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Can We Be at Peace With Unsolvable Suffering? A Qualitative Study Exploring the Effectiveness of Supportive Communication and Resilience Building

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The authors provided six 180-minute interpersonal assistance workshops using teaching materials from the End-of-Life Care Association: 90 minutes each on supportive communication and role-playing. The content included the following:

- Suffering people are "at peace" with someone who understands their suffering, which starts with building a relationship through empathetic listening. The goal is not to "understand them" but for them to "feel understood."
- Realizing the suffering of others and recognizing the internal moral and emotional strength of those who live with suffering.
- Resilience building: helping caregivers face difficulties even when helpless; remembering one's support networks and valuing oneself.

Participants (n = 114) wrote reflective journals after each session. Two domains and 10 key themes were identified through thematic analysis. The domains comprised topics on the importance of using listening techniques, such as repetition, waiting in silence, and asking questions (not to understand but for dialogue). The 3-month postinterviews revealed that participants could ease their sense of weakness by helping suffering people, which is relevant to work, grief care, and daily life. Changes in relationships between participants and patients were also identified. Role-playing can teach supportive communication, such as listening attentively and accepting others, which may help supporters engage with people experiencing incurable suffering.

KEY WORDS

at peace, end of life, resilience building, suffering, supportive communication

One problem facing Japan in the 21st century includes a declining birth rate and an aging society. Whereas population aging is underway in many countries, the aging rate in Japan is unprecedented. Japan is forecasted to reach the super-aged status (defined as more than 20% of the population being 65 years or older) by 2025.[1] The national government has promoted policies including community medical care plans and advanced care planning to support terminally ill patients within the community rather than in the hospital.[2] However, even if such a system is established, people face a shortage of trained personnel to assist those who experience unsolvable, incurable suffering at the end of life.[2-4] Furthermore, there have been few opportunities to learn from a multidisciplinary perspective about the structure of suffering and resilience building. Although many workshops regarding palliative and self-mental care are occasionally held, their effects remain unclear.

The End-of-Life Care (ELC) Association was established in 2015.[5,6] The association has held many study sessions for interpersonal assistance across Japan, presenting information in a way that is easily understood by everyone, regardless of age or occupation. People in all professions, including those in health care, should learn the basics of interpersonal assistance and continually learn in real-world work environments. Furthermore, each person should continue his/her learning based on the basic principle that people who are suffering are "at peace" when they have someone who understands their suffering, it all starts with

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building a relationship through empathetic listening, and the goal of the communication is not for caregivers to understand patients but for patients to feel understood.[5,6] "Being at peace" encompasses positive emotions such as being happy, not suffering, smiling, and feeling well. The features of supportive communication—repetition, being silent (waiting), and asking—were based on previous research by Murata[7] and Morita et al and a practical guide for refractory suffering and palliative sedation therapy in advanced cancer patients.

This qualitative study was conducted by the ELC's Okinawa team to demonstrate participants' learnings through their ELC experiences. The purpose of this study was to examine whether the study sessions are successful in "strengthening of minds" or cultivating "resilience" in participants, and providing them the tools and strength to carry on, even during the COVID-19 pandemic that has exacerbated suffering when people have experienced increased difficulties and suffering.

METHODS

From January 2019 to December 2020, we held 6 workshops, each with the same "interpersonal assistance" content but different participants, using the teaching materials provided by the ELC Association.[5,6]

Participants

Convenience sampling was used to select the participants for this study. At each study session, an advertisement introducing the workshop was prepared, and the first author asked for it to be posted 1 month before the day of each session on the Okinawa Medical Association's homepage. The participants who saw the advertisement and were keen to participate applied voluntarily. Those who participated in the middle of the workshop, left early, and did not agree to write the reflective journal were excluded.

Workshops

The teaching contents used in this study session were created by the Japan ELC Association based on the comprehensive and vast empirical knowledge compiled from home visit doctors who have supported more than 4000 patients facing death.[5,6] The materials include 80 PowerPoint slides; the flow of each study session is described in Supplemental Digital Content 1 (see Supplemental Digital Content 1, http://links.lww.com/JHPN/A74). Each session lasted 180 minutes. Before beginning each session, we asked all participants to freely write down their impressions of how they feel about helping people who are suffering.

First Half (90 Minutes)

As summarized in Supplemental Digital Content 1 (see Supplemental Digital Content 1, http://links.lww.com/JHPN/A74), the workshops are organized as follows. Before starting the study session, we asked participants to complete a questionnaire regarding assistance for suffering people.

Next, the Five-Step Caregiving Model (A-E in Supplemental Digital Content 1, http://links.lww.com/JHPN/A74) for people who are suffering was described in detail. For item A, participants learned about supportive communication from the perspective that "people who are suffering are 'at peace' when they have someone who understands their suffering." The goal of the communication is not for "me to understand them, but for them to feel understood." What kind of person is "someone who understands" from the perspective of the other person? It is a "listener." The authors suggested to listen attentively to the suffering and by using repetition, being silent, and asking. The authors explained that "being silent" means waiting for the other person to start or stop talking without giving advice. The authors also encouraged participants not only to be silent but also to use appropriate nodding and eye contact.

For item B, the authors introduced the concept of "realizing" the suffering of others. In the field of palliative care, pain is divided into several types. However, in this article, suffering was divided into only 2 parts: resolvable suffering and unresolvable suffering. Unresolvable suffering may be close to spiritual pain.[7] The suffering that can be resolved includes physical symptoms such as physical pain, and people can be provided medication. In contrast, unsolvable suffering was defined as "pain caused by extinction of the being and the meaning of the self."[7] The unsolvable suffering was mental and spiritual, as people try to understand why something is happening to them and not to others, with thoughts of loss of autonomy such as "Why only me…?" or "I'd rather die than be a nuisance to others."

For item C, participants learned about recognizing the internal moral and emotional strength of those who live with suffering. While suffering, a person can acknowledge the support offered by another person, which they may not have noticed before. There are 3 types of support: "future dreams," "supporting relationships," and "freedom of choice."[7] Participants learned that sufferers could be at peace when they have "support" even in the midst of unresolvable suffering.

The next step (item D) concerned learning about practicing ways to strengthen support for sufferers, further deliberated in the Results and Discussion sections. The fifth step helps people realize their ability to support themselves.

For item E, the authors reminded the participants of recognizing their internal strength and self-support (resilience).

Supporters often encounter a sense of helplessness, feeling and thinking things such as "I can't help" or "I'm not needed" when faced with people who are experiencing great suffering. To ensure that the supporters stay involved without withdrawing from these sufferers, we must understand that people who would like to support someone need support the most. We value a connection with people who

recognize that they can handle themselves by applying the attitude of "good enough" and building resilience to be able to continue being involved without withdrawal. The authors defined resilience as the ability to continue to face difficulties even when we are helpless.

Second Half (90 Minutes)

After a break, part 4 involves the practice of supportive communication using repetition. The participants repeat example sentences alternately in pairs. When the first speaker says, "I couldn't sleep last night," the second speaker repeats, "You couldn't sleep last night," while mindfully including appropriate nods and intervals. After the role-playing, participants constructively examine the conversations they just had. Some are asked by the facilitators to share their impressions with all the participants. The authors asked the observers not to criticize the other person but to list the good points and areas for improvement.

Next, everyone is involved in a role-playing activity. The authors present information about a patient with cancer experiencing unsolvable suffering and then divide all of the participants into groups of 3. Participants take turns in each role as described in item 5 in Supplementary Content 1 (http://links.lww.com/JHPN/A74). Participants playing the role of the patient are asked to read the case report before they assume the role. Each round of role-playing takes 6 minutes. In the first 4 minutes, we asked the listeners to listen carefully to the patient's suffering by using only "repetition" and "being silent" (waiting for the next words silently). In the last 2 minutes, the authors asked the listeners to practice "asking" about the support that patients had been provided in a tough situation. The patients shared how they were supported (using words that conveyed support), and the authors asked the listeners to recall which words had made the patients aware of their self-support and strengthened the impact of their support of the patients. Before starting the role-play, the facilitator demonstrated the techniques; after the rounds of role-playing, the participants were asked to provide each other with constructive feedback and share their impressions with the whole group.

At the end of the workshop, the authors had a facilitated discussion with all participants. In the discussion, the participants were queried about their reflections on what they experienced and felt. The discussions were conducted in Japanese by the first and corresponding author for 10 minutes. The main author listened and accepted the participants' opinions and then encouraged them to share their reflections. The semistructured interview guide was based on Kolb's experiential learning theory (ELT)[8] and included the questions listed in Supplementary Content 2 (http://links.lww.com/JHPN/A75). After the discussion, participants were asked to perform reflective journal writing based on their experiences and perceptions. Olmos-Ochoa et al[9] reported that reflective writing is said to encourage a writer to learn from an event, because it necessitates focused and analytical thinking.

The journals were collected and then translated into English. The translation was mainly performed by the first author, who had been directly involved with the participants and heard their raw impressions. The author read between the lines and tried to find hidden meaning in what was said or written. Two other authors who were familiar with English reviewed and analyzed both the Japanese and English journals. Thematic analysis based on Kolb's ELT was independently performed by each author. After a discussion, key themes were identified by reaching a consensus among the 3 authors through extensive discussions until agreement.[8]

Approximately 3 months after the study session, semistructured, individual interviews were conducted with the participants as part of the follow-up evaluation. The authors referred to Kirkpatrick's evaluation model for the follow-up period.[10] The semistructured interview guide was also based on Kolb's ELT.[11] The interview questions can be found in Supplementary Content 3 (http://links.lww.com/JHPN/A76). Although the discussions were not recorded, the main author took notes during the interview. After transcribing the interview notes as field notes, thematic analysis was conducted based on Kolb's ELT.[8]

We used convenience sampling to select the participants for this study. We went by chance, selecting participants who had applied for the study sessions. The occupation, age, and affiliation of the participants were random. At the beginning of the workshop, the authors announced that the contents of the reflective journal would be anonymized and used in this study, and then they obtained their approval. All participants orally agreed that the contents of their questionnaire could be used for clinical research. The Ethics Committee of Okinawa Chubu Hospital approved the study protocol. Data used in this study were made anonymous, and no direct quotes were attributable to participants.

RESULTS

In total, 152 people participated; the number of participants in the 6 sessions was 17, 14, 48, 20, 36, and 17, respectively. Of the 152 participants, 114 completed reflective journal writing. The occupations of the participants are described in Table 1. Thirteen participants attended the study session more than once, and 4 people participated 3 times or more. A total of 114 responses were collected (retrieved immediately after each session).

Using thematic analysis, the authors identified 2 domains and 8 key themes from the completed questionnaires (Table 2).

In Supplementary Content 4, (http://links.lww.com/JHPN/A77), the authors summarized the impressions and changes in thinking immediately after the study session.

TABLE 1 Health Care–Related Occupations of 152 Study Participants

	n	%
Medical doctor	8	5.3
Nurse	62	40.8
Co-medical	26	17.1
Clerk	16	10.5
Other (people not employed in the field of health care)	11	7.2
Medical student	18	11.8
Unknown	11	7.2

Using thematic analysis, 2 domains and 10 key themes from the participants' experiences and perceptions were identified. In the reflective observation, many participants responded that it was impressive that they could have a simulated experience of the patient's feelings by playing the patient in the role-play. Many also mentioned the importance of listening in supportive communication and learning about the techniques of repetition and silence (waiting for next words silently). In the abstract conceptualization, many participants described that their sense of weakness in helping suffering people had been eased. In addition, other participants mentioned that the techniques of repetition and silence could be applied to grief care. They also realized that it was crucial for them to strengthen emotional support by using repetition and silence in daily life and the workplace.

Approximately 3 months after the workshop, semistructured, individual interviews were conducted with 28 participants as a part of the follow-up evaluation. The authors lost contact with 86 participants because no responses were obtained from them, and thus, their follow-up interviews remained incomplete. The 28 participants included 2 medical students (7.1%), 3 medical doctors (10.7%), 18 nurses (64.3%), 3 other co-medicals (10.7%), and 2 care workers (7.1%). The semistructured interview guide was also based on Kolb's ELT.[8]

The 28 field notes from the participants' interviews were analyzed. Using thematic analysis, 2 domains and 6 key themes from the participants' experiences and perceptions were identified, as shown in Table 3. During reflective observation and abstract conceptualization, many participants replied that they had overcome their sense of weakness to suffering and suffering people, making it easier to assist. They also mentioned that it was integral to provide supportive communication using repetition and silence, being aware of the support, and applying it to their daily lives and workplaces. In the active experimentation, many of the participants answered that they actually practiced listening using repetition and being silent as well as asking about support, which was very effective. In addition, some of the participants answered that they became aware of self-affirmation, accepting themselves as "good enough."

DISCUSSION

The approach of exploring ways to achieve a peaceful mind, even if the suffering could be perfectly resolved, was derived from severe clinical settings such as relationships with people who were near death.

The ultimate goal of our study session included the following key elements:

- **People who are suffering are "at peace" if they have someone who understands their suffering.** The basic principle is that it all starts with building a relationship through empathetic listening. The goal of the communication is not for "me" to understand "them" but for "them" to feel understood.
- **Practitioners should become more aware of support through suffering and find a way to be at peace in the midst of unresolved suffering.** As previously mentioned, unsolvable suffering entails spiritual pain. While suffering, a person can acknowledge the previously unnoticed support offered by another person.
- **Resilience building: facing difficulties even when we are helpless, knowing our own support networks, and recognizing and valuing ourselves.** People can praise themselves when they help someone; in contrast, it is very painful to feel "not needed by anyone" or be unable to help anyone.[11,12] In such a situation, trying to be aware of the relationship with and support from someone who accepts you as "good enough" can help. Feeling that we are good enough, even if not perfect, can help build our confidence to live.

TABLE 2 Impressions of Assisting Suffering People: Before the Workshop

Sense of weakness and difficulty in helping suffering people.
- I feel difficulty in facing and managing it.
- I feel that sufferers are psychologically unstable and difficult to empathize with.
- I'm worried about how to deal with sufferers.
- When I am in front of a suffering person, I cannot do anything for them.
- We can't feel free to talk to those who are suffering.

Negative images
- To feel left in the dark or with no end in sight
- I think helping suffering people is delicate, and there are no correct answers.
- Sad, negative images

TABLE 3 Conceptualization and Behavior Change: Key Themes Identified From the Field Notes of Semistructured Interviews 3 Months After the Workshop

Theme (Kolb's ELT)
I. Abstract conceptualization
1. A change in the perception of the involvement with suffering and suffering people • *My psychological pressure toward suffering patients eased, making it easier to talk to and keep staying with them.* • *I no longer feel stress about silence between the patient and myself.* • *I have come to recognize "hope" and "reality" in understanding suffering.* • *Before the workshop, I was not confident about dealing with suffering people, feeling "what could I do?" because I was not a medical staff member. However, through the workshop, I learned that "suffering people feel happy to have someone who understands their suffering" and learned about "acknowledging and supporting the suffering that the other person has."* • *I realized that it was possible for all of us to help someone stay calm without using medical expertise and without belonging to medical and nursing care fields.* • *Until then, I was trapped in medical care and said, "I have to do something...it's not good if I can't do anything ...," but I understood what was important and I felt a little relieved. I was able to reaffirm the meaning of helping someone.* 2. Being aware of the meaning and the importance of listening • *I have come to focus on listening.* • *I feel that I need to sit close and listen attentively to feel a sense of distance and to be at ease.* • *Through the study session, I realized that it was important to just listen rather than encourage the patients.* • *Whenever I receive a consultation, I try to pay attention to "what is the best for that person."* • *I realize that a sense of value differs from person to person and that it is very important to closely understand the other person's feelings.*
II. Active experimentation
3. Actual use of repetition and silence when listening to someone • *When communicating with patients, I try to place importance on listening rather than encouragement or explanation.* • *Listening and repetition led me to have a smooth conversation with the patient's family.* • *I began to practice repetition and being silent, which enabled me to confidently deal with suffering people.* • *I often practice repetition in the conversation. Also, my sense of weakness to silence has eased. Sometimes, the conversation ends because of silence, but I think that's fine. I put my support to practical use as a key method to listen to someone's feelings.* • *I practice repetition and being silent. In the past, people were often complaining about something but seemed to be at peace when talking, and some of them said "thank you." Therefore, I think repetition and silence are very effective methods.* 4. Actively getting involved with suffering people and strengthening support by asking • *I listen to and accept the other person's words, make them understand what I have received, and try to help them verbally express more.* • *I think I've come to notice "people who are suffering" and "people who are suffering from trying to help" in daily life. I've been able to talk to them more frankly regardless of the contents of their stories.* 5. Accepting oneself as "good enough" • *After many ELC workshops, I was gradually able to accept that "I am good enough."* 6. Actual changes in relationships with people involved • *Before the study session, my relationship with my daughter was unstable and strained. However, after the workshop, I could improve the relationship by understanding her feelings by listening and asking, which has helped us reconcile.* • *I was in charge of a female patient in her 20s who suffered from terminal cancer. She was always putting a brave look on her face in front of everyone. But as I listened to her story using repetition, she began to cry, "I'm afraid to die." I saw her tears for the first time. I hugged her and cried together saying, "You have been thinking in that way." She passed away with a wonderful smile in the end.* • *I was suffering from frequent phone calls from my 90-year-old mother living alone. She said, "I have raised five children, but I don't have any of them to rely on," and "the elderly are treated as a nuisance," I said, "That's not the case." However, I continued to receive daily calls from my mother. After the workshop, when I listened to her using repetition, she cried and said, "I am feeling miserable." I repeated, "You are feeling miserable." After that, she talked about her thoughts so far. She still lives alone but has joined the community and stopped calling me every day.* • *I listened to the story of my friend who suffered from depression, using repetition and silence. She seemed to recognize me as "a person who can understand her," and she said she was very happy to be able to speak.*

This qualitative study revealed the participants' change in perceptions, emotions, and learning processes after the ELC workshop based on Kolb's ELT. Using reflective journal writing, some participants showed actual behavioral change and reported their views that some of the techniques were also effective for people experiencing intractable

suffering. One of the participants was able to help a young terminal cancer patient admit that he/she were afraid to die and to share his/her suffering; this might have helped the patient experience a peaceful death. Another participant reported that her mother's frequent phone calls and complaints had stopped after the participant had used supportive communication. Furthermore, many participants could ease their sense of weaknesses, and they were willing to get involved in helping suffering people confidently. These tendencies were also observed during the survey conducted 3 months later. Therefore, these results indicate that changes in consciousness and behavior might be brought among the participants.

The authors would like to emphasize the need to apply these techniques in the real world, particularly in the workplace. It is anticipated that, in the coming era, a large number of people will struggle with absurd and inexplicable suffering and that the number of people who can confidently support such suffering people will be overwhelmingly few.[13] Therefore, it is proposed that people in all professions, including those working in health care, should acquire the basics of interpersonal assistance and continually learn this in real-world workplace environments. If each person can continue learning based on the basic principle, the number of high-quality supporters will increase.[5,6] The authors also valued a connection with people who recognized that they could handle themselves by applying the attitude of "good enough" and building resilience to be able to continue being involved without withdrawing. The attitude of "good enough" can prevent supporters from compassion fatigue.[11,12] It is important to hold repeated workshops rather than offer only 1 session. In fact, even during reflective journal writing, the participants' techniques were firmly established, and their understanding was deepened by repeated participation in the workshops.

The fifth habit in Stephen R. Covey's masterpiece, *The Seven Habits of Highly Effective People*, emphasizes the importance of "trying to understand the other person first"; it also endorses the method of repetition discussed in this study. Thus, the supportive communication performed in our workshop has already been suggested as a useful tool for end-of-life patients and to build trust with the other person in daily life.[14] Furthermore, some reports show that a connection with people who empathize with suffering people has helped prevent suicide and burnout.[11,12,15]

There are several limitations to this qualitative study. First, few responses in the follow-up survey were obtained largely because we could not collect participants' contact information at the end of the workshop. The method of data collection (convenience sampling) and the high rates of attrition could affect the findings because of biases or error caused by nonmissing data. Second, although our approach did not use as rigorous a method of qualitative research as other approaches, the content of the discussion and the reflective journals were rich and reached data saturation. Third, because pretest and posttest analyses were not conducted to evaluate the participants' actual ability, the objective causality and effectiveness of the study could not be established. However, applying Kolb's ELT to the content of the reflective journals, most participants seemed to express reflective observation (step 2) and abstract conceptualization (step 3). In addition, some of the participants seemed to reach the active experimentation (step 4) in the self-evaluation 3 months later.[8]

The presentation of suffering may vary by patients' communicative abilities. Dementia can affect older adults' ability to communicate, and the factors (such as memory loss, communication, and awareness of surrounding) that might affect the way that suffering is presented or experienced remain uncertain. However, seeing the reflective journals of the participants, even if they had dementia, supportive communication was often effective to calm their minds. As the spiritual and philosophical perspectives of the Japanese culture and Western cultures may have some differences, the authors are considering holding the same workshops for foreigners in the future.

The purpose of the present workshops was to learn ways to deal with the problem of suffering, which all human beings experience. Many people are becoming isolated and experiencing inexplicable suffering during the COVID-19 pandemic.[16] Thus, practices that can enhance resilience in a society are expected to become more important in the future. The results of this study can be used to build resilient communities that are designed to facilitate close relationships, allow people to provide assistance to those who are isolated, and help others feel at peace in the face of unsolvable suffering.

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