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The Lived Experience of Suffering of Males After Blunt Trauma: A Phenomenological Study

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ABSTRACT

Using a phenomenological design, the researcher explored the question of what is the experience of suffering as voiced by male patients 7–12 months after hospitalization for blunt trauma. Seventeen male volunteers were interviewed and asked questions about how they suffered, what made their suffering more or less bearable, and how they were transformed through their suffering. Participants experienced changes in patterns resulting in a perception of suffering. Participants reported mostly experiencing physical, emotional, and social forms of suffering, whereas fewer experienced economic and spiritual suffering. Experiences of suffering resulted from the threat to their normal state or sense of wholeness because of their injuries. Intrinsic and extrinsic factors were identified, making the participants' suffering more or less bearable as they regained their lost state of normal. Positive attitude and motivation were significant intrinsic factors, whereas quality supportive care was the most significant extrinsic factor. Poor quality care was a significant negative extrinsic factor resulting in experiences of increased suffering. Through their experiences of suffering, the participants were transformed, amending their previous state of normal. Knowledge gained through this phenomenological study may be useful to nurses in guiding their care to alleviate patients' suffering and help them find meaning.

Key Words

Blunt trauma, Nursing, Phenomenology, Suffering, Transformation

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The authors declare no conflicts of interest.

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DOI: 10.1097/JTN.0000000000000289

BACKGROUND/SIGNIFICANCE

Human beings possess wholeness: unitary, integrated biopsychosocial-spiritual beings who are in dynamic interaction with their environment (Bender & Feldman, 2015; Fawcett & DeSanto-Madeya, 2013). As a result of this dynamic interaction, human beings experience events, some that threaten their ability to maintain a state of wholeness and health (Eriksson, 2007). Blunt trauma is such a life-altering event.

People, regardless of their socioeconomic status, occupations, or where they live, have the potential of experiencing a blunt trauma event (Fantus & Fildes, 2003a). Blunt trauma is a serious injury because it more frequently results in multiple-organ system injuries than penetrating trauma (Fantus & Fildes, 2003b). In 2012, blunt trauma as the result of a motor vehicle accident (MVA) or a fall accounted for 72% of all traumatic mechanisms of injury for people aged 20–74 years whereas penetrating trauma such as gunshot wounds or stabbings accounted for less than 13% of traumatic injuries (Nance, 2013). In that same age range, men experienced 69% of the traumatic incidents (Nance, 2013).

Blunt trauma results in the experience of suffering. Suffering is a complex, unique, and subjective human experience in response to a perceived or real threat to one's sense of wholeness (Cassell, 1991; Eriksson, 1997; Ferrell & Coyle, 2008; Malpas & Lickiss, 2012). Suffering results when one's beliefs and values are put to doubt to a degree that causes a lack of trust in the past (Cassell, 1992). Suffering impairs men's connectedness, beliefs, values, meaning, and sense of life's purpose, thus their sense of wholeness (Chio et al., 2008). Life's purpose and meaning are tested in times of suffering (Frankl, 1959; Travelbee, 1971). Although relieving suffering has been a long-term goal for both medicine and nursing, the phenomenon of suffering continues to be poorly understood and is frequently not recognized in relation to one's wholeness (Arman, Rehnsfeldt, Lindholm, Harmin, & Eriksson, 2004; O'Mahoney, 2005).

Because of improvements in rapid assessment and clinical interventions, more people are surviving blunt trauma events only to potentially experience suffering for longer periods (Glance, Osler, Mukamel, & Dick, 2012; Paiva, Rossi, Costa, & Dantas, 2010). Although the suffering experience is central in health care and a motive for

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nurses, there is a lack of understanding about suffering and therefore a lack of effective nursing care strategies to address suffering (Eriksson, 1997, 2007; Milton, 2013). If nurses can assist patients in finding meaning in their suffering, then they can assist their patients enduring their suffering (Deal, 2011). Therefore, the poorly understood suffering of blunt trauma patients is a significant issue for nurses and the focus of this phenomenological study.

PURPOSE

The human experience of suffering is an important focus for nursing because it may result in a need for nursing care (Deal, 2011). Nursing lacks research to guide recognizing and addressing their patients' suffering (Rydahl-Hansen, 2005). The purpose of this study was to gain a fundamental understanding of the lived experience of suffering, bearing suffering, and becoming through suffering as described by male blunt trauma patients.

RESEARCH QUESTIONS

The research question for this phenomenological study was as follows: What is the lived experience of suffering for males who survived 3–12 months after the life-impacting event of blunt trauma? Subquestions included the following: How or in what ways did the participants suffer? How was their suffering made bearable or unbearable? How were they changed by their suffering? What meaning did they find in their suffering?

METHODS

The focus for this study was the lived experience of suffering. The central concern of phenomenological research is experiential meanings that provide a rich description of the lived experience of a phenomenon (Finlay, 2009). A phenomenological inquiry is "interested in seeing how people interpret their worlds, and how we can interpret their interpretations" (Shank, 2006, p. 132). Phenomenology holds the basic assumption that people use language to construct and convey meaning and thus they can reveal the meaning of an experience through conversation. It trusts informants and values exploring the participants' lived experiences within their natural context (Polit & Beck, 2008).

Although culture influences how men and women perceive things, there is also evidence that biology plays a role. Neuroscience research with its advancements in brain imaging has demonstrated differences between the sexes (Miller & Holden, 2005). Sex hormones affect stress responses differently in men and women. Fear results in a higher stress response in females because of estrogen, whereas testosterone reduces males' pain reactions. Studies have also implicated sex hormones in the male tendency to express unhappiness externally through drinking and violence whereas females express it internally, resulting in depression (Miller & Holden, 2005). To control for these biological influences in the experience of suffering, the researcher limited this study to male participants.

The study was approved by both the institutional review board of a designated Level I trauma academic medical center and the university where the researcher was a doctoral candidate. The researcher collected data from the medical center's trauma registry to identify males older than 18 years who had a mechanism of injury resulting in blunt trauma in the previous 3–12 months and were discharged alive. Because a phenomenological investigation requires participants to communicate effectively, the researcher excluded individuals who did not identify English as their preferred language for communicating or had a documented history of dementia. The researcher also excluded individuals who were prisoners. Participation in the study was voluntary, and no compensation was provided. Participants were not excluded on the basis of race, ethnicity, or socioeconomic status.

Gathering data about the participants' lived experiences of suffering consisted of one interview in a natural setting using an open-ended semistructured interview process. Participants were provided the questions before obtaining their consent. By receiving the questions prior to the interview, participants had time to organize their thoughts, which may have reduced some of the stress in revisiting their experiences. When interviewed, participants were encouraged to tell their stories in their words. This approach supported the probing of the complex issues, clarification of answers, and obtaining sensitive information. The interviews lasted between 50 and 75 min and were digitally recorded with participants' permission.

The digital audio recordings were professionally transcribed and reviewed against the recordings prior to review and validation by the participants. Participants were instructed to make sure the documents reflected their experiences and approve them for use in the study. The few requested changes were made by the researcher to the documents before coding. These steps contributed to the credibility of the study.

Data saturation was achieved with a sample size of 17 men. Participants ranged in age from 25 to 69 years, and their traumatic events had occurred in the previous 7–12 months (Table 1). Six of the reported accidents were related to falls, five to MVAs, four to skiing or snowboarding accidents, one was work related, and one occurred while helping a neighbor. Fifteen of the participants experienced one or more fractures as a result of their accidents, whereas six experienced concussions (see Table 1).

Analysis of the data used steps suggested by Cohen, Kahn, and Steeves (2000), which included data immersion, followed by data transformation and reduction. The NVivo 10 (QRS International, 2015) software program was used to help facilitate the process. Using van Manen's (1990) selective or highlighting approach, participants'

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TABLE 1 Study Participant Data

Age	Accident	Injuries	Employment
55	Bicycle, hit by car	Pelvis, spine, and thumb fractures	Working
65	Tractor accident	Compound ankle fracture	Retired
52	Raking snow off roof	Concussion, subdural hematoma, two fractured collar bones, ruptured eardrum	Working
49	Motor vehicle accident	Punctured lung, 14 fractured ribs, chipped C7 vertebra, subdural hematoma, shoulder tears	Working
67	Fall, down stairs	Concussion, C1 fracture	Retired
64	Skiing accident	Tibia and fibula fractures	Working
41	Fall, raking snow off roof	Concussion, subdural hematoma	Working
30	Motorcycle accident	Tibia and fibula compound fractures, fifth metacarpal fracture	Working
56	Snowboarding accident	C2 fracture, C6–C7 dislocation	Working
25	Work accident	Extensive skull and facial fractures	Working
45	Skiing accident	Tibia, fibula, and ankle fractures	Working
69	Fall, off curb	Tibia fracture	Retired
67	Fall, on ice	Concussion, subdural hematoma	Retired
34	Fall, from tree stand	Wrist fracture, concussion	Working
67	Fall, on ice	Left femoral neck fracture	Retired
57	Motor vehicle accident	Split sternum	Working
63	Skiing accident	Concussion, fractured skull, six broken ribs, a broken scapula, broken nose, broken cheekbone	Retired

Note. From The Experience of Suffering as Voiced by Male Patients Three to Twelve Months After Hospitalization for Blunt Trauma *(Doctoral dissertation) (p. 66), by L. D.Filhour, 2016, Ann Arbor, MI: ProQuest. Copyright 2016 by L. D. Filhour. Adapted with permission.*

words or phrases were copied from the various transcripts and clustered under nodes.

The initial coding of the transcripts resulted in the creation of 27 nodes identifying relevant concepts as they emerged from the data. Through the reduction process, nodes reflecting the participants' experiences of suffering clustered into five groupings: physical, emotional, social, economic, and spiritual. Although it was not a conscious act on the part of the researcher in this reduction process, these groupings did align with nursing's concept of men possessing wholeness: unitary, integrated biopsychosocial-spiritual beings (Bender & Feldman, 2015; Fawcett & DeSanto-Madeya, 2013). Examples of things making suffering more bearable or unbearable were clustered into factors intrinsic and extrinsic to the participant. After analysis, the researcher asked participants to validate identified themes to ensure they reflected the meaning participants gave their lived experience of suffering (Ploeg, 1999). Sixteen of the 17 participants returned their review and validated the themes.

RESULTS

Four themes emerged from the analysis: (a) Threat to Normal, (b) Pattern Change, (c) Regaining Normal, and (d) Revising Normal. The analysis process also identified subthemes. Subthemes for "Threat to Normal" related to how the participants defined themselves in relation to their physicality, their families, or their work. Subthemes for "Pattern Change" reflected five forms of suffering: Physical, Emotional, Social, Economic, and Spiritual. Subthemes for "Regaining Normal" reflected intrinsic and extrinsic factors that made suffering more bearable or unbearable. Figure 1 demonstrates the relationship of the themes.

Theme 1: Threat to Normal

To understand the experience of suffering, it was important to understand the basis of that suffering. Suffering resulted from a threat to self and the importance of the meaning given to the event (Kahn & Steeves, 1986). Participants in the study experienced suffering related to a threat to how they defined themselves, their holistic normal state, or their meaning. Although not asked as a direct question during the interview process, when analyzing the transcripts, statements were identified that gave clues to how the participants defined themselves, their normal state, or their meaning. The analysis identified participants defined themselves or their meaning in

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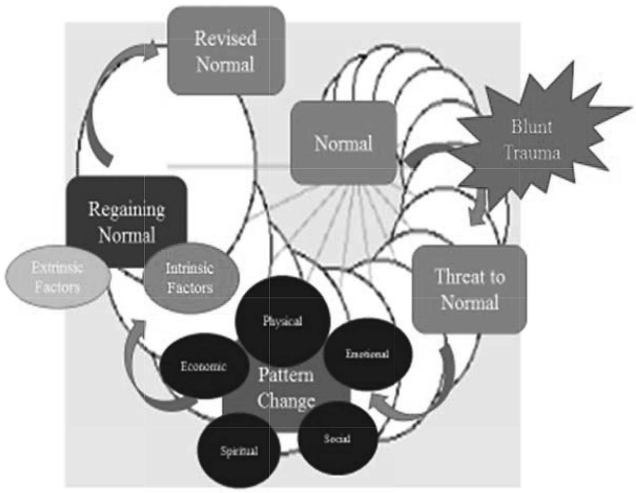


Figure 1. Themes model. *Note.* From *The Experience of Suffering as Voiced by Male Patients Three to Twelve Months After Hospitalization for Blunt Trauma* (Doctoral dissertation) (p. 70), by L. D. Filhour, 2016, Ann Arbor, MI: ProQuest. Copyright 2016 by L. D. Filhour. Adapted with permission.

relation to their physicality, families, or work. Examples of statements made by participants included the following: "Being an athlete and being healthy defines me. I was blessed with a nice strong body"; "That's the purpose of my existence, is to make sure that everything is great for my kids"; and "The suffering for me is not the pain so much, it's more the inability to do what I love to do and get out and do my work."

Theme 2: Pattern Change

Human beings are in constant dynamic interaction with their environment (Bender & Feldman, 2015; Fawcett & DeSanto-Madeya, 2013). Patterns evolve as a result of this mutual, simultaneous, and interactive process (Baumann, Wright, & Settecase-Wu, 2014), and blunt trauma disrupts these patterns. Suffering is the result of a person perceiving an impending or actual destruction to his wholeness or patterns, and that suffering continues until either the perceived threat passes or the person's wholeness and patterns are restored through some other fashion (Cassell, 1991).

Coding of the participants' pattern changes as experiences of suffering resulted in an alignment with this concept of wholeness. Participants verbalized disruptions in their physical, emotional, social, economic, or spiritual patterns as experiences of suffering (Table 2). Analysis revealed the forms of suffering were not mutually exclusive but where interrelated (Figure 2). Also, not all forms of suffering were experienced equally. Physical and emotional suffering accounted for the majority of the experiences reported, followed by social, economic, and spiritual suffering in that order. Table 3 demonstrates the relationship among how the participants defined themselves, their type of injuries, and their various forms of suffering.

Physical Suffering

Physical suffering was the form most frequently experienced by the participants in the study. Physical suffering clustered into five major types: pain, decreased activity tolerance, sleep disruption, memory loss, and constipation. Physical suffering was also identified as contributing to emotional and social forms of suffering.

Pain associated with the physical injuries was a significant source of suffering because for many of the participants, they had not previously experienced pain this severe. Pain, along with not being permitted to bear weight on fractures, significantly limited their physical activity. Pain and reduced physical activity disrupted usual or normal sleep patterns, adding to the experience of physical suffering. Pain was made more bearable with the use of narcotics but resulted in constipation and increased suffering.

Emotional Suffering

Emotional suffering started at the time of the accident. As survivors of a traumatic event, participants were psychologically unprepared for the massive expectancy disconfirmation (Janoff-Bulman, 2004). Their internal world became a state of upheaval and disintegration because previous assumptions that provided stability and coherence were found to be inadequate or inaccurate to understand their new posttraumatic world. They found themselves in a world of many unknowns. This threat to what they believed and understood negatively influenced their sense of wholeness and thus served as a source of their emotional suffering identified as worry, doubt, anxiety, and stress.

Uncertainty about the future, loss of self-integrity and dignity, and lifestyle changes resulted in a threat to the patient's sense of wholeness and thus resulted in the experience of emotional suffering (Janoff-Bulman, 2004). Loss of self-integrity and dignity resulted in the participants experiencing feelings including being humbled, demoralized, and vulnerable. Emotionally, losses are considered more significant than gains (Redeimeier, Rozin, & Kahneman, 1993), which supports the significant suffering experienced by the participants in this study. Reported behavioral changes including impatience, aggression, and depression also reflected experiences of emotional suffering.

Social Suffering

Social suffering resulted from a threat to previous normal social interaction patterns for 10 participants. Analysis of the data demonstrated that social suffering was

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TABLE 2 Suffering Frequency and Overlap

Physical	Emotional	Social	Economic	Spiritual	Overlap	Frequency
0	1	0	0	0	EM	1
1	0	0	0	0	PH	1
1	0	0	1	1	PH + EC + SP	1
1	1	0	0	0	PH + EM	2
1	1	0	0	0	PH + EM	
1	1	0	1	0	PH + EM + EC	1
1	1	1	0	0	PH + EM + SO	3
1	1	1	0	0	PH + EM + SO	
1	1	1	0	0	PH + EM + SO	
1	1	1	0	1	PH + EM + SO + SP	1
1	1	1	1	0	PH + EM + SO + EC	5
1	1	1	1	0	PH + EM + SO + EC	
1	1	1	1	0	PH + EM + SO + EC	
1	1	1	1	0	PH + EM + SO + EC	
1	1	1	1	0	PH + EM + SO + EC	
1	1	1	1	1	PH + EM + SO + EC + SP	2
1	1	1	1	1	PH + EM + SO + EC + SP	

Note. From The Experience of Suffering as Voiced by Male Patients Three to Twelve Months After Hospitalization for Blunt Trauma *(Doctoral dissertation) (p. 74), by L. D. Filhour, 2016, Ann Arbor, MI: ProQuest. Copyright 2016 by L. D. Filhour. Adapted with permission. EC = economic; EM = emotional; PH = physical; SO = social; SP = spiritual.*

associated with a change in role, relationships, or socialization. Blunt trauma resulted in injuries causing participants to experience a change from their normal role pattern of caretaker to a new role of one needing care. As one participant stated, "If you thought you were independent, you're going to be humbled by the fact that you are going to need care." Dependence was the most frequently reported type of social suffering experienced by the participants.

The shift from caretaker to one being in need of care threatened their self-image. They were humbled when they recognized they needed to accept help from others. Social suffering because of a change in their role also contributed to emotional suffering. This experience of emotional suffering was especially true in relation to changes in the participants' role with their children, even when their children were adults. The participants suffered emotionally when they saw the suffering they were causing to their families. They also suffered emotionally because their vulnerability was now exposed; their role as caretaker of their children was threatened.

Participants also experienced changes in relationships. Some individuals who they considered to be "good or close friends" became distant or unsupportive whereas other mere acquaintances rose to the situation and provided needed support. These changes also influenced their experiences of suffering.

The physical injuries resulting from the blunt trauma accident made physical activities more difficult to tolerate for the participants. That decrease in activity tolerance negatively impacted previous normal socialization patterns. "You quickly lose touch with the day-to-day activity through all the things that you would normally do, whether it's socializing at bars or restaurants, the gym, work, any other social activities where I would see people," stated one participant. Emotional suffering such as depression also contributed to a decrease in socialization for some participants.

The decrease in socialization occurred within their families as well as externally. Because of their physical limitations, some participants were not able to tolerate stairs and thus needed to change where they slept in their home, impacting their socialization with their spouses. Participants who were dependent on others for help experienced decreased socialization when that help was not readily available.

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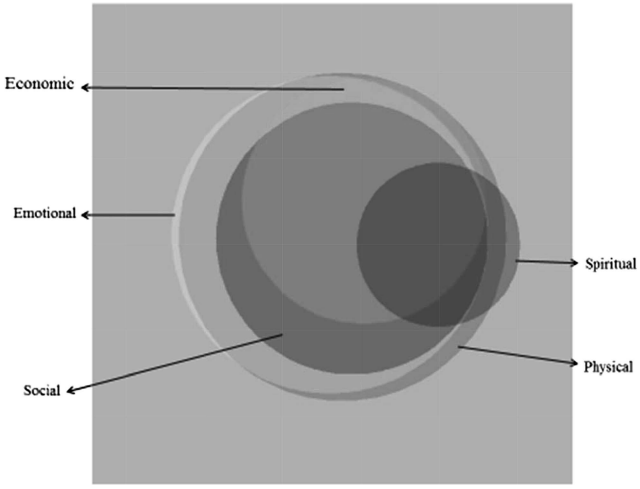


Figure 2. Frequency and interrelatedness of the five forms of suffering. *Note.* From *The Experience of Suffering as Voiced by Male Patients Three to Twelve Months After Hospitalization for Blunt Trauma* (Doctoral dissertation) (p. 75), by L. D. Filhour, 2016, Ann Arbor, MI: ProQuest. Copyright 2016 by L. D. Filhour. Adapted with permission.

Economic Suffering

Economic suffering was reported by nine of the participants. This form of suffering related to decreases in income secondary to the inability to work, expenses not covered by insurance such as $40,000 helicopter bills, or a lack of insurance. Economic suffering contributed to emotional suffering in the form of doubt and worry. "The thing that worried us, worried all of us were some of the hospital bills were not covered," reported one participant.

Spiritual Suffering

Spiritual suffering related to a threat to the participant's normal pattern of spirituality and was the least experienced form of suffering. Only four participants reported an experience that reflected spiritual suffering. These few reports did not mean spirituality was not important to the participants in the study. More participants found spirituality played a role in helping them bear their suffering rather than contributing to it.

Theme 3: Regaining Normal

Intrinsic Factors

As bones mended and concussion healed during their recovery process, participants progressed toward regaining their normal state and sense of wholeness. This study found the journey was made easier by things that helped them bear their suffering and was made more difficult by things

TABLE 3 Relationship Among Self: Definition, Injuries, and Forms of Suffering

	Defined Self			Injury		Suffering				
Participant	Physicality	Family	Work	Fractures	Concussion	Physical	Emotional	Social	Economic	Spiritual
#1	P			FR		PH	E	S		
#2			W	FR		PH	E			
#3		F	W	FR	C	PH	E	S	EC	SP
#4			W	FR		PH				
#5	P	F		FR	C	PH	E	S	EC	
#6				FR		PH	E	S		SP
#7		F		FR	C	PH	E	S	EC	
#8	P			FR		PH	E	S	EC	
#9	P			FR		PH	E	S		
#10	P	F		FR		PH	E	S	EC	SP
#11	P				C	PH			EC	SP
#12				FR	C	PH	E	S	EC	
#13				FR			E			
#14	P			FR		PH	E	S	EC	
#15	P			FR		PH	E			
#16	P			FR		PH	E	S		
#17	P			FR	C	PH	E		EC	

Note. From The Experience of Suffering as Voiced by Male Patients Three to Twelve Months After Hospitalization for Blunt Trauma *(Doctoral dissertation) (p. 90), by L. D. Filhour, 2016, Ann Arbor, MI: ProQuest. Copyright 2016 by L. D. Filhour. Adapted with permission.*

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that made their suffering more unbearable (Filhour, 2016). Positive factors intrinsic to the participants helped them bear better their suffering. Positive attitude and motivation to recover were common intrinsic factors among the participants in this study. Attitudes contribute to both understanding and predicting social behaviors (Ajzen, 2001). "One is either the master or the victim of one's attitudes" (Starck & McGovern, 1992, p. 29). People have the freedom to change their attitudes about a seemingly meaningless situation by activating the will to meaning (Frankl, 1959).

Another intrinsic factor was participants' knowledge, either from previous experiences or from newly acquired ones (Filhour, 2016). Participants' knowledge, or more importantly their understanding, played a role in helping them bear their suffering of the unknown and regain lost control. Understanding, unlike knowledge, is intrinsically valuable (Boylu, 2010).

The participants' spirituality was another intrinsic factor that helped in better bearing the suffering. Frankl (2000) recognizes the spiritual dimension as a major source of both strength and healing in men's effort to address suffering. For Frankl, the human spirit is what we are and is the essence of men's humanness. Spirit is not from a religious concept but rather as a human dimension that contains the therapeutic resources of self-transcendence and self-distancing.

Extrinsic Factors

Extrinsic factors were essential to helping participants in their lengthy process of recovery and regaining normal (Filhour, 2016). Beneficial support from others reflected physical caring for and emotional caring about the participants. However, some extrinsic factors made suffering more unbearable, negatively impacting the participant's journeys. Poor quality of care by health care providers was a significant negative extrinsic factor (Filhour, 2016). It was unbeneficial and did not reflect caring for or about the participant and contributed to physical, emotional, and social suffering.

Theme 4: Revising Normal

During their recovery time, participants had the opportunity to reflect on their experiences and for many of them, this reflection led to a transformation, a revised normal (Filhour, 2016). Recognition of the fragility of life and participants' own vulnerability served as the basis for these transformations; a change in what they felt was important. Because of these new perspectives, participants reported focusing more on today and less about the future. They also reported a decrease in their risk taking and a greater focus on time with their families. For many participants, this was their first experience being a patient and being someone in need of care. As a part of their transformation, they reported an increase in empathy for others with injuries or disabilities. Other common changes included a slowing in their pace of activity so that they could better appreciate "the little things."

IMPLICATIONS FOR NURSING

As beings possessing wholeness, participants in this study suffered physically, emotionally, socially, economically, and spiritually. Participants recognized their need for support from others to address their suffering. Nurses play a critical role in providing that needed support. The results of this study can be useful in guiding nursing practice.

Assessment

The study demonstrates the importance of collecting information about the patient's life prior to the blunt trauma event (Filhour, 2016). A thorough assessment can assist the nurse in understanding the patient's values and life purpose or meaning. This is useful because threats to these values and meaning are the basis for the patient's experiences of suffering. Thus, with an appropriate assessment, the nurse can better anticipate and manage the various forms of suffering.

Through the interview process, participants in this study shared what was important to them, their personal meaning. Meaning was found through what they gave to life, got from life, and their attitudes. As suggested by Barnes (2000), personal meaning was found in the descriptions of the things they enjoyed and valued. This study revealed three main sources of meaning, reflecting personhood or normal: physicality, family, and work (Filhour, 2016). By identifying the patient's personal meaning, the nurse can better anticipate potential sources of suffering and thus provide therapeutic care to help the patient avoid or bear suffering.

Knowledge/Control

Nurses can actively reduce the patient's experience of emotional suffering by providing knowledge the patient can use to gain understanding and regain lost control (Filhour, 2016). For most participants, this event of blunt trauma and its associated experiences of suffering was new. A lack of understanding what was happening as well as their reduced ability to do things for themselves contributed to a loss of control and emotional suffering. Acquiring new knowledge and understanding through education from nurses in addition to exploring the Internet or self-learning through trial and error helped participants bear their suffering. Participants shared their need for information about what they might experience. This need was a major motivator for them to participate in this study in that they hoped it could help others.

One participant reported significant emotional stress, worrying about the possibility of developing compartment syndrome. His stress was significant because he did

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not really understand what it was but assumed it had to be significant because of the frequent assessments by the nurses. He reported how his suffering was reduced when one nurse took the time to explain the syndrome and the device being used to measure the pressure. This new knowledge helped him understand what was happening and regain what he perceived to be lost control.

Participants who perceived they were permitted and encouraged to be actively involved in decision making about their care, their requests considered and respected, were better able to bear their suffering because they expressed feeling in control (Filhour, 2016). For example, one participant was permitted to provide his own wound care because of his training as a surgical technician. He shared, even though the care process was uncomfortable, he could better bear it because he controlled it. He did an exceptional job keeping his wounds infection free.

Caring For/Caring About

Because of the blunt trauma injuries, participants were in need of support in the form of physical care and emotional caring. They needed to be cared for to help make the physical suffering more bearable and care about to make the emotional, social, and spiritual suffering more bearable (Filhour, 2016). One participant was a practicing physician boarded in emergency medicine and a faculty in a medical school. His blunt trauma event was his first significant injury and hospitalization. He commented how his experience as a patient cast him into a role of dependence and it dramatically changed his perspective. He became aware of what it was like as a patient to be dependent upon someone for a drink of water or assist with toileting. He shared how he could quickly differentiate between a caregiver going through the steps of an activity to get it done and one who was actually thinking of him, caring about him. Feeling cared about was as important as feeling cared for, which helped him better bear his suffering. He also shared how this traumatic event transformed how he practiced medicine and made him more aware of and attentive to his patients' physical and emotional needs.

Although blunt trauma injuries were a significant source of pain and physical suffering, participants verbalized increased emotional suffering because of their perception of caregivers not listening to them (Filhour, 2016). One participant with a pelvic fracture reported a significant increase in physical pain after being taken from his bed to radiology three times within 4 hr. In addition to his increased physical suffering, he also suffered emotionally because he felt a lack of caring because of a perceived failure to plan and coordinate care. Another participant with multiple rib fractures had his request for positioning ignored by the radiology staff because they needed to get the test done and did not have time to take him to another room where his request could have been accommodated. "They set me back two days in my recovery!" Again, this event not only increased physical suffering but also increased emotional suffering.

Because of the high occurrence of pain, medically induced constipation was also a significant source of suffering for most participants (Filhour, 2016). Only one participant, because of his previous experiences, knowingly modified his diet to avoid this form of suffering. For those who did experience constipation, many reported physical suffering as severe as that due to their blunt trauma injuries. Physical suffering was compounded by emotional suffering when some staff members were perceived as being indifferent to the participants' complaints of constipation. Participants also reported emotional suffering as a result of the interventions to relieve their constipation. This study clearly demonstrated the need for proactive management of medically induced constipation to reduce or avoid the physical and emotional suffering.

Finding Meaning

Rumination is an important cognitive process used by a person in dealing with a stressful situation. Rumination includes recurrent thinking related to an event with the intent of making sense of the event, problem solving, reminiscence, and anticipation (Martin & Tesser, 1996). Ruminative thinking is conscious, theme-focused, and occurs without direct environmental cuing. It can be related to the person's past, present, or future. Nurses' care should support the patient's rumination important to finding meaning and posttraumatic growth. Rumination by the sufferer is important to making sense out of what happened and positively contributes to posttraumatic growth (Tedeschi & Calhoun, 2006). Finding and recognizing meaning and value to the experience make the distress easier to bear (Tedeschi & Kilmer, 2005).

SUMMARY

Nursing care should assist the patient in creating meaning and thereby alleviate suffering by making it bearable (Filhour, 2016). Caregivers can be neglectful and uncaring when the patient's existential suffering is not identified and the patient is not viewed holistically (Arman et al., 2004). Patients are at risk for increased suffering if nursing does not go beyond recognizing and addressing just their physical needs (O'Mahoney, 2005). Nursing must embrace holism through caring and address the patient's various sources of suffering, including anxiety, stress, pain, fear, confusion, isolation, and despair (Filhour, 2016). This study provides a holistic understanding of suffering that can be useful in guiding nurses in their efforts to alleviate suffering or make it bearable.

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The experience of suffering caused participants to explore issues related to existence, perspective, and meaning (Filhour, 2016). These reflective insights influenced participants' abilities to endure, overcome, or be transformed by their suffering. Nursing can play a critical role in helping the patient with this exploration through the therapeutic use of self (Freshwater, 2002). Suffering serves as an effective and profound agent for changing patients' thinking and behavior (Stark & McGovern, 1992). The sufferer can find new meaning in life in the presence of love and caring within a symbiotic relationship between the sufferer and the caregiver.

Surviving trauma results in the person confronting his or her fragility and vulnerability (Filhour, 2016). They struggle with understanding their new world, making sense of it, and finding meaning. With the supportive help of nurses and through their cognitive processing, victims of blunt trauma undertake the process of rebuilding their assumptive worlds. Appreciating their new sense of vulnerability encourages meaning-making that focuses on their significance and worth (Janoff-Bulman, 2004). Survivors of blunt trauma, shaken from their routines and complacency, are faced with making choices and changing what they value. The combination of suffering, recognition of vulnerability, and sense of meaninglessness serve as catalysts for the trauma survivor's posttraumatic growth (Janoff-Bulman, 2004) and a need for nursing care.

"No human being can escape suffering, for it is a part of the human condition" (Stark & McGovern, 1992, p. 25). Suffering, rather than just touching the physical, emotional, mental, spiritual, and social being of a person, touches the whole of the person. Paradoxically, suffering also serves as an effective and profound agent for changing a person's thinking and behavior. Nurses have the responsibility to help their patients recognize, feel, and accept suffering (Filhour, 2016). It is through qualitative and quantitative observation and therapeutic use of self that nurses can develop the tools to help their patients find meaning and effect change.

KEY POINTS

- Suffering is a personal experience rooted in the meaning the person gives to life, his or her state of normal. The loss of that meaning or state of normal results in the experience of physical, emotional, social, economic, and spiritual suffering.
- Through the process of enduring suffering and being transformed by it, the sufferer finds new meaning and a new state of normal.
- Nurses can relieve suffering and facilitate this transformational process by providing care that makes the sufferer feel cared for physically and cared about emotionally.

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