Dressing an existential wound (DEW) – a new model for long-term care following disasters

Arne Rehnsfeldt RN, PhD (Professor)¹ and Maria Arman RNM, PhD (Associate Professor)²

¹Stord/Haugesund University College, Stord, Norway and ²Karolinska Institutet, Huddinge, Sweden

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Background: Presence, concern, compassion and universal or ontological unity between human beings have emerged as crucial to the healthy development of people who have experienced disasters.

Aim and objectives: The aim of this article was to present a new model for long-term care following disasters. The objective of the model was to contribute to the readiness for long-term care following disasters in professionals and nonprofessionals as a result of their understanding of the model.

Design: A longitudinal qualitative study of Swedish tourists affected by the South East Asian tsunami in 2004 is the empirical base for this clinical model, which was developed within the framework of caring science.

Methods: A hermeneutic method was used.

Results: The model is based on the assumption that life issues are an important aspect of long-term follow-up after a disaster. The term ‘life issues’ refers to the following: existential questioning of life’s content, values and priorities; people’s relationships with each other; and the importance of health, suffering, love and death. Life issues also refer to the way in which survivors form a new understanding of life after a disaster experience. Existential care is based on a charitable attitude of compassion and mercy towards one’s fellows, be they professionals, families or wider society. By presenting eight theses, the model provides an approach based on compassion that works as an existential dressing for survivors of disaster.

Conclusions: The model gives a knowledge base and approach for the long-term care of survivors, including practical advice.

Keywords: long-term care, caring, disaster, existential, health, suffering, understanding of life, communion, clinical model, hermeneutics, permissiveness, attentive care.

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Introduction

Compassion, concern, interdependence and universal or ontological unity between people has emerged as crucial to healthy development for disaster survivors (1, 2). A new clinical model was suggested in a recently published book. The model assumes that existential life issues are an important part of long-term follow-up after a disaster. The term ‘existential life issues’ refers to the existential questioning of life values, priorities, people’s relationships with each other and the importance of health, suffering, love and death. Life issues also include the way we understand life and, in particular, how survivors form a new understanding of life after a disaster (3). After a sudden trauma, assumptions about life that were previously taken for granted are overturned (4) and need to be rebuilt. The way we process questions about life presupposes a caring human communion where the patient is invited to a place to rest in an atmosphere of genuine hospitality, permissiveness where every expression is accepted as natural, intimate connection and possibilities (5). This sense of communion has been conceptualised as a sacred dimension that people share (6) as a presence in the moment.

Existential care is natural as related to natural life issues and based on an attitude of compassion and charity (1, 7) that takes place in caring communion. Comprehensive synthesised assumptions about long-term existential support for people affected by disaster form the model. This study gives constructive proposals for the systematic rethinking of long-term charitable existential care by the formulation of eight assumptions.

Disasters affect individuals, families, social communities and societies. Disasters include natural catastrophes,
terrorist attacks, wars and accidents where some people die and others may lose their health and life opportunities such as work (8). What does it mean to be in a disaster? Initially, it is experienced as a physical strain, but this can become an existential strain in the longer term. Generous resources for support may be made available in the early stages immediately after a disaster, but many survivors report that they feel abandoned in the longer term, as documented in Swedish and Norwegian government papers (9, 10). In the Nordic context, survivors of the Estonian shipwreck of 1994, the Asian tsunami of 2004, and the terrorist attacks in Norway in 2011 have all made clear that they thought support was cut off far too soon.

Although it is easy to imagine the most acute stages of a disaster, when everything is in chaos and mere survival is the issue, the ability to empathise with the plight of survivors and their loved ones is much more difficult in the longer term. Human suffering after a catastrophic experience is deep and prolonged, with lifelong implications, and it presents both practical and existential challenges. Health and personal development are affected (4, 11). The life that survivors thought they would be living is changed forever; accepted life values and judgements are overturned. The important questions to be considered are what type of support do people need in terms of health and personal development, and by whom should such care be administered? We have studied the issue in the Nordic context from a caring science perspective (1, 3).

The inspiration for the study came from the theoretical thinking in the framework of a caring science that was developed at Åbo Akademi University. The essence of this scientific discipline is Eriksson’s ‘Theory of caritative caring’ (5). The following core concepts apply here: man as a unit, health, suffering and caring. Suffering is not just a feeling or a pain; it is a fundamental state of being that can make deep wounds in humans but also lead to human growth (12). The scientific ethos represents the spirit in which the research is carried out, and also reflects the basic and emancipatory idea that life and health should be served by caring science, as well as alleviation of suffering in a caritative loving spirit. Also Logstrup’s thinking on universal understanding of life in relation to lived utterances and ethics is a source of inspiration (13).

When a disaster strikes, and people are confronted with unfair suffering, violent death, or meaningless loss and pain, they enter a ‘boundary situation’ (14) where they are confronted with their inner being. It is in these situations, however, that people may come into contact with life’s universal elements and reach a true understanding of life (13). In these circumstances, people are particularly exposed and vulnerable, lacking the normal defence of the social facade. This is, accordingly, an ontological experience which has to do with the essence of being. This is true not only for the survivor, but also for the person who offers help and support. Logstrup refers to the qualities that emerge in such meetings as ‘spontaneous life utterances’, which can include, for example, openness in speaking, trust and mercy. Logstrup argues that man’s basic understanding of life becomes visible in these situations. If we assume, for example, that compassion is a spontaneous life utterance that is something that spontaneously comes to us when we encounter extreme vulnerability in another person, we can also talk about interdependency as a basic or universal utterance of life. Interdependency means ethically and existentially that one person is entirely dependent on another to maintain dignity as a human being. Answering the ethical demand inherent in the existential situation of the afflicted person is a spontaneous life utterance mirroring interdependency (13).

Empirical studies – health in suffering

People’s capacity for health and dignity is astounding, not only in moments of great vulnerability, but also in life-changing events where life itself is at stake. Of the Swedish tourists returning from the South Asian tsunami of 2004, only five per cent reported continuing post-traumatic symptoms at follow-ups three and 6 years later (15–17). This shows us that suffering is a natural way of experiencing severe life events and is not incompatible with health. Suffering can initiate innate healing processes when health is viewed as central to life and existence (12).

Through studies of disaster literature, we have found that people often want long-term support after disasters, but that knowledge of and practical models for such support are not available. There is also an increased understanding that ‘natural healing’ of people affected by disasters is far more common than pathological reactions that require professional health care (1, 16, 18). Moreover, Pietrzak et al. (19) noted that after 18 months, people stricken by a hurricane were very resilient to long-term mental health disorders. In the official Norwegian government report on the terrorist attacks in Norway on 22 July 2011, the investigators concluded that healthcare and emergency staff was ill-prepared and unsure of how they should respond to the survivors’ suffering, and psychological and emotional needs. The report discusses the need for disaster training and also suggests that psychologists and psychiatric experts should be included as experts. In the report, one also wonders if there is need to train healthcare professionals in compassion and mercy (10). When an international panel of scientists studied the evidence-based knowledge on psychosocial interventions available after
mass trauma situations, it was seen that the methodology of ‘debriefing’ directly after a disaster may neither prevent post-traumatic stress disorder (PTSD) nor provide protection against future mental health problems in the people affected (20). A recent study of postdisaster services in Europe stated the need for further evidence-based updates to the psychosocial care services made available after disasters (21). The study also notes that the family provides a large amount of social capital in local communities, and this constitutes the main source of care as regards mental health and existential matters. There is much research about the importance of keeping in touch with friends and family and other social groups, but less research has been carried out on how this is translated into interventions in the form of caring activities that contribute to healing. Lack of social contacts and relationships is, in fact, a possible cause of PTSD, whereas good social support is related to better emotional well-being. This support is necessary from a few months to several years after the disaster. The study notes, however, that social support often peter out too quickly.

Another issue discussed in the literature relates to the possibility of giving hope to survivors whose world view has often been shattered (cf. darkness in the understanding of life (7)). One possible way to give hope is to show a concrete participation in doing and being (cf. the concept of compassion) with survivors rather than just doing things for them (20).

Post-traumatic growth is another approach discussed in relation to the health of survivors. Post-traumatic growth means to experience positive changes despite having been through challenging, traumatic and difficult circumstances in life. Post-traumatic growth proves the possibility of improved relationships with others, changing one’s priorities in life, a richer spiritual and existential life and the experience of greater inner strength (22, 23). It appears that women are better able to reach post-traumatic growth than men. A possible explanation for this could be that women look for more support from others (23, 24). Studies on gender aspects in the health of disaster survivors would be very useful (25). In most studies of post-trauma follow-ups, women exhibit greater vulnerability than men (2, 18). There is also a link between social relationships and post-traumatic growth in general. One study showed that there was an association between post-traumatic growth and post-traumatic stress: the more growth, the less stress. One explanation for this may be that perceived post-traumatic growth may be an attempt to find meaning in a meaningless event, that is a kind of protection from traumatic life events, an illusion, in effect, to maintain some form of adaptation to the situation (23). Swedish follow-ups on the psychological health of tourists exposed to disaster showed a low rate of sick leave after 14 months, as well as less use of medicines. In fact, these factors were lower than in the general population (26). Another 3-year survey showed that recovery continued but that the trauma had a long-term impact, particularly where the survivor was more exposed to the possibility of death or bereavement (18, 27).

An interview-based study of well-known disasters and trauma researchers has suggested that healing means to exceed or transcend suffering. Suffering can be transcended when a person reaches a new experience of wholeness and meaning. This is facilitated by relationships that are continuous in nature. Such relationships can help survivors convert difficult life events into a life story; people can rebuild their lives by means of the story, which includes decay (11).

Disasters can be major or minor, natural or the cause of accidents. They may also take place at the micro-level when a single person or a loved one is injured or even murdered. The model for natural existential care after disasters is also designed for use in all such settings over a long period. It should be used by families, carers, society and professionals.

Aims and objectives

The aim of this article was to present a new model for long-term care following disasters. The objective of the model was to contribute to the readiness of professionals and nonprofessionals to provide long-term care following disasters by improving their understanding of the model.

Method

The empirical data were conversation interviews performed with 18 Swedish tourists who were affected by the South-East Asian tsunami disaster in 2004, and some of their relatives at home. The research participants had suffered the loss of close relatives, been injured and witnessed death and horror to varying degrees. All of them were participants in the Red Cross support groups from which they were recruited. Data collection started 1 year after the disaster and took place every second month for 1 year. This resulted in 60 qualitative dialogue interviews (28), which were transcribed verbatim and analysed. The analysis was carried out in stages and using an interpretive hermeneutical approach inspired by Gadamer (29). As a result of the interpretation process, a new understanding emerged, which was formulated as abductive theses as a kind of evidence-based qualitative hypothesis. It is a way of discovering meaningful patterns in scientific knowledge. This is achieved by using facts, theoretical sources and empirical data to formulate new ideas (30). The DEW model was shaped in an ‘abductive leap’ and later developed and validated using empirical and philosophical sources.
The study was approved by the Regional Ethical Review Board in Lund with ethical approval number: 152/2006.

Findings

**DEW — eight basic abductive theses forming the model**

Any support or care for a fellow human being must be based on a notion of what the affliction means to the person, and what they may need in the present circumstances. Whether the realisation of this is conscious and overt or intuitive, arising in the moment, it influences the whole attitude and approach to care. The abductive theses below aim to provide a basic understanding of what it means to be affected by a disaster and to give care in such circumstances. In dressing existential wounds, the attitude is an essential part of the dressing, which is achieved by natural human love and care, and by adopting and integrating the theses below. Tolerance is an utterance of love and the word ‘interest’ is a modern word for love. The eight abductive theses form a conscious and overt framework for long-term care of people affected by disaster (Table 1).

**Thesis 1. The existential wound is natural — as are caregiving and support**

Based on the assumption that the condition of the survivor is natural, the care and actions taken by others are natural. Reactions after surviving disaster are natural and neither dangerous nor pathological. Very few people become insane, although they may feel as if they are at critical moments.

Terrifying and random events are impossible to prepare for. People affected by disaster, on either a micro- or a macro-scale, have their previous views ripped apart and their understanding of life overturned; it is natural to have a strong reaction.

To dress an existential wound after a traumatic or disaster experience seldom demands expertise; however, it does require specific insight and knowledge. Everyone has this insight, which is charity, an inherent spontaneous knowledge. The healing of the existential wound is also a continuous natural process.

**Thesis 2. Charity brings light into darkness**

The existential wound is dressed by a fellow human being. The acts of care based on charity are central when applying the dressing. In the darker moments of life, communion with a fellow human being may bring light into the darkness as well as vital hope. In a critical situation, the meaning and effect of caring acts and gestures are not proportional to the scope of the act. Small efforts made with genuine interest, such as a hug or offering a cup of coffee or a meal, can open closed existential doors so that the light from life can seep back in.

The person dressing an existential wound does not have to do so while playing a specific role, even when it is done as part of a job. To dress an existential wound is basically a voluntary act of care and builds on a deeper sense of ontological interdependence between people, a universally human attitude. The voluntary nature of care is a key to the inner world of the survivor even if it takes place within an organisation or is given by a professional caregiver at work. By allowing the unselfish attitude to come forward, charitable love shines out in a caring gesture. The fellow human being becomes a testimony that goodness still exists.

To experience goodness and consideration from fellow human beings may bring light into a situation experienced only as evil and dark.

**Thesis 3. Permissiveness is the basis of the existential process**

The dressing of the existential wound presupposes that it is taken care of in a spirit of permissiveness, meaning that there are no intentions or goals to make the other person change or become better in some way. Accordingly, no therapeutic ambitions are involved. There are no intentions other than to do something good for the other person in the moment.

Using a spirit of permissiveness, the survivor is given the opportunity to be fully dignified in their present situation. There is an insight that the present course of events or situation cannot be changed. It is not possible to eliminate the suffering and the existential wound; only relief is possible.

The actions taken by the survivor are seen in the light of permissiveness: what is human is natural. There is no desire for a response or gratitude; the only intention is to contribute to some kind of relief, a relief that may make the unendurable experience endurable for a short time or moment. The effort may or may not succeed, but the existential wound must be dressed in any case.

**Table 1 The eight assumptions of DEW**

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Thesis 4. Attentive care gives inner relief by outer care

In a spirit of permissiveness, the fellow human being offers the survivor what we call attentive care, a concept that represents attendance. Attentive care means inner caring by external measures, where care of the body affects the soul. Attentive care is analogous with maternal love, which gives the experience of security.

For survivors of a disaster, the ability to react to the normal everyday needs of nutrition, hygiene, warmth and sleep becomes diminished. This means that the fellow human being must attend to the other person’s basic needs for comfort, nutrition, hygiene and sleep.

Attentive care is a natural way of being together: to take a walk, to prepare for a bath, to read aloud or to dine together. It is the loving and unconditional care that does not demand anything in return. Patience and resilience are natural parts of attentive care.

Thesis 5. Concrete tasks may need to be performed in fellowship

It may be necessary to perform concrete tasks in fellowship. For the survivor of a disaster, life may be experienced as full of insurmountable problems and obstacles. In this case, to dress an existential wound may mean to carry out practical everyday tasks. Intensive suffering can paralyse normal abilities and reactions. Concentration and memory can also be affected. The healing of existential wounds may be so tiring that it leads to apathy.

As a fellow human being, the carer needs to give full attention to the other person and may even need to move into the other person’s home to make sure that basic everyday processes continue to function. Examples of such processes include paying bills, mending a car, liaising with authorities or attending a medical visit; these are things that the survivor may not be able to do alone. Helping with these activities, by making a phone call, giving a lift or going to a meeting, may give concrete protection to the affected person.

Thesis 6. Learning and development take place in communion

The essence of the existential wound as a lived phenomenon is to discover and be confronted with the basic conditions of life: death, solitude, meaningfulness, dependence on others, frailty and material transience. Suddenly and involuntarily, survivors of disaster have been shocked into a deep and painful realisation of death’s possible victory over life, and the unpredictability and vulnerability of human life. Painful insights into the true conditions of life may be rare in everyday life, but, in life-decisive dramatic circumstances, survivors come face to face with the basic conditions of life. This leads to them realising the mystery of life, becoming aware of the existential questions asked by life, adopting challenging new positions and gaining a new understanding of life.

In these circumstances, we can learn by being in communion with others. In such communion, the survivor is the expert with an insight based on lived experience. Other parties can bring the peace and balance that will allow reflection. Such dialogue must take place in a spirit of equality where meaning can be created in communion.

Discussion about the understanding of life can be very concrete but can also deal with universal issues such as meaning and meaningfulness, as well as thoughts on the inner vs. the outer life. Learning and developing an understanding of life can only take place when both parties are in communion and are prepared to learn and develop.

Thesis 7. The existential wound is opened up and closed at varying intervals

The existential wound, and the pain and suffering it causes, can vary in depth, and the length of healing required. It is a rhythmical but lifelong experience, and can reopen with almost full force at any time in life, independent of time and place.

The existential wound can also be closed due to natural healing and personal development. It can also be temporarily closed by distraction or activity. To live with a closed existential wound can be just as painful as living with an open one. Among other things, to dress an existential wound means to understand the natural changes experienced by the survivor. The wound can be either open or closed in relation to the degree of existential pain, as both conditions are natural and lead to recovery. Having an open-minded attitude ensures that we support the survivor in his or her choice as to when and to what extent the wound should be opened up.

Thesis 8. Existential implications and paradoxes of health

The narratives of people affected by disaster reveal aspects that can be conceptualised as ‘health healing movements in the paradoxes of health’. Examples include movements between the experience of chaos and peace, between what is confusing and hard to accept vs. new insights and visions that appear. By changes in thinking, emotion and will, where old ways of thinking are mixed up with new insights and experiences, people can grow into an understanding of life that integrates these different life experiences. Light can seep into the darkness in the form of new insights into existence and life. When people have concrete, lived experiences of ‘evil’, new views are gained on ‘good’ aspects of life. The
paradox is that the experience of disaster opens up new insights into the realities of life. What was previously unknown or hidden may be revealed as new truths. When reading the narratives of our research on persons affected by the South East Asian tsunami disaster, such paradoxes occur again and again. When people tell their stories spontaneously, it is clear that the telling in itself binds together the seemingly diverse dimensions of dark and light into a coherent whole. Often, the existential basic conditions of life are mentioned as life and death, meaning and meaninglessness, community and solitude, dependence and independence, and possibilities and hopelessness. As a result, we can see that the contradictions and variations in survivors’ feelings and thoughts are part of the natural healing process and also an indication of health.

It is necessary for the survivor to resolve paradoxes such as depth and shallowness, or the severity of life vs. the easiness of everyday life in the existential shadow of the disaster in order to find a new understanding of life. Before the existential opening that the experience led to, everyday life may have been dualistic: either–or, black or white, or good or bad. However, after the disaster, these opposing aspects of life must be integrated into a whole where life is both good and evil at the same time. It is as if the doors to the most secret or holy room have been opened and a new reality has appeared (horrifying but fascinating), a reality that no one but the tormented person is able to grasp.

What does this knowledge mean in relation to postdisaster care? Understanding the chaos, contradictions, and the sometimes abrupt changes within survivors, is a way to focus on – and participate in – the natural struggle to understand life, health and existence.

Discussion

As there is no model for long-term care in disasters, and as empirical data point out the necessity for this kind of care in afflicted persons, this model fills a gap in disaster research. It also offers a possibility for understanding the health of persons afflicted by a disaster, and how to relieve their suffering. Empirical data, together with concepts from caring science, have helped us to formulate the DEW model in a hermeneutic process. Accordingly, we see it as using a theory model approach, as suggested by Benight and McFarlane (31); it is a model for long-term care that is based on theory and research as well as using a language that can be understood by survivors as it is close to their own. We have had discussions with all the participants in our study to validate the eight theses in the model. Minor adjustments have been made. The participants approved and supported the outcome.

The abductive theses reflect the natural existential life issues we have found in our data. Caring science has helped us to interpret these experiences and to give them a conceptual language. By understanding these concepts based on lived experiences, advanced care can be performed either by professional or by nonprofessional caregivers. In a way, the model describes the ethical demands inherent in an existential experience (13).

When we presume that the existential wound is natural, it is based on the narratives of the research persons but also an ontological interpretation. The ontological interpretation stems from the concepts of interdependence and spontaneous life utterances. Spontaneous life utterances such as compassion or openness of speech are evoked in the face of a crisis situation as people are suddenly aware of their interdependency (13). The research persons mostly talked of the help they received from relatives or friends (2). So when helpers saw the situation of the afflicted person, they were open to natural spontaneous life utterances including mercy. This was mainly voluntary and built on what Logstrup (13) noted as a spontaneous understanding of interdependence. Another expression of natural care is when attentive care can give inner relief by outer care. Attentive care is comparable with maternal love, where tender care and safety can be experienced (12).

A new understanding of life can evolve when one is confronted with the basic conditions of life such as death, frailty or meaninglessness (7, 11). There is a health potential in this suffering, especially if together with another person in communion. In this circumstance, the parties can create meaning in communion (2, 32).

Also many proofs of caring communion are seen in data where seemingly small gestures such as offering a cup of coffee or giving a hug may open closed existential and emotional doors. This gesture of caring makes charity shine through in the moment of togetherness (33). Also permissiveness when dressing the existential wound is a sign of communion. There is no ulterior motive for changing the other person and she or he can therefore be fully dignified in the present condition.

The paradoxes of health where paradoxes such as meaning and meaninglessness, or possibilities vs. hopelessness are present simultaneously, are compatible with health as endurable suffering where the person is in a struggle of suffering between opposites such as meaning or meaninglessness (12).

Further clinical application research is required to try out the evidence base for the model. Also, to create a middle range theory would be an important step for further research. According to Smith, a middle range theory is within a disciplinary thinking, the theory gives a substantial explanation or interpretation to the field of study, it is rooted in research and practice, and the theory can be used in a variety of clinical settings and in different groups of clients (34).
Concluding remarks

The DEW model for long-term existential care for people affected by disasters gives a knowledge base and approach for the long-term care of survivors, including practical advice, as the model is open and must be appropriated by each individual, be it a family member, friend or professional caregiver. This appropriation is aimed at finding an individual way of performing the care in relation to the unique needs of the person who is the survivor. It is important to state that theoretical models and concepts cannot be used directly but must be adopted by caregivers as a sounding board for confirming and recognising the needs of attentive care.

A model for existential long-term care in disasters does not exist in the global disaster literature, and this model can be used instantly. It is important to create models that can be used by both professionals and nonprofessionals, as disasters usually afflict many people and the normal health care resources may be inadequate to care for all.

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Author contributions

Both authors have written the manuscript and worked equally.

Ethical approval

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