philosophy of how things all fit into the human condition. Here we all are as human beings, growing, maturing and seeking meaning in our lives...it's become clear to me that it's not a question of justice...they deserved this, they didn't deserve this. It's not. It's beyond justice, is it about learning? I don't know whether it is. I think that it helps to develop skills, resources...and work through things but not succumb to it because if you succumb to the suffering and just fall in self-pity and wallow in it, it's there is a level of learning of accessing a resiliency or accessing resources...to make your way through the pain. I guess one of the things I've really learned is that pain and suffering doesn't last forever. That's an important one.

Participants held a variety of perspectives which they relied on to make meaning of their experiences and that demonstrate the need to hold multiple perspectives to reasonably reflect the multiple meanings that arose for them in a given situation. They spoke of the potential results of exposure to suffering across the continuum from destruction to transformation.
They spoke of the dark effects as well as the redemptive qualities in relation to their experiences. Some examples of the multiple meanings maintained are:

**Pastoral Care**

Humanity is born to suffering…it’s what we do with the suffering…and it can become meaningless, it can become dead end, it can be, it can be all consuming, it can be life killing, soul destroying, it can also be transforming and transformed…you know, I accept suffering…um, suffering is there, you empathize with the person and you help the person, a beautiful sunny day is there and you enjoy it, you live for it, you leave the dinner dishes and go for a walk.

**Psychologist**

Whilst it’s not easy for me to say what the meaning is, I can say it gives me profound meaning and by that I mean it feels very worthwhile…if my energies and my effort and thoughts and attentions and investments and commitment…but there isn’t one neat little meaning…if it is dark at times, again the paradox is that it’s exquisitely beautiful and profoundly moving… in the darkness. No situation of suffering is without some redemption. There’s always sunlight, some hope, even in the face of death.

**Physician**

Within it (suffering) there contains an element of goodness. And so suffering doesn’t have to be looked at as the evil enemy. I think it’s strangely enough, it’s probably easier to talk about that in the non-physical suffering, in that I see more value to the non physical suffering. (This physician wonders out loud if his struggle with this is related to his medical training to fight against physical suffering and the notion “it shouldn’t be happening”).

**Social Worker**

My inclination (in explaining the presence of suffering) is to lean into the mystery of why things happen; not necessarily knowing that I’m going to find an answer because I don’t think there is one. It is what it is. Sometimes I’m good at that and sometimes I’m not.

**Speech and Language Pathologist**

We don’t yet have the tools to explain the inexplicable…there are many, many things about our lives that we don’t understand…

**Physician**

So...so finding, I think it’s a combination of awe...not needing to find meaning, but always looking for it. But not needing to know, the answers cause we can’t.

For some of the participants their way to create meaning of what they witnessed relied on the use of symbols with special meaning and relevance for them in relation to specific types
of experiences. Here are examples of the representations identified by participants and a sense of the participants’ sense of their relevance in relation to their experiences:

Speech and Language Pathologist
*For me, the heron is a symbol and a sense that things will workout. It is symbol of richness or abundance. It is like you know swamps are also places of amazing fish and birds, there’s sort of a natural component, and there’s beauty in itself in the situations. It is a reminder to look and notice there’s beauty in the looks as well. I find I need reminders of that, there’s this whole universe out there and you’re a wonderful part of it. I’m part of it and part of the beauty is someone to behold it. Part of the experience of suffering is someone to grow from it. So the more I participate and have the courage to look or ask questions or whatever, that’s my job. That’s how you do it, it’s there for you if you’re willing to seize the opportunity, regardless of how much it hurts or benefits you.*

Nurse
*I have the Arbutus tree [see Figure 4]...as my little symbol...and to me the Arbutus tree, which thrives on these rocky, umm, harsh soil and windy ground, and looks so beautiful as it...it’s kind of gnarled with life and wind. And similarly the human spirit which can thrive in hardship and struggle and sorrow and just come out so magnificent...*
Pastoral Care

The image that comes to me is the crucifixion. Now and yet, I know I don't use that image very often, in talking with people. Boy. Well, this is food for thought.

Just as participants described what they did with what they saw, the participants also described what they did to allow themselves to engage in the work particularly when they
may have felt a limit to their impact on the suffering they witnessed. The participants noted that to promote movement to a place of acceptance of the uncontrollable aspects of their work this movement was not bound only in those moments. To promote this movement requires preparation, which can include quiet time, prayer, meditation, and sitting in silent reflection.

**Physician**
I practice, I'm just more mindful of being calm and present and then the words come and that, I think, helps not just me but I think it helps the patient and family too. And I've learned over the years that the benefit of just being calm and okay in the presence of death goes a long way...it goes a long way. It goes a long way to calm others that are more anxious about what has happened and then some words might be needed but some words aren't needed just because of the ability to hold the emotion and not be freaked out by it.

It can be important…. practicing presence and mindfulness, just being really aware of, of what's going on and sort of the nuances of family dynamics and trying to meet people where they're at ...with an open heart and with compassion is really important. And just that generosity that Buddhists talk about, generosity of spirit and generosity of care, and you know...

This kind of supportive self-care can also take place in recovery times away from work. These times away or recovery time participants seemed to feel raise the awareness of the survivability of suffering while reaping the benefits of other aspects of life and work, like children, family, friends, teaching, studies and other learning from what has been witnessed. An example how this might looks is,

**Physician**
And then how you care for yourself, and that, you know and how you manage your own growth within that work is really important. And then balance, balance, balance.

**Nurse**
So that thing between having babies at home and raising kids at home and working in hospice I think were an incredible balance and incredibly positive and they’ve enriched each other. And also the teaching enriches my nursing and my nursing enriches my teaching and I think that’s been an incredible balance.
Evolution Over Time

It was consistently noted by participants that the opportunity provided by the interview to reflect on their practice over the period of their work was a rare and appreciated opportunity. With this rather unique opportunity to reflect over the period of their career they were aware of an evolution in their personal and professional selves. This kind of awareness was not something that was frequently part of their experience. The kinds of changes they noted were related to their work with others, in relation to self, their relationships with those suffering, in relation to their expectations of themselves and others. It is clear in the participants’ comments that a commitment to continued self-exploration and self-care are significant factors. It is also clear that an openness to change or to be affected by the work is also significant. In this theme as with others there is awareness by participants that their evolution was not limited to any one specific realm but included several realms simultaneously. In terms of the changes or their description of their personal evolution, some perspectives provided:

_In Relation to Others_

Physician
I think we have moved as a profession (medicine) and now are able to say “Arggh, I’m not coping, how do I make it different, I think that has made a big difference in being able to come back each day and to talk more openly, so we’ve evolved and made it easier for people to cope.

Physician
If I look back over my twenty, thirty years of medicine it’s so much easier to show your emotion now. You know, I think it’s always been easier for women, there are days when I would cry, there’s no question that I will often cry with families and I don’t feel badly about that...
In Relation to Self

The evolution of self was reflected in comments about their sense of self now in relation to the work. They noted more ease in sharing the load, their tendency to be less “shocked” or “surprised” by what they saw. They noted feeling more open and authentic in the work over time, with an increased sense of self worth. There is a sense they can work more deeply without being “knocked for a loop”. In addition, there is a sense of greater understanding that has accumulated from their experiences and is most clearly noted on reflection. Just as with understanding there has been a growth in relation to increasing recognition or acknowledgement of their spiritual self over time in the work.

Nurse
You don’t take care of it (the suffering) all yourself, you can share the load, and I think I share a lot more now. As before I felt that I had to deal with anything that came up, if it came up in front of me I felt it was my destiny to deal with it. And I don’t necessarily believe that now.

Nurse
I think when we start we are more open and far more giving...I think I can be more authentic but at the same time as being more authentic and more present, I don’t think I have the need to take it on, cause I’m more aware of what’s my suffering and what’s their suffering and I think that changes the way one works. I was very cognizant of taking a step back after about a year...there’s survivability for the caregiver involved. I have become much more, uhm, satisfied and content with my own human limitations and working within those.

Nurse
I’ve grown in the work as a team member, I’ve grown in my own spirituality which has broadened and changed...

Psychologist
I don’t think that I’m any less sensitive than I was in the beginning but I am able to absorb the different forms of suffering and place it within a philosophy of understanding the human condition so that it doesn’t knock me for a loop. I get the sense of what it really is...it is something that as a human being I participate in, maybe I’ve developed resilience.
Social Worker
When I first started working, I was so green and was feeling very, very green, and I guess just trying to get comfortable...so I had a lot of negative self talk going on...trying to find some comfort in being present to, working with women who are again flirting with death, and going through treatment. It was intense but I think I was also, focused on learning and finding my own comfort and my own style, relating to clients that it (the suffering) didn't sink into a deeper level, like I feel that it (the suffering) has now.

Social Worker
I don't quite struggle so much with the ego stuff any more... so their story is able to get down to the more deeper essence of me, because it doesn't have to filter through that ego level that was happening. It feels that I'm working with people maybe from a depth, a greater depth, of my heart and then some other times I feel that I can just go from one client to another without having it sink in, so it goes both ways.

Pastoral Care
I guess I've become more comfortable with, mortality, with death. With the acknowledgment, “Yeah, I'm going to die” I think if anything it's pushed me to go out and experience life more. To feel it, to see the sunset and to do more than just see it, you know?

Physician
When I look back on my practice as a physician, I think I've really come to appreciate, silence. And in entering those spaces, of suffering, silence was something that I think, although I may have denied it, that I feared or felt it was my role to break the silence, to offer words of support. And, through, through then reflecting on how helpful that was or that wasn't, I've come to recognize that it's actually silence and presence that is more comforting, than jumping to say something, or to necessarily reassure, either, truthfully, or potentially, not truthfully reassuring, which I think earlier on in my career, I wished that that was the case for these people. But that ultimately wasn't helpful and that was easy to recognize early...These changes didn't just happen over night. It is only on reflection that I notice the difference and I see I have grown, as a result of the accumulated impact of the work. It has been a gradual progression in the depth of my relationships with others.

Expectations
In relation to their evolution over time the participants described changes in their expectations in relation to their ability to deal with pain and suffering, their spiritual beliefs and their relationships with patients and families.
Pastoral Care
I would have to say it (the work) gives me meaning... it's a job I feel I do well and I feel a lot of whatever the term is self worth? I guess I know that it (my involvement) helps because I see that reflected in the person the way they change, the way their pain is, is changed, it's alleviated or the way they feel the pain. It still hurts but it hopefully no longer overwhelms them.

Nurse
I no longer have the wish to alleviate all suffering, I have the wish to learn to withstand suffering, to hold it with the purpose, so that it can turn into something else and here I'm not talking about physical suffering because as I've said, I'll resort to the medical model quite quickly when we've got physical suffering.

Pastoral Care
My perception of God, in the sense of purpose and meaning in the universe, um, has modified... I can no longer sort of blithely say that, whatever the term is, God is in heaven and all is right with the world. Um, I don't accept that one anymore.

Nurse
I think at the beginning those first months... oh, the experiences were very intense and I remember those families and those patients and I think you thought you would never forget them or you'd always keep in touch, and you really can't, can't year after year. It's something to do with a certain kind of guard that gets put down on both sides.

Pastoral Care
Earlier in my professional life when I would accompany people who were suffering, I felt there was an awful lot of pressure on me to bring resolve. And there would be an awful lot of personal transference if that person or situation reminded me of something similar in my life. I would notice my emotions and my thoughts and my anxiety levels rising, getting mixed up in their story. Rather than letting it just be their story... not to say that I've evolved to the place now where I still don't do that.

Pastoral Care
I guess I learned very quickly... not to try and fix things. But there's very little, there's some things you can fix, but very few. I've learned to try and reassure people that they are not, they're not alone. I think that's a huge part of suffering, suffering alone is so much more difficult, I've learned in a sense to let go and I'm finding that people are usually okay with that... I'm getting more used to it.

Physical Evolution
The participants also spoke of changes physically in relation to the experiences of witnessing suffering. The physical changes described may coexist with changes in other areas noted and were manifest in changes in the body's reaction.
Physician
Physically I felt quite ill about those (witnessing suffering) things. But I don’t, maybe I’ve just grown up and don’t have the same internal turmoil. I don’t think about what I do as kids suffering...I think I was still altruistic in those (earlier) days...I wanted everything to be perfect, everything was going to be right...whereas now I think it comes with maturity, being around and being able to look back perhaps to reflect and see that so much good has come from the bad. That yes, death is part of or suffering is part of what we do but you can make a difference... it’s not looking at suffering as a failure necessarily...

Nurse
I used to feel an angst, right there (pointing to centre of the chest) right? Now there’s a good point, used to feel an angst, an internal, umm tightness that I had to get there and I had to be there right away and I’ve now come to very much more trust in, kind of some of the process of it...You know there’s a growing confidence in me. That timing is just what timing needs to be...I’ll be there if I need to be there, and if they need me I’ll be there and they’ll call, I don’t feel like I have to be all things to all people...I don’t feel like I need an urgency to be the best or to be umm, fabulous for patients...you know I just feel a lot more calm in my need to serve and to help. Feel much more trusting, much, much, more trusting in the process. And that I think has been ahh, a great change...I don’t have that urgency and that’s a really wonderful way to feel.

Pastoral Care
I don’t feel the fear that I can remember the first, oh when I first started doing this kind of work. Other people’s suffering, other people’s pain, other people’s dying certainly scared me. No, it’s, I do not have that fear at all. What would I, what do I fear? I would fear, um, I guess I would fear working with people whom I can’t reach...that still scares me. A feeling of inadequacy that I can’t help their pain, I can’t touch them...for whatever reason...I don’t recognize the change, but I can see the change has happened.

Physician
Well, I used to um, in the olden days, I used to get quite anxious before and try and think about what I was going to say...It was just a potentially difficult situation and so I was driving and thinking what am I going to say, what are they going to say da-duh, da-duh, da-duh-duh-duh-duh-da. And then I was driving in my car and I had the top down... and I saw the night sky, the stars and the moon and I just have this overwhelming sense of connection with a larger, my large self, God, being whatever you want to call it. And I just had the sense of, ah (sighs), I don’t need to worry about what I’m going to say, like everything will be okay and so I really learned from that to just pause and calm down and breathe. And just not worry about what you’re going to have to say... and not plan words and just go into the situation initially quiet and slowly figure out in the moment what’s helpful, what’s needed.
Connecting with Something Larger

The theme of connecting with something larger is a notion described by all the participants. It is presented as the final piece in the narrative because it was clear from the discussion with the participants that without some connection with something larger the participants questioned their ability to remain engaged in the work. It was also the one theme that was described using the largest segments of interview time and produced the largest volume of transcript material. The participants spoke of this theme in a variety of ways. It is a difficult theme to describe with language. Some of the participants relied on established or conventional connections with something larger like a belief in God or the teachings in Buddhism, and some created their own. Although the notion of a connection with something larger was commented on regularly there was a sense in each interview that this was a very personal area of their experience and there was some initial hesitation, reluctance or shyness to discuss the details.

Physician
...because it’s not ... something that, typically is discussed. I mean we can as team members say “Wow, that was magic” but we don’t really talk about where the magic comes, cause that just takes it, you know there are some people at work that I would enter into that with, but for the most part even saying it’s magic, is moving yourself outside the box.

The participants also voiced their own hesitation in relation to their sense of connection with something larger.

Counsellor
I think also what happened is, beginning to believe more sincerely that there actually is something outside the realm of this human experience. Which I had paid lip service to before had wanted to believe it, wasn’t quite sure that I did but through this work, I am becoming more of a believer in the spiritual realm...before it was saying it, but not entirely believing it, now the belief is beginning to deepen or intensify, I sort of feel like I’ve seen the soul.
After establishing some comfort and rapport in relation to this topic in the interview, participants began to put voice to their reflections about their connection with something larger and spent large portions of the interview presenting their experiences and sense of the connection and its significance in relation to their work. As the participants spoke of their connection with something larger they relied on a variety of terms to describe their experiences. Some of the significant terminology relied on and defined by the participants is presented to familiarize the reader with how these participants used some language that is very open to interpretation.

In describing their experiences of connecting with something larger participants relied on the words like spirit, spiritual, presence, connectedness, and attunement to describe what they were aware of. The word spirit was used in relation to an eternal sense of self that is the transcendent essence of human beings. Some participants also referred to this description as soul.

The use of the word spiritual in relation to the connection to something larger applies to something within and beyond the self that connects or bridges the individual and the something larger. The social worker noted, “It’s the spirit within me that connects, which bridges, the existential”. For the psychologist, spiritual refers to her personally developed understanding of what life is about, it’s an ongoing quest and growth.

A sense of presence is described by being right there, completely present and hearing others unconditionally. To feel supported and cared for, a feeling of being loved, in the belief that one is part of something larger.

Believing in a connection with something larger for one participant “frees me up to do the work”. The sense of freedom allows a focus on the connection that can be made. When
feeling connected there may be an accompanying sense of feeling good and along with that a feeling there is some larger purpose. It allows the individual to feel connected to those they witness suffering, to feel connected to God, and/or connected to the universe based on their beliefs and understandings related to how the individual self defines connection. In those moments the sense may be as one physician noted, “I’m getting and they’re getting it... it’s just a great connection”.

Another term used for this connection is attuning. Attuning is described as a connection experienced at a level beyond awareness; it provides information and insights spontaneously. A psychologist noted “it (a new insight or awareness) would like come to me as pure intuition and I’m just the mouth piece”. In those moments there is a sense that the information feels right for the circumstances and the person, there is no need to question and the source is beyond the individual in the moment. Here are the voices of the participants regarding their connection with something larger.

Physician
I do think there’s a sense of spirit in everybody and everything...and we can’t define that spirit...there’s a sort of burning gift in everybody that we need to ignite and even if there’s death that spirit lives on, it’s that sense of the person...I do think there always is going to be that living on...and to try and find that for every family...this individual’s understanding of this concept of spirit is irrespective of any specific or formal affiliation with religion or spirituality.

Social Worker
I guess I attach the word with spiritual, I don’t know if it’s within the same context to which you’re exploring, but for me, it’s that connection to something larger, something beyond myself. It’s that bridge between; it’s the spirit within me that connects, which bridges, the existential.

Social Worker
That presence is just being right there with a client being completely present and hearing them unconditionally. Really trying to understand where they’re coming from and not just attaching my meanings to where and what they’re saying. That sense of connectedness is to feel there’s meaning, there’s acceptance to feel a part, to be held
not in a physical sense but to feel supported and cared for, that’s connectedness and love just to know that one’s part of something larger.

Physician
It's hard to put words to...sometimes just with the, I'm not sure what it is. It's the quality of the connection with a particular family or patient where you come out and you just know or you just feel that, you feel connected and good and that there feels like there's some larger purpose. Not to make it sound lofty what you've been doing...but you just come out and you feel really connected. That's it, you feel connected. You feel connected to them. You feel connected to God, you feel connected to the universe. You feel connected. You feel like things are happening for a reason and maybe it's just that sort of feeling of love or connectedness and it doesn't have to be that they're appreciating you or showing you love. It's just that you know that what is happening is real and important and somehow going on for both of us. So I'm getting...and they're getting it. It's just a great connection.

Psychologist
Attuning to a person...it's at a level beyond my awareness...I find myself saying things that are absolutely perfectly right but I wasn't aware of figuring it out in a thinking way...it would like come to me, as pure intuition, like “you’re going to get through this”...I'll find myself saying things that seems to come from a greater source...and I'm just the mouth piece. Although I'm aware of saying it and I stand by it because it feels very right...and I know I've done this a number of times and these have been hugely powerful...statements that the others have held onto.

*Physical Sensation*

In addition to participants talking about their experience of connecting with something larger, they also spoke about the physical sensation when they entered those moments of feeling the connection with something larger as they work. These descriptions are another example of the mind/body duality present at so many levels within the participants' descriptions of these participants’ experiences of witnessing suffering.

Nurse
There’s a real sense of witnessing important things...there’s a real central feeling, kind of like core heart, mid-chest area. I think that’s where I feel this...it may seem strange but it’s almost experienced like a bit of a warmth and it feels uhm, almost seems to have a solid form. It’s like, there’s a place where it has a solid form, you know it would probably be like soul activated.
Psychologist
The feeling of my heart opening, it's difficult to describe, because it's in a realm of a physical experience. I literally do feel responsiveness...and the responsiveness isn’t just a recognition, it isn’t just um a feeling, it actually beyond a feeling...its does actually feel like an energetic joining...like a deeper resonance of the word empathy, because I go with the person...it doesn’t happen with all people but it’s part of the potential power I think to work with my patient at that moment...when I do that I find I can be very, very effective and very simple in my comments but they seem to zero in. The feeling (of connection) is very ephemeral, at times I wonder if it is beyond me or if it is just me accessing, it’s very immediate for me, it’s just right there, it’s very normal in my day I don’t have to meditate to do it, pray for something...it may be a function of the two people together, me and the other, I and Thou.

Counsellor
There’s an incredible solidness, actually that I feel physically, very solid, very grounded and it has to do with letting go of actually, not being attached to things.

Physician
It comes not as sound or a picture, and again, it may be in a warmth and again, the physical, hard to describe, but an opening. There’s like, more space between everything, more space between the words, but there’s more space between, the molecules. So the table isn’t as heavy, the tears aren’t as heavy.

Physician
So that physical feeling that I have, to me feels like presence, either me touching presence, or presence coming through me. And I, when I feel that, as good as it feels, physically, um, I really give it to the space and the room and the people there, although it would be nice to just hold on to it all for myself...

Physician
So I think for me sort of that spirit feeling is a deep connectedness with a knowing that we are the same. That's what it is for me and to describe what I feel, well I guess my heart just feels full. If I had to say physically, my chest--I'm aware of it in my heart--it sounds kind of funny, but I just feel full up, just full of emotion and my heart feels stretched and full. And with that often comes my eyes filling up a little bit too. And I feel really calm and like I'm just in the right place at that time.

Pastoral Care
What I notice is there’s a huge dramatic feel, ...there’s a profound sense that goes through my body, something is going on here spiritually...so to me it’s all sensory, I can feel electrified, extremely alert, all of the sudden...and sometimes it’s a very horrible feeling, a really scary feeling...a sense that you can get a sense of more evil, something evil is here...
Practices related to sense of connection

The sense or belief in their own connection with something larger provides these participants support in relation to the day-to-day experiences of witnessing suffering. The participants have different ways they engage with their connection with something larger, these are some examples of practices they rely on are:

Physician
Sure, I pray, and I don’t, I can’t ask for, this is where I’ve changed, I can’t ask, I’ve gone beyond the point of asking God to help with everything, because I don’t believe that that’s part of what his plan is. So it’s more that, the guidance, and the strength, really and not to change the plans, because I don’t think, those are going to change...

Physician
Buddhism talks about suffering a lot, um, and, the impermanence of everything, and the power of meditation in, in dealing with, or processing, or shedding, I’m not sure what it does, but I know that it’s helpful and I’m very fortunate to have a work environment that has a meditation room that I take advantage of...um, daily, usually. And I try to do it when I’m feeling most pressured and stressed. Umm, which is the time when it’s the most difficult to do it, but the most beneficial.

Social Worker
The forest is my sanctuary, I just feel so much more grounded there, and my spiritual practice is through nature. I don’t know if my spirituality has actually helped me make sense of what I witness; it has helped me to be able to hold it with greater peace. I can hold it with compassion instead of anxiety and anger, and I can hold it with greater contentment.

Nurse
I just started walking in there (the forest) and immediately I just felt this, this...this is it. This is where I need to be. And this was many years ago, ten or twelve maybe and I remember the fact came to me as I’m walking that my spiritual name and I don’t know why that phrase came to mind, but I thought, my spiritual name is...forest walker. I have given myself that spiritual name then...I do truly believe that my connection is in the forest.

Pastoral Care
...they’ve reopened the chapel, in the hospital...thank goodness...and it’s ah, a sanctuary, a safe place, a sacred place, and it’s somewhere I drop in to. Just to go in and to, to kneel down, which I don’t normally do at church anymore even... but it seems to be, what works, and just to pray. Um, that’s one of the things. I have a regular sort of prayer time at home and I will add, uh, patients’ names to that list. Just
as a way of remembering them without, without carrying them twenty-four hours a day.

Physician
I think you know that you speak to families and there’s always, always, light and something positive that comes out of it, and sometimes they don’t see it, but it will come. And you know, it’s hard, because some families just don’t have um the same, we’re all different, I don’t expect anyone to be the same, but not all families can have, see the positives. It’s all just bad, bad. And it’s really hard to, you can’t say, “Oh something good is going to come out of this” because it’s not what they want to hear. But for me, I need to know that so that I can keep doing what I’m doing.

Illustrations by some of the additional participants’ perspectives express this relation with something larger. In many cases the participants relied on the use of metaphors to help them convey something difficult to describe. The use of metaphors provided them with a short cut that allowed them to capture the broad notion leaving the particulars to the imagination. There is a sense of mystery in these experiences and a “holding the why with a loose hand” and asking the questions of life and death in these situations they have witnessed. There is a sense of amazement and appreciation at how fellow human beings faced with—what from the witnesses perspective seem as overwhelming complexities, demonstrate such courage as they carry on. Some participants recognize the inherent power necessary in being present; being still, while holding openness and a sense of wonder. Several individuals confirmed their own need to maintain the awareness that it is not possible to know everything and the reality of life is that nothing is permanent, life is impermanence. Some participants articulated an acceptance of the inherent unfairness in the world.

These participants relied on a variety of methods that allowed them to hold a sense of faith in a connection within the universe. For some this universal connection is not in a specific religion or dogma, but fell within a sense of order and cycles of nature. These individuals’ sense of faith could be conventional, or unconventional. The faith they maintain
is in something beyond them they believe can support those experiencing suffering as well as those witnessing suffering with many of life’s difficulties. The existence of faith in something larger allows those who hold such a belief a sense “it’ll be just fine” or “it is, what it is”.

The participants have created stories of their experiences that highlight the intricacies and complexities of their human interaction while providing a conviction that the experience is not limited to what goes on between the individuals. They each in their own way express a conviction it is also influenced by that difficult to describe but unanimously supported sense of connection with something larger, a presence beyond the individuals that is felt.

In Telling Their Story

Several artefacts of significance arose during the initial and follow up interviews. These artefacts are: how these individuals spoke about the complexities of the work and advice for others in their respective disciplines. Some participants initiated providing information in these areas and others didn’t and were invited to add comments.

In the process of talking about their experiences all participants spoke about how difficult it was to put language to some aspects of their experiences and how infrequently they had the opportunity to do so. When prompted with a direct request for information on how they learned to talk about their experiences they provided some insights into their skill and ability to talk about this subject. The participants unanimously noted as a part of the interview process they had rarely if ever had the opportunity to talk about their work in this way. Participants affirmed that articulating their experience remains a struggle. Often participants noted they practice in their heads and in their hearts the words to describe what happens for them in those experiences. These participants noted formal and informal education in
addition to discussions with friends and colleagues at deep levels has enhanced their ability to articulate their experiences and enhanced the development of a broader vocabulary to describe these kinds of experiences. They also noted that a genuine invitation, in a safe environment, was necessary for participants to talk at some depth beyond a superficial level of conversation in this area.

**Thoughts on talking about their experiences**

Some examples of their thoughts on talking about their experiences include:

**Psychologist**
The truth is that I don’t have any pat (answer), or I still struggle with it...it’s such a deep experience and I’ve lived it long enough, I’ll grapple with it in the moment and each time I grapple with it, other phrases or other metaphors come up...and so a metaphor is often a bridge because it allows the imagination to come in...the truth is that I still grapple.

**Counsellor**
You know what, it doesn’t come from up here (pointing to her head), it actually comes from here (pointing to her heart) so for me when I actually speak about it and the initial thing is oh, this is hard because I get stuck in my head I think. And so when it comes actually from my heart...from a deeper knowing, from you know that soulful knowing...then the words come without even, without a thought attached to it at all, if that makes any sense at all.

**Nurse**
It’s not a simple one I guess practice. Um, I’m one of those people who very much likes to be able to put words to these sorts of experiences. I value these experiences in my life and so I guess I’ve always been trying to find voice for it as I will continue to keep trying to find further voices for it as we have done here...I would say that education has helped somewhat, um my own analysis probably helped quite a lot in that it’s helped me identify what is important to me, who I am.

**Nurse**
I think it (learning to talk about the work) came through that time of prayer and mediation, you know and writing and preparing to teach and preparing to write about it in other places which to me has been critical.

**Pastoral Care**
I don’t know but the first thing that comes to mind is... this profession is a passion and so it’s on my mind and in my heart a lot...plus my additional training...that gives you an ability to articulate some of it...all they do is talk. You’re in group for
two hours every other day with everybody in that circle while they’re hammering, “how do you feel?”, “how does that make you feel?”, “how do you feel about that?”... so that really helped an awful lot to give a vehicle by which to communicate it.

Physician
I learned to talk about the experience because it has occurred more than once. I think if you do it (only) once, you don’t need to come to terms with it, you know. We do it time and time again and each time it's different. So you know you can walk into suffering this time and then your suffering will have a different face perhaps with your next experience. Um, I think in order to cope with it, it has to be a self-journey or a self-acknowledgement and you have to have time out to think about who you are in that dimension and therefore I think to articulate it to ourselves. To go on so that we can go to the next one and almost debrief ourselves. And I think it’s the constant debriefing that allows you to focus in, identify what you’ve feeling, what you’re doing and move on.

Physician
...I think that’s a big piece. You know, a safe environment certainly, and a recognition that, because you’re asking the question, truly asking the question, that it’s, it’s an opportunity to talk about it...so yeah, a genuine, a genuine invitation.

Physician
I think the language... reflects uhm ...for me its part of sort of spiritual seeking. So whether that’s reading, going to listen to different talks or spiritual teachers or Buddhist retreats or I think you gather a language for spirit. Which unless you, read or you seek it, it is sometimes harder to put into words. So think it’s that spiritual seeking and uhm, education in a way, that gives, helps with your language. And the same sort of doing some of the emotional work and spending some times with wise friends or therapist or you know I’ve got a good group of like minded self reflective friends, and we have good discussions so you develop language because it’s not the first time you’ve talked about some of the things... you have a different vocabulary than when you seek something deeper and richer, and try and put those things into words.

Advice for other health care professionals

It seems fitting to end this story of these participants’ experiences of witnessing suffering with their own words of advice for others in their professions:

Physician
I would encourage them...I could encourage them to find a, either start working with a team of people that they... felt connected to, or affinity to. I think it’s important to have real colleagues, and to really work as a team. To feel that support and that love and care of who you’re working with... because I think this
kind of work you need to have a team. I would encourage them not to work full time, if they could in any way avoid that. I would remind them about the benefit of balance and time away. And...I would just remind them that, that often this kind of work will bring up personal things, that, that...they need to sort of have someone that they can talk to about that. A therapist, a wise friend, a counsellor or someone that, someone they can talk to when they’re struggling. And, and to, and the best thing... is to have colleagues that you can tell you’re struggling.... So, I think that, that the team that you set up, or who you chose to work with, is really important.

Physician
...the advice that I would give, probably ...to breathe and wait and something will shift.

Nurse
I think just take time to enjoy the richness of the experience and um, take time for recover and, and ah, take time to allow that suffering and all of the, to speak and not just to gloss over it. ...And you know, there’s the sadness, there’s the sacred, and there’s the humour and you know to be able to enjoy all of it.

Nurse
Know thyself. I don’t know if there is any other advice. Maybe take care of yourself. Maybe, advice is a very difficult thing to give because we end up giving the advice that we need ourselves.

Psychologist
So my advice would be, if you come into it, know you want to come for the long haul because it will become richer, your footsteps will become sturdier, ah, the outcome will be finer and it’s absolutely worth it. But if you’re a short-term investor, this ain’t the job for you. It just isn’t. There’s too much self-scrutiny, hard searching, researching, um and work that needs to be put in for the yield. The yield starts, it can start in the early times, but I think the yield gets better and better as the years go by.

Pastoral Care
When I train other chaplains I tell them “be prepared to be forever changed by the lives and the people that you come in contact with”. In this work you will bear the scars and you will bear some of that pain with them, but through that you will be transformed as well.

Nurse
I think it’s not unconnected with your personal growth. You have to be, well I guess, in any area, it’s not, but especially in palliative care, you have to be prepared to look at yourself and your own life and your death. And you have to be prepared to be just like these open arms in some ways and just, just learn from the experience of being there. You can’t go into it, there’s lots of things you can’t
know when you go into it. You have to be willing to be moved and to be changed by it. So I think you have to be someone who wants to really look at the really hard and deep things about life. And I think you have to be courageous in a certain way. It’s more courageous in the sense of you have to be really be there. You have to really let yourself be there and, um and let yourself be changed, I think, let yourself receive. Maybe that’s it, you have to really let yourself receive who knows what. You have to be willing to; it’s almost like standing naked in the rain and just receive. Who knows what you are going to receive. Um, and somehow...got to believe that that’s going to be okay.

Counsellor

YOU ABSOULUTELY CAN NOT DO THIS WITHOUT DOING YOUR OWN WORK AND CAN NOT DO IT WITHOUT DOING YOUR ONGOING COMMITMENT TO ONGOING WORK! And that would probably be in bold, underlined, capitalized letters, exclamation marked, you know type format. Because I think that in order to maintain the integrity of this form of work, and as any work, the opinions of the people can bring up, we’re all going to die. We’re all going there. So think it’s really critical that we look at our own fears and our own hesitations, our own trepidations, all of that because we can’t expect the clients who we work with to step into that area if we are not willing to do it ourselves. That would be the biggest...

To summarize the data broadly, the story begins with the participants, what they have seen, what they felt, how they were affected by what they saw and what they felt, how the experiences affected them, and their evolution in relation to their continued involvement in work which includes regular opportunities to witness suffering. It is a fascinating story with many ups and downs, twists and turns, it is a story of similarities and contrasts. It is a story with many perspectives, beliefs and emotions as a part of it. It is a story that illustrates the agony and the ecstasy of their chosen work that involves witnessing suffering. Another voice to be represented within the comprehensive narrative comes in the researcher’s narrative that follows.

Researcher’s Narrative

In this researcher’s narrative I will comment on process and the impact of the data analysis process. I will also begin to make some preliminary connections to the literature. I
will begin with some overall observations about my experience in preparing and collecting the data in relation to conducting the interviews.

The preparation for the data collection process began with the review of literature on the topics of vicarious traumatization and post-traumatic growth. My purpose was to research the literature to determine what is already there and what has not been documented. Because I came with a research question arising out of clinical practice, I wondered if I would find the answer by digging deeply in the literature. What I found in the literature was interesting and enlightening, but did not wholly answer the research question, so I was encouraged that my research may have value beyond my own curiosity which has manifest the last eighteen years as my “need to know”. It was clear in the literature there is support for both the notion of an experience of vicarious traumatization and post-traumatic growth. What seemed to be lacking, from my perspective, were deeper explorations of the experiences themselves, the process versus what appears to be a focus on the outcomes of experiences of this nature.

With this awareness of what was in the existing literature, my sense of the need for further research was affirmed. The question then became how best to deeply explore details about what these experiences are really like. The methodological question of how to begin research in an area not fully explored was answered by beginning the process of exploration. It was clear to me that this study would have to be exploratory in nature. So the questioning continued how best to explore these experiences? What methodology will allow for a deep and detailed exploration of the experience, which could result in an understanding of the essence of these kinds of experiences within a small and manageable group initially? The desire for this kind of outcome highlights phenomenology as one approach that could explore
the reality of these experiences in detail. With these thoughts in mind the process of recruitment and interviewing moved ahead.

As the interviewing process unfolded, I was aware that in each interview there were moments when in my head I could hear the words “yes, yes”, providing confirmation in relation to the subject matter that I anticipated from the literature or that were consistent with my own experience or both. There were also moments in each interview that I felt I wanted further clarification or substantiation around the information initially provided by participants. In many of these situations my desire for more information from the interviewee was met with repetition of language and description previously provided which indicated to me a clear limitation in relation to descriptions provided and desired. It confirmed for me an underlying feeling that there are some experiences that go beyond words or may be truly indescribable. That piece of bumping into the limits was both frustrating and reassuring because it affirmed what I noticed about gaps in the literature and gaps in my own experiences in similar situations. In almost every interview there came a time when the participant was silent and had no more to add. The exception was a nurse who sent a follow up e-mail regarding information she felt was important to add. This seemed confirmation that saturation within the interview had been reached; there was nothing more to add (van Manen, 1990; Bollnow, 1982). Then with each subsequent interview there was a building sense of this is what they can describe, there isn’t more or new information arising.

The process of reading and re-reading the transcripts was essential in pushing me deeply into the data. The repeated reading of stories moved me through a process in which at first I found myself comparing participant experiences with my own clinical experiences. Noting in my head, “yes, that happened to me”, “yes, I know what you mean” as well as “I’m not sure
what you mean, tell me more". Then I noticed I moved to comparing the participants’ experiences with each other. Then with each reading of the data I moved beyond the need to compare experiences to a deep curiosity about what the realities of these experiences are for each of the participants.

I was drawn initially to the larger structure of the variety of components that participants described that are a part of their experience. One of the first components that came up for me was an awareness of the participants’ inability to separate their stories and stories of those they witnessed suffering. There is an inherent link between the health care professionals’ stories and stories of those they witness experiencing suffering. In health care professionals’ description of their experiences there is an interrelatedness of the relationship between the health care professional and those individuals they witness suffering in their day-to-day work. The witnessed individuals’ experience of suffering is a primary factor that links the health care professionals and the individuals involved and without the experiences of suffering there would likely be no need for the health care professional to be involved. The circumstances bond them to one another.

I felt a resonance as a professional because as I read about their experiences I had memories of my own experiences of witnessing suffering arise. What I noticed was that the experiences that arose were not held in isolation in my memory but in connection with the experiences of witnessed suffering as well. When I consider the phenomenological question, what is the meaning of the experience for participants the story holds the meaning for them. The story includes the ups and downs of their day-to-day experience. Their stories include thoughts, emotions, beliefs, values, physical sensations, and what they notice happens within
as they witness suffering. The actions of a full review of the literature to identify what is known and what is not known is once part of ensure trustworthiness of the findings.

The initial themes that arose for me within the health care professionals’ experiences are aspects of how they told their stories. What I noticed was that these larger themes crossed all participants. There seems to be a need to define their work, and to describe the suffering they witnessed, and how they came to be in this kind of work. In their descriptions participants defined their personal language about their experiences, as well as describing the feeling of being in the experience, the impact of the exposures, how they process the effects of repeated exposures, their evolution within the sphere of their work, and the sense of their connection to something larger than themselves and the people for whom they provide care.

The participants’ comments confirm some of what is discussed in the literature. What is apparent is that exposures of witnessed suffering are complex and include physical, psychological, social, emotional and spiritual elements noted in the literature (Cassell, 1982; Chapman & Garvin, 1993). There are costs and benefits resulting from these experiences. These costs and benefits are described in relation to the health care professional experiences’ and what they witness in those for whom they provide care. There is support for the notion suggested by Tedeschi and Calhoun (1995), of personal growth in relation to the perception of self, changes in interpersonal relationships, and in philosophy of life. In addition there is acknowledgement that these health care professionals’ experiences can also include experiences of vicarious traumatization consistent with work by Figley (1995) and McCann and Pearlman (1990). These various notions were represented in my journals after I conducted the interviews, noting physical, psychological, emotional and spiritual elements as
a part of my reaction to what the participants described. I also noted these aspects as the stories from my past clinical experience were reviewed.

In the early review of these interviews, health care professionals describe positive and negative effects coexisting in their experiences of witnessing suffering, just as an individual being witnessed may simultaneously experience pain and growth. These kinds of experiences are common in the descriptions provided by health care professionals and demonstrate the maintenance of a sense of duality holding two independent opposing forces jointly. As my awareness of the presence of the sense of duality developed, I began to see it represented in a variety of ways within the participants experiences. I also noted that I had many examples of this phenomenon in my clinical experiences as well. The areas of duality noted in the interviews included physical, emotional, and the cross over between mind and body. The one exception to this sense of duality was in relation to a connection with something larger. Despite the fact that the language, beliefs, representations, or lack thereof were all very uniquely personal, there was a unanimous acknowledgment of a connection with something larger than themselves and those they cared for that was described as a significant part of the participants' experiences. The sense of connection with something larger was something participants spoke of in great detail while it was also noted to be the most difficult for participants to talk about. The challenge in speaking about this was noted to be in terms of personal and professional shyness, as well as in relation to the difficulty in finding language that captured descriptions of this nature. I also noted in the editing process my own reluctance and severe hesitation to manipulate or change the narrative sections dealing with the participants' connection with something larger. It felt like sacrilege to change, edit, reduce or paraphrase something that was clearly so sacred to them. I agonized about how best
to hold the sacredness of what they told me while respecting the research obligation to represent the essence of the meaning of the phenomenon.

The nurses and physicians in this study exclusively commented on the sense of responsibility and the distress they experienced in relation to the experiences of witnessing suffering in relation to physical pain. Those who provided primarily spiritual or psychological care in some cases acknowledged that they had a different experience of working with physical suffering. These individuals perceived physical suffering as beyond their direct scope of care, although they saw themselves as able to intervene even when physical pain was present. Psycho-spiritual care providers acknowledged their reliance on different approaches and interventions when working with individuals experiencing physical pain than those used by physicians and nurses. They confirmed the need for care in relation to physical pain while noting they did not see the resolution or direct treatment of physical pain as their responsibility. Their focus was to support through physical pain even when it did not resolve.

In the interviews the research participants noted shifts in life priorities, a new appreciation for each day, and an awareness of the influence of maintaining and nurturing connections with others; all these factors have been described as evidence of growth (Calhoun & Tedeschi, 1999). In each of the initial interviews there is evidence of empathic connection to all human beings who suffer, which is consistent with Pearlman and Saakvitne’s work (1995).

In these initial interviews there is evidence of the participants desire to describe the “thin places” which Gomes (1996) describes as what some might call the supernatural, or others would describe as something transcendent (O’Leary et al., 1998), or something like the divine
other (Calhoun & Tedeschi, 1999). It is clear the participants struggle to articulate their experiences. The participants stories demonstrate what Schaefer and Moos (1992) describe as the self-regulatory system of feedback loops in which some benefits from dreaded or distressing situations can be appreciated, or what Tedeschi and Calhoun (1995) describe as a reciprocal relationship between wisdom and meaningfulness.

In addition, these interviews demonstrate links again with a sense of duality. The notion that the struggles and challenges presented by witnessing events that include traumatic material can at times some how enhance or encourage the health care professional to continue to grow in their work over time and may even reduce the sense of distress in their day-to-day experiences, and could possibly promote resilience in the future (Beardslee & Podorefsy, 1988; Green, 1986; Tedeschi & Calhoun 1995; Rutter, 1987; Werner, 1984).

In the review of these interviews, there is clear evidence of posttraumatic growth within Tedeschi and Calhoun's (1995) five domains of growth which included enhanced relationships, a greater appreciation of life, opening up of new possibilities for living, spiritual development and a greater sense of personal strength. Each of these interviews added depth and breadth to the description of experiences of what that experience of growth looked like, as well as the meanings participants associated with them. The interviews strongly confirm and expanded existing theoretical and clinical work in the literature. It is clear from the interviews the complexity within experiences of this nature that contributes to the variety of outcomes. It is clear that these witnesses experienced a range of outcomes from their experience covering a broad range on a continuum. It is clear that some of their experiences could be considered vicarious trauma and some are described as growth, transformative or transcendent. This confirmation and expansion of knowledge acquired
moves the edges and depth of understanding of the meaning of these kinds of experiences for those involved. With this new knowledge comes implications for others entering and working in areas of this nature. It confirms that individuals working in areas where they will regularly witness suffering need to maintain a deep awareness of their own experience. They also need to continue to enhance their ability to articulate their awareness in a meaningful way to others. The process of articulating their experiences breaks through the isolation that is so often inherent in these very difficult kinds of situations. A sense of isolation can increase risk of additional suffering. Continued practice to talk about all aspects of work of this nature moves this knowledge beyond the individuals involved and as a result expands the circle of responsibility. This kind of movement allows for and encourages a greater sense of shared responsibility and understanding. Moving information of this kind from being held internally in isolation to expressing it externally breaking the barrier of isolation is essential.

In the sharing of this information comes the creation of space for teaching and learning, opportunities to promote growth and to reduce risks related to these complex issues in the future.
CHAPTER V
DISCUSSION, IMPLICATIONS, RECOMMENDATIONS AND CONCLUSION

"The cure for pain is in the pain".

Rumi

As a researcher with a complex question arising from my years of clinical practice in relation to witnessing suffering, I had hoped this research would answer some of the nagging questions that are a part of the day to day experience of repeated exposures to suffering. In particular, I had hoped this research could expand the understanding of experiences of witnessing suffering other than vicarious traumatization. This study has provided a deeper and more comprehensive look into experiences of witnessed suffering through the eyes of others, but as one might expect it leaves some questions open to further investigation.

Study Overview

What came from this research are the stories of the lived experiences of these health care professionals regarding their experiences of witnessing suffering. Taken as a whole, how do these stories inform us? What do these stories tell us? The stories describe the significant personal and professional effects of the experiences of witnessed suffering on each individual. The health care professionals’ stories highlight the broad and individual aspects of their experiences. These stories also confirm some of what is represented in the literature in relation to the notions of vicarious traumatization and vicarious post-traumatic growth. These stories reinforce the complexity of experiences of this nature. In addition, this research provides an in depth opportunity for exploration in a small and varied group of health care
professionals. The method chosen for this research encourages the opportunity to notice and
draw out the essences of their lived experiences.

In this section I will summarise and discuss some of this study’s key research themes, and
identify the links and gaps in the literature in relation to these themes. I will also comment on
the limitations of this study, provide recommendations for future research, and suggest
implications for clinical practice and professional education.

Overview of Themes

This overview will include a discussion of some of the significant themes noted in this
research. The themes to be discussed in some detail are: the impact of witnessing suffering,
meaning making and the connection with something larger, the sense of duality, and the
evolution over time. The inclusion of these themes is directly related to their presence in the
stories of the health care professionals. The selection of these particular themes is related to
the frequency in which they appeared in the interviews, the amount of time participants
spoke about theme, and the depth of the content provided as their stories unfolded. These
themes represent uniformly consistent themes for all the participants in terms of inclusion
and emphasis. See Figure 6.

The Impact of Witnessing Suffering

As noted in the findings, there is an inherent link between the experience of the individual
suffering and the health care professional witnessing the experience of suffering in their role
as care provider. All the participants in this study were unable to talk about their experiences
of witnessing suffering without first describing what they have witnessed. Frank (1995)
highlights the significance of storytelling for ill people. The participants in this study are not
ill but working with the ill and dying. Like the ill these professionals rely on storytelling.
They rely on storytelling, “because stories can heal, the wounded healer and wounded storyteller are not separate, but are different aspects of the same figure” (Frank, 1995, p. xii). He notes, “sooner or later, everyone is a wounded storyteller” (Frank, 1995, p. xii). The reliance on storytelling maintains the health care professional role of helper in that, “As wounded, people may be care for, but as storytellers, they care for others” (p.xii). The significance of the impact of being in the experience as a health care professional while simultaneously a witness was repeatedly acknowledged in this research. Frank (1195) notes,

People tell stories not just to work out their own changing identities,

but also to guide others who will follow them. They seek not to provide

a map that can guide others—each must create his own—but rather to
witness the experience of reconstructing one's own map. Witnessing is one duty to the commonsensical and to other (p. 17).

This notion takes us back to the professionals’ role as witness and their sense of responsibility to provide testimony to what they have seen and their experience of it.

The circumstances they witnessed were described as typical for these individuals but would be described as beyond the typical for most others in other areas of work. In examining the literature in relation to facing difficult life circumstances, what is found most often are the negative effects for an individual in a variety of life events like life threatening illness, disability, accidents and bereavement (Affleck et al., 1985; Calhoun & Tedeschi, 1989-1990; Edmonds & Hooker, 1992; Hamer & Sontz, 1978; Schwartzberg, 1993;). In the majority of studies relating to vicarious experiences of trauma the literature cites consequences of experiences of this nature as negative effects like burnout (Farber, 1985; Kahill, 1988; Lalotis & Grayson, 1985) compassion fatigue and vicarious traumatization (Arvay & Uhlemann, 1996; Cerney, 1995; Charney & Pearlman, 1998).

The participants in this study acknowledge the existence of consequences of this nature while describing their professional experiences day-to-day, but their experiences were not limited to only negative effects cited in the literature in relation to experiences like this. The few studies that comment on any positive effects in relation to difficult life circumstances are primarily related to illness/injury (Hammer & Shontz, 1978; Turner & Cox, 2004) trauma (Linley & Joseph, 2004, 2005) stress (Houston et al., 1978). In relation to the notion of
vicarious posttraumatic growth for an individual facing difficult life circumstances the research is limited and is represented in work by Cadell, 2003; Cadell, Regehr, & Hemsworth, 2003; Kramer, Patt, & Brown 2004; Polatinsky & Esprey, 2000). The work of Pearlman and Saakvitne (1995) note the influence on clinicians of hearing /witnessing the heroic struggle and survival of others results in an awareness about their own vulnerability and potential strength; this perspective was represented in the experiences of participants in this research. In addition, other work (Calhoun & Tedeschi, 1999; Sodegren, Hyland, Crawford, & Partridge, 2004; Yalom & Liberman, 1991) suggests clinicians may experience positive change in their world view and general philosophies of life as was apparent in this research. Additionally, Calhoun and Tedeschi (1999) highlighted other changes that were also noted by participants in this study, namely a shift in life priorities, a new appreciation of each day and enhanced awareness to maintain and nurture connections with others. The participants’ stories in this research confirmed Calhoun and Tedeschi’s (1999) findings that clinicians who experience a controlled shaking of their foundation may do so without the high cost of those having the direct experience, and may still receive benefits of growth or positive change as a result of these exposures.

As proposed by Tedeschi and Calhoun (1995), the participants in this study noted changes in the areas of self, change in interpersonal relationships, and changes in philosophy of life. The participants in this study described themselves as being aware of their own personal strength and vulnerability in a new way as a consequence of their work. In relation to their life relationships they noted a decrease tolerance for "fluff and trite" and increase desire for total honesty, openness, reciprocity, and receptive shared perspectives with those they relate to. They also noted the surprising depth and swiftness of connection that
developed with those they witnessed suffering, describing what might be called a traumatic bond.

In addition they spoke of that sense of “we are all connected”, that the suffering of one is the suffering of many. In terms of philosophy of life, the participants’ noted how their work had expanded their view of life itself, enlarging the picture of what life is. With this expanded view comes the expansion of the dimensions within their life, and their appreciation for the range of features of which they were now aware. They noted an appreciation and clarity about valued aspects in their life including an awareness of the tentative and fragile nature of all aspects of life as well as a shift way from “sweating the small stuff” to embracing the beauty of today.

The participants’ stories confirmed many of the tasks and cognitive process of coping discussed in the literature when they described how they managed what they witnessed daily. Antonovsky’s work (1987) describes three necessary foundational categories for positive change, which are manageability, comprehensibility, and meaningfulness. Taylor’s (1983) work describes the notions of meaning, mastery and self-esteem enhancement. Many of the participants’ comments highlight their reliance on features of this nature in their day-to-day experience. The areas that participants in this study devoted a great deal of time and depth to in their descriptions were the areas of the meaning-making for their experiences, and their sense of connection to something larger.

One Part of Meaning Making: Connection with Something Larger

Participants spoke of a variety of ways in which they sought to make meaning of what they witnessed, and which was not always possible in a practical sense. They also stated quite clearly that no matter what strategies they rely on in the management of the impact of
their experiences day-to-day, an essential feature beyond all others is that sense of connection with something larger. They reported that they couldn’t do the work they do without that.

Participants all demonstrated an initial shyness or hesitation in speaking about this particular aspect of their experience. They also spoke of their difficulty in finding language to describe their experiences of this nature, although despite their concerns, it appears they had more ability to speak about these areas than they were aware of. One of the unique aspects present in this study and not available in the literature in relation to their connection with something larger— is the participants’ description of their physical reactions when they experienced this kind of connection. The participants noted a sense of expansion in these moments that seemed to appear most often in the core of the body. The sense of expansion was not restricted to this physical sensation, but was also noted as an enlarged awareness, which resonates with the description in Gomes (1996) work regarding the “thin places”.

Given the participants’ hesitation to speak about their connection with something larger it is no surprise there is some acknowledgement of these experiences in the literature but limited research reported in this area. The connection with something larger participants’ spoke of is described in the literature as experiencing God, something transcendent or something like the divine (Calhoun & Tedeschi, 1999; James, 1985; O’Leary et al., 1998). This kind of observation links easily to the work by Antonovsky (1987); Baumeister (1991); Frankl (1963); and Janoff-Bulman (1989) on meaning making. In the search for meaning, participants highlighted their own personal way of connecting with something larger as one way of coming to terms with experiences that appeared at times beyond comprehension and seemed to require a sense of acceptance of just that. Berger’s (1967) work relates to the participants’ description of their reliance on a connection with something larger for meaning
making as inviting a “sacred canopy”. This canopy is described as a self maintaining overarching notion that shelters us from chaos. It is a demonstration of what is considered a higher order schema. Higher order schemas deal with fundamental issues about our self-worth, power, the benevolence of others, including issues of trust, safety, intimacy, and meaning (Tedeschi & Calhoun, 1995). Participants noted the reliance on this kind of higher order schema is noted as one way they can retain meaning in life when what is witnessed may appear senseless and tragic. McCann and Pearlman (1990) speak of a supra ordinate schema “the frame of reference” which includes causality, locus of control and hopefulness. Many of the participants’ comments regarding their connection with something larger appeared consistent with some aspects of a higher order schema. Frankl (2000) addresses this point in his formulation in relation to attempts to create an overall meaning, “the more comprehensive the meaning, the less comprehensible it is”, (p. 143). Given this perspective, what is clear is the participants of this study felt only with their own personal acceptance of a connection with something larger were they able to see life including the suffering they witnessed as having value and purpose. Only when they did see it as having value, purpose and worth was it possible to make an emotional and practical investment or commitment to their life’s work. With that acceptance comes the clarity of action and purpose that appears to reduce the health care professionals’ suffering in relation to the impact of witnessed suffering and only then can they do the work.

The Sense of Duality

Another of the overarching themes within the stories of these health care professionals’ experiences is the maintenance of a sense of duality within the experiences of witnessing suffering. What does the literature say around the notion of duality? Although the language is
different, Calhoun and Tedeschi (1999) discuss ways in which growth and distress may coexist across a variety of personal realms. The health care professionals participating in this study spoke regularly of this coexistence or sense of a duality across a number of realms. The participants noted regularly a mind/body duality. The appreciation of paradox is a common element resulting from facing difficult/traumatic events and is outlined as one part of the seven part model for coping with trauma outlined by Tedeschi and Calhoun (1995). In addition, Calhoun and Tedeschi (1999) speak of the experiences of clients and clinicians who come to recognize the paradox that they may benefit from their struggles with trauma and as a result see themselves as both stronger and more vulnerable. The basic paradox or foundational aspect of maintaining the duality within experiences like this are that "good can come from bad or that loss can produce gain, or that one must do and not do" (Tedeschi & Calhoun, 1995, p.86). Thinking of this nature, which is based on these apparent contradictions and paradoxes, has been described by Kramer (1990) as the cognitive components of wisdom. This notion of gaining a deeper sense of knowing is consistent with the general sense provided by participants in this study. The participants identified multiple physically, emotionally and cognitively examples of experiences of maintaining a duality and noted the ability to hold these dualities are necessary in allowing them their continued engagement in their work.

**Evolution Over Time**

The final overarching theme relates to the notion of change or the stability of a sense of impermanence in life. The participants spoke of what they have noticed personally and professionally over the years of their work lives. They also noted how rarely they had opportunities to reflect in a meaningful way about the changes they have experienced in
relation to their work. The participants noted over time a greater understanding of what they have witnessed and are witnessing. The sense of greater understanding acquired over time is consistent with the existing literature on growth and the development of wisdom (Linley, 2003). The areas of change or growth most often cited in this study were in relation to the sense of self, physical responses, emotions, expectations, and their spiritual self and spiritual development. Baltes and Smith's work (1990) suggests that practice with life problems; personal efficacy and cognitive mechanics are some of necessary aspects that play a part in the development of wisdom. The participants noted more ease in the work itself, less shock and surprise at what they witnessed over time, a sense of greater openness and depth in their work, and an expanded awareness of the spiritual aspect of their development. They noted a greater degree of comfort accepting circumstances best understood by not knowing or understanding. It is noted that with the development of wisdom some functions are enhanced and as a result provide opportunities to resolve life dilemmas, engage in life review, and to develop spiritually (Tedeschi & Calhoun, 1995). One of the benefits of conducting research of this nature is that when relying on a methodology that asks participants to review aspects of their life this action itself may further facilitate the development of personal wisdom in the participants themselves.

In summary, the findings of this study of the participants' perspectives and direct experiential knowledge of their experiences of witnessing suffering are consistent with Tedeschi and Calhoun's (1995) model of growth. That model was formulated to reflect the experiences of individuals directly involved in traumatic life experiences. A review of the findings from this study compared with Tedeschi and Calhoun's (1995) model of growth highlight a fit at the global level, reflective of the participants' description of their
experiences. Just to review, the growth model holds that growth is perceived when some change has taken place in the view of self and/or the world, when the change is perceived to have resulted in a more profound understanding of the self and world. This understanding allows for changes in behaviour that effectively ward off future distress, while engaging in previously unconsidered or untried activities or providing rewards previously unattained. The loss associated with the experience is transformed into more value in the present and future. This transformation of value is only possible because of the struggle and the challenges that result from the exposure to the trauma and perhaps only because of that experience (Tedeschi & Calhoun, 1995). The conclusion appears to be that those affected by difficult/challenging life events whether they are the person experiencing it or someone in the role of a witness or care provider may feel wiser and blessed, which is paradoxically the result of loss or suffering or witnessing loss or suffering.

Research Limitations

This study, although providing an in-depth exploration of the experiences of these individuals’ experiences of witnessing suffering, also leaves questions yet to be answered. Some of the limitations of this research were due primarily to the limitations inherent in any study of an exploratory nature. It is not possible to completely answer a variety of questions in relation to the mixture of variables associated with each individual. The choice of methodology provides good depth of exploration, but limits the study by the relatively small number of participants necessary to obtain such depth. Selecting a methodology that focused on establishing the meaning of the experiences of participants did not permit exploration of gender differences, although there were male and female participants in the study. It also did not allow for sorting any influences related to age and developmental stage, temperament and
personality characteristics, or cultural or religious belief systems. It did not allow for a full exploration of interdisciplinary differences, although small numbers of a variety of disciplines participated in the study.

In this study it was not possible, beyond establishing that change or growth occurred, to sort fully all aspects of the experiences of change or growth noted by participants. It was also not possible to define growth from this research, or to discern how it affects work experience once it has developed. This research did not fully clarify the relationship between distress and growth. Given the small and specific nature of population of this study the findings lack transferability to any other specific populations, but this research does illuminate some significant and salient features related to this phenomenon that suggest further research is indicated. The study contributes a deep, rich descriptive first step in understanding the experience of witnessing suffering leaving some questions unanswered that are ripe for future research.

Research Implications

Some of the implications of this research and previous research in relation to the experiences of vicarious traumatization and vicarious posttraumatic growth demand continued attention. The areas for future research that arise directly from the limitations of this study include exploring the possibility of gender differences, age and developmental stage influences, the influence of temperament and personality characteristics, cultural or religious beliefs, and disciplinary differences.

The awareness that those who have witnessed suffering experience their own individual personal and professional consequences related to witnessing suffering is necessary information for individuals in these fields. However, knowing this is not enough. Nothing is
without consequence, particularly witnessing suffering. It is clear the consequences of exposures of this nature may be quite varied in their impact. It is also clear that there may potentially be a number of factors that foster quite a variety of outcomes. Since the research base for what are described as negative effects is better established, the present research suggests the importance and timeliness of further exploration in relation to the notion of vicarious impact, and specifically vicarious post-traumatic growth. It would be useful to more clearly identify and understand the influencing factors and their relationships alone and in combinations. It would be useful to determine what factors or combinations of factors enhance the creation of further benefits, as well as those that may reduce or eliminate distress or other negative consequences.

Since participants identified how rarely they have opportunities to reflect and talk about their experience related to witnessing suffering, this suggests there may be value in creating specific opportunities for activities of this nature and then assess the impact for health care professionals over time. Could this be a tool to enhance post traumatic growth? Having identified that these participants experienced a sense of growth, what is growth in relation to experiences of this nature? Can it be assessed beyond self assessment? Could self-assessment provide a bias?

The participants in this study have highlighted that their sense of connection with something larger plays a significant role in their continued involvement in challenging work. Can we better understand this influence? How might this sense of connection be cultivated in either a clinical or educational setting with the hope of enhancing growth and prolonged positive work involvement.
As noted in this study, the development of wisdom appears to have a significant role in the ability to do work of this nature. It is important to explore what types of preparation and practice in difficult situations could be integrated into clinical practice or training to promote the development of wisdom. Can wisdom be taught? If so how?

The notion of the maintenance of a sense of duality that arose in this research regarding these experiences will need further exploration. Is it possible to teach how to maintain a sense of duality? If so how? If there are necessary pre-conditions in relation to the development of duality what are they and how might they be cultivated? How does the sense of duality develop? What fosters its development and what hinders it? Despite the deep and real look at the picture provided by these health care professionals as a result of this research, there remain many questions to be explored in this area. Further research is necessary given the existing unanswered questions.

Implications for Practice and Education

I have chosen to begin this section with the advice for other health care professionals provided by participants in this study. The voices of the participants have held the key to the discovery of the significant aspects of the complex phenomenon of witnessing suffering highlighted in this research. The participants’ clarity in their advice to other professionals “know thyself” and “do your own work” certainly highlights the need for a continued investment in regular, structured, supported self reflective opportunities in practice and training. Further exploration and options for implementing the participant-generated suggestions in the form of advice for other health care professions is worthy of additional attention in the future. The summarized participants’ advice follows:
- Balance work of this nature either with other work or working part time and maintaining other life focuses.

- Work in a team of like minded individuals who maintain a team identity and practice reciprocity within the work environment.

- During the most intense moments of exposures the professionals suggest, take whatever time is necessary in those moments (foster presence), care for yourself in the process, breathe and wait when necessary for something to shift. Take in the richness, take time to recover and take time to take in the sadness; that’s the sacred, enjoy the humour, enjoy it all.

- Know thyself and take care of yourself.

- Maintain an awareness of the benefits that arise in the long haul and know the yield gets better and better over time.

- Do your own work and be prepared to look at your own fears, hesitations and trepidations, your own life and your own death

- Be open and willing to be moved and changed, be willing to receive

In addition this research suggests there may be benefits in learning more about how to cultivate meaning making and a connection with something larger as well as holding duality in relation to difficult life/work experiences. The professionals in this study highlighted the importance and need for preparation and practice to acquire these skills. A commitment of this nature will require financial and practical support. Access should be simple (within the work setting) and made available across all disciplines. Since each professional group likely has on-going continuing professional education and development requirements offerings in
relation to those requirements may be a good fit. It will also be essential to provide similar opportunities early in professional education and training.

Additional suggestions based on the advice from these health care professionals:

- Provide opportunities for paid secondments in complimentary areas (options for variety and balance), teaching or research sabbatical opportunities and job sharing.
- Provide funded opportunities to cultivate team identity and shared perspectives within an ever changing work environment.
- Provide periodic individual and group structured rituals of reflection on site whenever possible
- Encourage/support utilization of paid holidays and unpaid leaves.
- Maintain a professional expectation at all levels of personal self reflection and provide individual and group alternatives for such support on site at all phases of professional development.
- Provide on site space for reflection/meditation while maintaining staffing levels and schedules that allow for practices of this nature.
- Provide supported practice exposures to difficult situations that encourage skill development and practice in these types of situation which may enhance the cultivation of wisdom over time.

Beyond the recommendations provided by the participants this research combined with the literature suggests consideration in a number of areas. As a part of this research subtle differences were noted between how physicians and nurses (who care for the body) and the health care professionals providing primarily psychosocial/spiritual care react. The difference arose in their reactions to witnessing physical suffering, but not in relation
to other forms of suffering, and related to a differing sense of responsibility for managing/controlling or eliminating physical pain. Physicians and nurses, who provide direct care to the body, expressed a higher sense of responsibility compared with those who provide psychosocial/spiritual care. If it were possible to confirm this notion in additional research it may have implications for clinical practice. If this notion exists, does it add to the risk of vicarious traumatization? Is it possible that a mediating factor like the health care professionals' connection with something larger and/or their ability for holding duality affects that sense of responsibility when the practical limits of science have been exhausted. It would be interesting to know more.

Concluding Comments

This study has provided the unique opportunity for me to take on the role of a researcher and to deeply explore a clinical question carried for a significant number of years. It has provided health care professionals who rarely find time and opportunity to speak about their experiences to do just that. The participants ability to describe the un-describable has provoked awe and wonder in my work with them. It has confirmed my hunch that the intimate moments shared while witnessing the suffering of others make significant impressions on the witnesses. These experiences carry significant meaning for all those involved. The participants highlight two essentials features that assist them in what appears to be their path of continued growth in their work. The two essentials are meaning making with the creation and cultivation of their connection with something larger and the ability to maintain a sense of duality in their work. It is clear that health care professionals can be influenced by witnessing suffering and that they may experience trauma and/or growth as a result of these kinds of experiences. Even knowing now that for these individuals these two
essential features played a significant part in their individual experiences there remains some mystery to understanding exactly how individual outcomes develop. This exploratory work confirms the need for further research that will lead to more direct applications for clinical practice and professional education. This research affirms there is hope that even in the darkest moments there remains the possibility of growth.
References


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APPENDIX A
Letter of invitation
March 1, 2004

Dear Colleague:

I am writing to invite participation in a research study of health care professionals (physicians, nurses, social workers, chaplains, occupational therapists, physiotherapists, all allied health professionals affiliated with interdisciplinary teams) experiences other than vicarious traumatization of witnessed suffering. This study is designed to explore these experiences to better understand the experiences of witnessing suffering on health care professionals. It is hoped that with a better understanding of experiences of this nature it may be possible to discover ways to promote increasing the possibility of positive outcomes for health care professionals.

The research will be conducted by myself, a registered social worker, under the supervision of Dr. William Borgen of the department of Educational and Counselling Psychology, and Special Education in partial fulfillment of requirements for doctoral studies in the Individual Interdisciplinary Studies Graduate Program at the University of British Columbia. The study involves two interviews of about 1.5 hours each. Participants will be asked to describe in their own words their experiences other than vicarious traumatization of witnessed suffering. The time commitment for each participant is a total of three hours. The confidentiality of all participants will be respected.

If you are interested in participating in this study or would like more detailed information please contact me, Jamie Sork at ( ) or via e-mail at . Thank you in advance for considering involvement in this research and for distributing this invitation to other health care professionals who may wish to participate.

Sincerely,

Jamie Sork, MSW, RSW

Jamie Sork
Student
Individual Interdisciplinary Studies
Graduate Program
E-mail: 
Tel: 
Fax:
APPENDIX B
Interview Questions and Probes
Interview Questions and Probes

Introductory comments and interview questions and probes

Introductory comment:
In the selection of your profession in health care, one of the experiences that is part of your work experience are experiences of witnessing suffering. The purpose of this study is to collect information from health care professionals to better understand what they experience at those times.

First interview:

Given the purpose of the research is to explore the experiences of health care professionals other than vicarious traumatization who have witnessed suffering I want to talk with you about how you see yourself in relation to your experiences at work. We can discuss your experiences in any way you like. We might begin with your general experience first of what you experience in relation to events of witnessing suffering other than vicarious traumatization? How would you like to proceed?

Can you recall an experience in your past work that involved witnessing suffering and describe what you experienced?
The thoughts, emotions, beliefs, values, and physical sensations you have experienced.

In the day to day, when you witness suffering what do you notice happens in you?

Is the situation you just described unique or similar to other situations in your work?
If this one is different what is different about it and how you reacted?
If it is similar to other reactions what is similar about it and how you reacted?
Do all situations regarding witnessed suffering feel like this one or is there a difference?
What feels different in you?
What feels the same for you?
Can you talk about the similarities and/or differences?

If the participant is struggling with a way to describe what they experienced, I would ask if they have ever had another time when they felt like this.
Would they be able to talk about that?

I would also invite them to think about the experience in relation to all aspects of their being, how it felt, sounds associated with it, smell associated, any physical reactions they noticed.

I would then ask if the reactions they have been discussing have always been like this or have they changed. If they have changed, when and in what way?
more about what the participant noted. The following probes would only be used if the participant presented some form of representation.

I might wonder out loud if they carry a representation of this experience within and if they can describe what that is or what it is like?

Have you had any other experiences that have resulted in the creation of some form of representation you are aware of? If so, can you tell me more about that? If you can't describe it what other means would you use to help me to understand your experience?

Other probes that might be used:
Have you noticed a difference in how feel about?
   a) your relationships with others? If so, what have you noticed?
   b) appreciation of life? If so, what have you noticed?
   c) sense of new possibilities? If so, what have you noticed?
   d) spiritual development? If so, what have you noticed?
   e) sense of personal strength? If so, what have you noticed?

If you have noticed changes in any of these areas or others what have you noticed?

If you have noticed changes how do you make sense or explain those changes to yourself and others?

If you have noticed changes how do you feel about those changes?

Second interview:

The second interview will be guided by the information brought into the interview from the preliminary review of the data. It will be an opportunity for the researcher and participant to be sure that what is their experience feels represented. If not, what needs to be added or changed to create that sense of recognition?
APPENDIX C
Consent Form
Consent Form

THE UNIVERSITY OF BRITISH COLUMBIA

A study of health care professionals’ experiences other than vicarious traumatization of witnessed suffering

Consent Form

This study is being undertaken to better understand the health care professionals’ experiences in relation to witnessed suffering. The study is under the direction of Dr. William A. Borgen (604-822-5261) of the Department of Educational and Counselling Psychology, and Special Education of the University of British Columbia. It is being conducted by Jamie Sork (604- ) a PhD student in the Individual Interdisciplinary Studies Graduate Program. The study is being conducted in partial fulfillment of the requirements for Jamie’s doctoral degree in Interdisciplinary Studies.

I am aware that this research will involve me participating in two interviews. Each interview will last approximately an hour and a half. All interviews will be audio taped and transcribed for study. In the second interview I will be given a summary of themes arising from the previous interviews in relation to experiences of this nature for comment, question or further discussion.

Without identifying me, direct quotations from the interviews may be used in reporting the results of this research. Any personal identifying information, such as name(s) is not required in this project. The information needed for the research project will be transcribed promptly. Audiotapes and transcripts will not be available to any persons other than the researcher and other members of the research team. Audiotapes and computer records will be retained for five years in locked or password protected files and then destroyed using appropriate methods. All information will be treated in confidence with two exceptions: 1) report of sexual or physical abuse of children and 2) threat of harm to self or others. These would be reported to the appropriate authorities.

The risks of participation in this study are related to distress experienced in the process of recalling past events. I am aware that additional counselling support is availability to me should I experience distress in the process of the interviews.
I understand that my participation in this study is voluntary and may be terminated at any time. Should I have any questions about the procedures, I may ask them at any time. If I have any concerns about my rights or treatment as a research participant, I may contact the Research Subject Information Line in the UBC Office of Research Services at (604-822-8598). All potential risks associated with participation in this study have been discussed with me.

I have read this form; have been given the opportunity to ask questions about the form and about the study, and have had my questions answered to my satisfaction. I acknowledge receipt of a copy of this consent form.

Date: ____________________________ Signed: ____________________________ Witness: ____________________________

Name (Please Print): ____________________________
APPENDIX D
Image Releases
I hereby give permission for Jamie Sork to use and publish my photograph of a heron and a duck in Lost Lagoon in her dissertation.

Victoria Colvin

April 28, 2005
Dear Jamie,

This is a letter of permission, permitting you to utilize my name and the image of the Arbutus Tree in your dissertation. In your dissertation I would like to be acknowledged in both the picture/drawing and the narrative by name, (Katherine Murray).

Thank you very much, I appreciated the interview experience with you, your beautiful presence and gentle being. I look forward to reading your dissertation and hearing your work.

Have fun completing the dissertation!

Warm regards,

Katherine Murray, RN, BSN, MA, CHPC(C)