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

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Abstract

Background

Super-aging, along with high death rates and limited social resources in Japan, has created an urgent need to assume responsibility for the wellbeing of older adults and patients who have reached the end of life in the local community.

Methods

From January 2019 to December 2020, we held six workshops with the same contents of interpersonal assistance using the teaching materials provided by End-of-Life Care (ELC) Association. The study session lasted for 180 minutes: the first 90 minutes entailed a presentation on supportive communication. The last 90 minutes were centered on role-playing. The objective of the supportive communication was not to understand the other person perfectly but to lead suffering people to think of supporters as understanding people.

The participants were asked to perform reflective journal writing immediately following each session to record their experiences and describe what they learned. We applied thematic analysis to the journal entries to identify key themes based on Kolb’s ELT (experiential learning theory). For the three-month follow-up, semi-structured interviews were conducted with each participant to assess their self-perceived changes.

Results

Reflective journal writing was completed by 152 participants. Using thematic analysis of the journal content immediately following the workshop, we identified two domains and 10 key themes based on participants’ perceptions. Participants realized the importance of using listening techniques, such as repetition and silence and understanding another person. Some mentioned they could ease their sense of weakness when helping those who are suffering, and that this awareness could be applied to work, grief care, and daily life.

Three months post-experience interviews were completed with 28 of the original 152 participants who had completed reflective journal writing. Two domains and six key themes were generated. Some of the participants continued to practice listening with repetition and silence. Some of them also asked questions that could help strengthen the support for the sufferers. Changes in relationships between the participants and patients were identified.

Conclusion

Using role-playing to teach supportive communication, such as listening attentively and accepting others by practicing repetition, silence, and asking, may be effective in encouraging supporters to confidently engage with people experiencing incurable suffering.
Introduction

The problems facing Japan in the 21st century include a declining birthrate and an aging society. While population aging is underway in many countries, the aging rate in Japan is unprecedented. This aging in Japan is forecasted to reach a super-aged status (defined as more than 20% of the population being 65 years or older) by 2025 [1][2].

The national government is promoting policies such as community medical care plans and advanced care planning to support terminally ill patients within the community rather than in the hospital [3]. However, even if such a system is established, we face a shortage of human resources to assist those who suffer from unsolvable, incurable suffering at the end of life [3][4][5]. Furthermore, there have been few opportunities to learn about the structure of suffering and the resilience in multiple occupations. Although many workshops regarding the palliative care and self-mental care are occasionally held, it is unclear that what kind of effect they will have.

The End-of-Life Care (ELC) Association was established in 2015. 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.

We propose that people in all professions, including those working in healthcare, should learn the basics of interpersonal assistance and continually learn in real-world workplace environments. Also, we believe that if each person can continue learning based on the basic principle—that people with suffering can also be happy if they have somebody who can understand them and their experience—the number of high-quality supporters will increase [6]

This qualitative study was conducted by the ELC's Okinawa team, and the article demonstrates what the participants have learned 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, giving them the tools and strength to carry on, even during the COVID-19 pandemic when people have experienced increased difficulties and suffering.

Methods

From January 2019 to December 2020, we held six workshops, each with the same “interpersonal assistance” content but different participants, using the teaching materials provided by the ELC Association.

Participants

We used convenience sampling to select the participants for this study.
We noticed the workshop using advertisements and social network service (SNS), and the participants were those who saw it and applied on their own. Participants who participated in the middle of the workshop, those who left early, and those who did not agree to the reflective journal writing 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 taken care of more than 3,000 patients facing death.

The materials include 80 PowerPoint slides; the flow of each study session is described in Table 1. 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.
| Agenda | Contents | Time allocation |
|--------|----------|----------------|
| 1. Pre-session questionnaire | Questionnaire | 10 minutes |
| 2. Introduction | Self-introduction | 10 minutes |
| | Explanation of the purpose of our study. | |
| 3. Five Step Caregiving Model | A. Supportive communication: listening attentively and leading suffering people to think of supporters as understanding people; applying techniques of repetition, silence, and asking | 20 minutes |
| | B. Realizing the suffering of others | 15 minutes |
| | C. Recognizing the internal moral and emotional strength of those who live with suffering | 15 minutes |
| | D. Methods for bolstering the moral and emotional self-support of the sufferers | 10 minutes |
| | E. Supporters recognizing their internal strength and self-support | 10 minutes |
| Break | | 10 minutes |
| 4. The practice of supportive communication | One-on-one practice of repetition and silence. | 30 minutes |
| 5. Case-based role-playing | Form groups of three (one person for each of the three roles: patient, supporter, and observer). | 30 minutes |
| | Engage in a 6-minute role-play; switch roles between rounds so that there are three total rounds (each person assumes each role one time) with a 3-minute interactive and constructive feedback session between each round of role play. | |
| | Roles: | |
| | Patient: a person with terminal cancer. | |
| | Supporter: a person who uses the techniques of repetition and silence to understand the patient’s suffering. | |
| | After the patient and supporter build a rapport, the supporter asks questions that would help improve and strengthen their support of the patient. | |
| | Observer: observes and summarizes the good points and areas for improvement for the patient and supporter. | |
| Agenda | Contents | Time allocation |
|--------|----------|----------------|
| 6. Looking back and reflecting | Participants can state what they have learned and what they would like to practice in the future and note these learning goals down during reflective journal writing. | 20 minutes |

(Table 1)

**First half (90 minutes)**

As summarized in Table 1, the workshops are organized as follows. Before starting the study session, we asked participants to fill out a questionnaire about assistance for suffering people. Participants were introduced and session goals were outlined as, “putting support in words,” “recognizing support in suffering,” and “self-acceptance/cherishing oneself.”

Next, Five Step Caregiving Model (A through E in Table 1) for people who are suffering were described in detail. For item A (supportive communicating, attentive listening, and accepting others, as well as listening techniques, namely repeating what you hear, listening silently, and asking questions), the key observation was that people who are suffering with unsolvable problems are happy when they have someone who understands their suffering. In the face of such suffering (e.g., when people ask themselves, “Why only me...,” regarding their situation and what they are going through), superficial encouragement and explanation do not work, and so it is necessary to try and truly understand the sufferer. However, it is difficult for anyone to perfectly understand another person. Even so, it is possible for sufferers to think of someone as a person who understands them. What kind of person is ‘someone who understands’ from the perspective of the other person? It is being a ‘listener’. By listening attentively to suffering with repetition, silence, and asking, it was possible for supporters to lead suffering people to think of them an understanding people.

It is important to differentiate suffering that can be resolved from suffering that is difficult or impossible to resolve. Suffering that can be resolved includes physical symptoms such as pain, and people can be provided medication. On the other hand, unsolvable suffering is mental and spiritual, as people try to understand why something is happening to them and not to others, with thoughts such as “Why only me...?” Yet, while suffering, a person can acknowledge the support offered by another person, which they may have not noticed before. There are three types of support, “future dreams,” “supporting relationships,” and “freedom of choice.” The next step of support is learning about practicing ways to strengthen support for sufferers. These aspects will be further deliberated in the Results and Discussion sections. The fifth step is helping people realize their ability to support themselves. 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 running away from these sufferers, we must understand that people who would like to support someone need support the most. We value a connection with someone who recognizes that they can handle themselves,
by applying the attitude, “Good enough” and building resilience to be able to continue being involved without running away.

**Second half (90 minutes)**

After a break, part four 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 take a constructive look at the conversations they just had. Some are asked by the facilitators to share their impressions with all the participants. We 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. We present information about a patient with cancer who is experiencing unsolvable suffering, and then divide all of the participants into groups of three. Participants take turns in each role as described in item five in Table 1. 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 “silence.” In the last two minutes, we 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 we 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, we asked the participants to provide each other with constructive feedback and share their impressions with the whole group.

At the end of the ELC workshop, we had a facilitated discussion with all participants. In the discussion, we queried participants about their reflections on what they experienced and felt. The discussions were conducted in Japanese by the first and corresponding author (HN) for 10 minutes. The main author listened and accepted the participants’ opinions and then encouraged them to share their reflections. The semi-structured interview guide was based on Kolb’s Experiential learning theory (ELT) [7] and included the following questions:

- What part of the ELC workshop experience left the greatest impression on you?

What techniques were provided, and how did you feel when you practiced supportive communication? (Experience/reflection)

- What lessons from this workshop could be applied to future patient care? (Conceptualization/planning)

After the discussion, we asked each participant to perform reflective journal writing based on their experiences and perceptions. Helen C. Richardson reported that reflective writing is said to encourage a writer to learn from an event, as it necessitates focused and analytical thinking [8][9].
The journals were collected and then translated into English. The translation was mainly performed by HN, who had been directly involved with the participants and heard their raw impressions. HN 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 three authors through extensive discussions until agreement [7].

Approximately 3 months after the study session, we conducted semi-structured, individual interviews with 28 participants as part of the follow-up evaluation. Questions were asked according to the interview guide presented below. Face-to-face interviews were not feasible as could not meet most participants in person, so we sent questionnaires, and received completed questionnaires, via e-mail. The semi-structured interview guide was also based on Kolb’s ELT [7]. The interview questions were as follows:

- As a result of the study, have you experienced any changes your thought process as a supporter? Please look back on the study session and tell us if there are any content or scenes that leave an impression on you. Also, did you experience any changes in how you think about yourself regarding helping those who are suffering, after experiencing the workshop? (Reflective observation/abstract conceptualization)

- After the workshop, did you experience any behavioral changes in your work or daily life? (Active experimentation)

Although the follow-up interviews 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 [7].

At the beginning of the workshop, we announced to the participants that the contents of the reflective journal would be anonymized and used in this study, and obtained their approval. All the participants orally agreed that the contents of their questionnaire were used for clinical research. The Ethics Committee of Okinawa Chubu Hospital approved the study protocol. Data utilized in this study were made anonymous and no direct quotes were attributable to participants.

**Results**

The workshops were held six times in total, from January 2019 to December 2020.

In total, 152 people participated; the number of participants in the six 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 2. Thirteen participants attended the study session more than once, and four people participated three times or more. A total of 114 responses were collected (retrieved immediately after each session).
| Health Care-related occupations of 114 study participants | Number | % |
|----------------------------------------------------------|--------|---|
| 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 healthcare)    | 11     | 7.2 |
| Student                                                  | 18     | 11.8 |
| Unknown                                                  | 11     | 7.2 |

Before the start of each study session, we asked the participants to fill out a questionnaire about assistance for suffering people.

Using thematic analysis, we identified 2 domains and 8 key themes from the completed questionnaires [Table 3].

| 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.                                          |

In Table 4, we summarized the impressions and changes in thinking immediately after the study session. Using thematic analysis, we identified two domains and 10 key themes from the participants’ experiences
and perceptions.
Table 4
Participants’ perceptions: Key themes identified through participants’ reflective journal writing after the workshop

| Theme (Kolb’s ELT) | 1 Reflections on the importance of the role play and what they have learned |
|-------------------|--------------------------------------------------------------------------------|
|                   | By playing the role of the patient in the terminal stage, tears naturally fell from my eyes. |
|                   | By practicing and putting into words, I was able to move my emotions, and by repeating the words from the other person, I was able to know his or her emotions. |
|                   | By playing the patient’s role, I was able to experience the actual feelings and suffering of the patient. |
|                   | As a patient, I was able to experience a sublimation stage like catharsis while having the other person listen to my suffering. |
|                   | By experiencing the patient’s role, I was able to reconsider how I was involved with such patients. |
|                   | 2 Realization of the importance of listening closely. |
|                   | I realized the importance of listening. |
|                   | I realized that it was difficult for us to understand the suffering of the other person perfectly, but it was possible for them to think of us as an understanding people. |
|                   | I realized that when I was consulted by others, I simply gave them advice. |
|                   | 3 Awareness of the importance of repetition and silence. |
|                   | I felt relieved when the listener repeated my words. |
|                   | I felt that I could be considerate the other person’s feeling by repeating their words. |
|                   | I was surprised that I was allowed to repeat the negative words spoken by the other person. |
|                   | I realized that I usually couldn’t wait patiently for silence and started talking without waiting for a response. |
|                   | 4 Awareness of the significance of acknowledging self-support in suffering |
|                   | The idea that I could acknowledge self-support from another’s experience of suffering was very impressive. That’s because I had never imagined such an idea. |
|                   | I realized that it was important to build our own support. |
|                   | I realized that there was support we could recognize only in difficult situations, and that there were different types of support. |
|                   | I realized that I had some companions who could help me. |
|                   | I felt that if we had supporters, we would be strongly encouraged and could get the confidence to live. |
|                   | 5 Awareness through the workshops, new learning |
|                   | I remembered the patients I had been involved with that impressed me. |
Theme (Kolb’s ELT)

> Every time I learned, my understanding had deepened, and I noticed new things.
> I had an opportunity to think about invisible suffering.
> I understood and deepened my understanding and thoughts on the structure of suffering.
> I realized the concept of feelings of self-acceptance.
> I realized the importance of holding study sessions regularly and repeatedly.

Abstract conceptualization

6 The usefulness of repetition, silence and asking in communication for assistance
> I thought I wanted to take a breath before talking and cherish a pause.
> I thought I wanted to listen to the patient’s story by using the method of repetition.
> I learned the attitude of facing sincerely, listening, and walking together with the people involved.
> I thought the technique of asking could be applied to my own family.
> I found that silence was not a burden for the speakers who were suffering.
> I realized that silence was a time for the speakers to sort their feelings.
> I thought I wanted to listen to the stories of others, and become aware of their dignity.

7 Overcoming a sense of difficulty to support suffering people
> Before participating in the study session, I had been bad at communicating with people who were suffering from fear and anxiety before death. It made me realize that I was frustrated and thought I had to encourage them. Through the role-playing, I could feel that the techniques of polite repetition and silence could make the other person feel comfortable.
> I could ease my sense of resistance to the word death.
> I thought I wanted to confront the suffering and despair.
> I was afraid of death and worried about my family’s death, but I thought I wanted to get involved without running away.

8 The importance of becoming an understanding person.
> I thought I wanted to be close to my parents and friends who were getting weak and unable to move, and I learned how to keep my own feelings at that time.
> I realized that understanding was the strongest light of hope for suffering people.
> I realized that it was very important to share suffering without being constrained by specialty.
> I wanted to be a person who understands and accepts the feeling of those who were afraid of death and who did not want to die.

9 The importance of being aware of support for others and ourselves, and strengthening those support.
Theme (Kolb’s ELT)

- I had the idea that I was supported, and felt that I might be able to support the other person by thinking about how I was supported.

- I realized that asking about the support for suffering people and enhancing their motivation could be used in our daily work and conversations with our family.

- I can see what I can do by visualizing who and how to strengthen the support. Even if I can’t do everything, I want to take actions so that I can turn any one of them into my strength.

- Applying the contents in work and daily life as well as grief care, and the possibility of being close to the end of life

- I thought that the techniques such as repetition and silence, which I learned at ELC, could be applied not only in the medical field but also in my daily life.

- I am sure that I can use these techniques at work and at home.

- I would like to make use of the learning contents for regional revitalization, child-rearing, and human resource development.

- I thought I wanted to put the techniques such as repetition, silence, and asking into practice for my family and acquaintances to support those who were suffering, even just a little.

- I would like to make use of the techniques to support my colleagues and juniors in the workplace who were mentally tired and taking leave.

- I felt that the mission in my life was to be close to people who had reached the end of life.

- Having experienced today’s workshop, I felt that I could improve the quality of my work.

- I thought those techniques could be applied to dealing with the children who lost their families.

- I thought what I had learned could be used for grief care.

- I could organize my thoughts to get ready for the day when I would take care of my family.

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.

In the abstract conceptualization, many participants described that their sense of weakness in helping suffering people had been eased. Also, other participants mentioned that the techniques of repetition and silence could be applied to grief care. They also realized that it was very important for them to strengthen emotional support by using repetition and silence in daily life and workplaces.

(Table 4)

Approximately three months after the workshop, we conducted semi-structured, individual interviews with 28 participants as a part of the follow-up evaluation. We lost contact with 86 participants and thus were
unable to complete their follow-up interviews. 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 semi-structured interview guide was also based on Kolb’s ELT [7]. The interview questions were as follows:

- After the workshop, did you experience any behavioral changes in your work or daily life? (Active experimentation)
- As a result of the workshop, have you experienced any changes in thinking as a medical staff member or a human being? (Active experimentation/abstract conceptualization)

We analyzed the 28 field notes from the participants’ interviews. Using thematic analysis, two domains and six key themes from the participants’ experiences and perceptions were identified, as shown in Table 5. 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 very important to provide supportive communication using repetition and silence, being aware of the support, and applying it to their daily lives and workplaces.
Table 5
Conceptualization and behavior change: Key themes identified from the field notes of semi-structured interviews 3 months after the workshop

| Theme (Kolb's ELT) |
|--------------------|
| Abstract conceptualization |
| 1 A change in the perception of the involvement with suffering and suffering people |
| When I was involved with end-of-life patients in a nursing home, my perception changed. |
| My psychological pressure towards 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 me. |
| 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 also 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. |
| From my own experience, I felt that “I can spend my life calmly even while I suffer,” but at the same time I also felt that I should not put that feeling into words. Therefore, when I heard the words in the workshop, I felt like I could understand myself better. |
| 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. |
| I reaffirmed that suffering people didn’t always seek advice, and there were many times when they just wanted me to listen to and accept their painful feelings. Sometimes I just want someone to listen to me. Therefore, I think that there is basically no difference between sick people who need support and healthy people in that both of them want someone to listen to them. It is important to put healthy people’s energy into people who need assistance. |
| 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. |
| I was reminded of the importance of having a sense of ownership and of interacting with the other person based on his or her position. |
| Active experimentation |
| 3 Actual use of repetition and silence when listening to someone |
When communicating with patients, I try to put an 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 silence, which enabled me to confidently deal with suffering people.

I tried using the repetition method in actual scenarios. I tried to stay close. He talked about a lot of things during the iterative process.

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 silence. In the past, people were often complaining about something but seemed to be calm when talking, and some of them said “thank you.” Therefore, I think repetition and silence are very effective methods.

I’m no longer afraid of silence. Currently, I practice silence without any resistance and can help the patients and their families express themselves using silence.

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 became aware of the support that suffering person people received.

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.

I realized that many people were suffering even though they were not at the end of life. As a social worker, I am trying to get involved with the residents in fee-based nursing homes while being conscious of “freedom to choose” to help them feel calm.

Accepting oneself as “good enough.”

After many ELC workshop, I was gradually able to accept that “I am good enough.”

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 twenties 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, the 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.
In the active experimentation, many of the participants answered that they actually practiced listening using repetition and silence 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”.

(Table 5)

**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. Our workshop is unique compared to those held by medical staff because:

- The contents can be learned together by various occupations, such as care workers and general citizens, and are not exclusive to workers in the medical field.
- We place great importance on role-playing. In addition to knowledge acquisition, we emphasize practical use of such knowledge in the real world.
- The session helped participants to not only learn interpersonal assistance but also build resilience.
- The learning skills are practical and can be applied in daily life and work.
- By using the unified teaching materials, instructors can conduct repetitive high-quality workshops.

The content that is emphasized the most in the workshops was classified into three themes.

1. **Realization of support in suffering**

Suffering can be defined as the “gap between hope and reality.” This includes suffering that can be resolved and that cannot be resolved. Suffering that cannot be resolved involves problems that cannot be fixed by explanation or encouragement (e.g., “Why am I alone...” or “I want to disappear if I’m annoying people”). Support offered for unresolved suffering can help the patient feel at peace. The three types of support are “supporting relationships,” “freedom to choose,” and “future dreams.”
2. Expressing support verbally

The most important theme is that suffering people are happy to have someone who understands their suffering. What kind of person is someone who can understand others? It is a person who can silently listen to another person’s words.

The tenets of effective listening are repetition, silence, and asking. The objective of the supportive communication was not to understand the other person perfectly but to lead suffering people to think of supporters as understanding people.

3. Accepting and cherishing oneself

We can praise ourselves when we help someone; however, life is not so simple and easy. It is very painful to feel “not needed by anyone” without being able to help anyone. In such a situation, try to be aware of the relationship with and support from someone who accepts you as “good enough.” Feeling that we are good enough, even if we are not very good, can help build our confidence to live. This qualitative study revealed the participants’ change in perceptions, emotions, and learning processes after the ELC workshop based on Kolb’s ELT.

In this qualitative study using reflective journal writing, some of the participants showed actual behavioral change, and the participants reported that they thought that some of the techniques were also effective for the suffering people. After providing supportive communication to people experiencing suffering that was difficult to solve, using the techniques of repetition, silence, and asking, we found it was possible for them to express their suffering more clearly.

One of the participants was able to help a young terminal cancer patient admit that they were afraid to die, and to share their suffering; this might help 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 three months later. Therefore, these results indicate that changes in consciousness and behavior might be brought among the participants.

We would like to emphasize the need to apply these techniques in the real world, particularly in the workplace. We anticipate 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 is overwhelmingly few. Therefore, we propose that people in all professions, including those working in healthcare, should learn the basics of interpersonal assistance and continually learn in real-world workplace environments. We believe that if each person can continue learning based on the basic principle—that people with suffering can also be happy if they have somebody who can understand them and their experience—the number of high-quality supporters will increase.
It is important to hold repeated workshops rather than offer only one session. In fact, we found that, even during reflective journal writing, the participants’ techniques were firmly established and their understanding was deepened by repeated participation in the workshops.

Alfred Adler, a psychiatrist and psychologist, proposed the acquisition of a “community feeling” as a condition for all human beings to live happily; the essential elements for achieving the feeling of community are self-acceptance, interpersonal trust, and contribution to people and society. “Accepting and cherishing oneself,” one of the important themes in the learning program in this study, can be considered as closely related to the idea of self-acceptance in Adler’s psychology [13]. In addition, in the fifth habit of Stephen R. Covey’s masterpiece, “The Seven Habits of Highly Effective People”, he emphasized the importance of “trying to understand the other person first;” it also endorses the method of repetition discussed in this study [14]. Thus, the supportive communication performed in our workshop has already been suggested as a useful tool for end-of-life patients and building trust with the other person in daily life [15]. Furthermore, some reports show that a connection with people who sympathize with suffering people has helped prevent suicide and burnout [15][16].

There are several limitations to this qualitative study. First, we obtained few responses in the follow-up survey largely because we could not collect participants’ contact information at the end of the workshop. Since follow-up surveys are important for establishing the effects of learning, we need to take an effective step to set expectations for follow-up surveys before holding the workshop. Second, although our approach was not as rigorous a method of qualitative research than other approaches and we had a limited number of participants, the content of the discussion and the reflective journals were very rich and reached data saturation. Third, since pre- and post- test analyses were not conducted to evaluate the participants’ actual ability, we were unable to establish objective causality of the effectiveness of the study. However, applying the 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 [7].

The purpose of the present workshops was to learn how to deal with the problem of suffering, which all human beings experience. Many people are becoming isolated and experience inexplicable suffering during the COVID-19 pandemic [17]. 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 and allow people to provide assistance to those who are isolated and to help others feel at peace in the face of unsolvable suffering.

**Declarations**

**Ethics approval and consent to participate**

The Ethics Committee of Okinawa Chubu Hospital approved the study protocol.

**Consent for publication**
The Ethics Committee of Okinawa Chubu Hospital also approved the publication.

**Availability of data and materials**

All data generated or analyzed during this study are included in this article. At the beginning of the workshop, we announced to the participants that the contents of the reflective journal would be anonymized and used in this study, and obtained their approval. All the participants orally agreed that the contents of their questionnaire were used for clinical research. Data utilized in this study were made anonymous and no direct quotes were attributable to participants.

**Competing interests**

No potential conflict of interest was reported by the author(s).

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**Authors’ contributions**

HN: contributed to the study design, data collection, data analysis, interpretations of the results, and manuscript writing. KC: interpretations of the results, and manuscript writing. TO: contributed to the study design, data analysis, and manuscript writing. All authors read and approved the final manuscript.

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