Distant suffering: A concept analysis
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Abstract

Background: Patients who are suffering may be commonly encountered in health care. The growing use of telehealth implies that encounters with patients who are suffering may increasingly take place at a distance. “Distant suffering” is a concept coined within sociology to describe the suffering of far-away others. It is conceptualized as a paradox, as distance changes the relation between the witness of suffering and the suffering encountered. Impacts may include a potential detriment to the sufferer and ethical implications for the witness.

Objective: To explore the concept of distant suffering and any relevance, implications, or important avenues for potential research within the healthcare sciences.

Design: Rodgers’ evolutionary concept analysis.

Data sources: Databases of Web of Science, Medline, CINAHL and PsycInfo were searched for the terms “distant suffering” or “mediated suffering.”

Review method: Attributes, surrogate or related terms, antecedents, consequences, and uses of the concept were extracted and synthesized.

Results: Thirty articles published within the past ten years were selected for review from the search results. “Distant suffering” was characterized as comprising 1) mediated far-away suffering, 2) a “recognizer” or witness, and 3) a potential role of a moderator. Antecedents include shared understandings and socially-influenced responses. Consequences include responses like empathy, compassion, pity, also indifference, cynicism and compassion fatigue.

Conclusions: Further research to explore distant suffering from healthcare sciences’ perspective could uncover valuable insights for those suffering, for healthcare workers, and anyone who are exposed to it. An improved understanding of how distant suffering is conveyed and moderated could enable targeted reduction of exposure or improve responses to distant suffering. Such knowledge could help diminish negative consequences for those suffering, for healthcare workers who are caring at a distance for those suffering, or for others who encounter distant suffering in their occupations or in daily life via media, social media, or digital communications.

Tweetable abstract: New analysis finds that exposure to distant suffering may have important implications for health and health care.

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Keywords: Distress, Health care, Mediation, Suffering, Witnessing

What is already known

• “Distant suffering” is a concept described in the social sciences, where witnessing far-away suffering connotes potential negative implications for the witness and the distant sufferer.
• Through the expanded use of telehealth care, healthcare providers may increasingly encounter suffering patients who are far away, yet distant suffering remains unexplored in the healthcare sciences.

What this paper adds

• This analysis uncovered relevant aspects and potential implications of distant suffering for nurses and other healthcare providers, which may also be relevant for others who encounter distant suffering in their work or daily life.
• Potential consequences for those encountering suffering at a distance include indifference, pity, and compassion fatigue, which have important implications in the healthcare context.
• Further research on distant suffering in the healthcare sciences could improve understanding of how distant suffering is conveyed and moderated to help reduce potential harms from exposure to distant suffering or improve responses to distant suffering within caring encounters.

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1. Introduction

Suffering is an important phenomenon within health care, and healthcare workers may be regularly exposed to patients suffering in their daily routines. Acting to help patients find relief from suffering could be posited as a basic tenet of healthcare practice, or even an obligation of clinicians (Cassell, 1982; Gantt, 2000).

Suffering is defined as “an individualized, subjective, and complex experience characterized primarily by ... intensely negative meaning” (Rodgers and Cowles, 1997, p. 1050). In the healthcare setting, suffering may be attributed to a disease, or to its treatment. In efforts to relieve suffering, healthcare providers may subject patients to even greater suffering (Cassell, 1983; Rodgers and Cowles, 1997), such as when an operation or chemotherapy to treat cancer causes physical suffering (Kuuppelomaki and Lauri, 1998), or when patients feel distrusted or mistreated in health care (Berglund et al., 2012). Suffering is often conjectured as equated with physical pain, but it may similarly be a response to pain or occur with the anticipation of pain. Suffering may have little to do with pain, even for patients in an emergency department (Body et al., 2015). Suffering can be associated with fear or dehumanization (Copp, 1990), helplessness, or other social or psychological factors and can result in a negative emotional response for the experient. It is also described as “severe distress” (Cassell, 1983, p. 522) or a negative cognitive or affective state characterized by the experience of a threat to one’s ability to feel whole or uncompromised, alongside the inability, powerlessness, or lack of resources to cope with that threat (Ortega-Galan et al., 2022). Suffering may result from loss, as loss of some good or some object, loss of one’s job or a loved one, loss of health or positive affect, loss of security, loss of peace or peace of mind, or loss of sense of control (VanderWeele, 2019).

The term “distant suffering” represents the relationship between a suffering human being and another individual who is at a distance, meaning not physically present with the sufferer, yet to whom suffering is conveyed. This phenomenon is described when suffering is carried across a geographic distance, or through a medium, and often both at the same time. The medium through which distant suffering is conveyed can include print media, or a telephone, screen, or other technology.

In everyday life, encountering distant suffering is a seemingly ubiquitous experience: people all over the world watch far-away disasters on television, or read newspaper reports of conflicts, or scroll through social media accounts of global or personal crises unfolding. Such distant suffering encounters may only grow more common as more and more individuals around the world gain access to the internet and digital technology.

Modern discourse on distant suffering arises from social theory, at an intersection where media and public norms meet. A number of paradoxes arise along with this phenomenon: in encountering distant suffering, does the witness benefit and go on to lead a more ethical public life? Or is the witness compromised by the distant nature of the exposure which innately prevents their direct response? Do distant sufferers benefit from having their situation made known to a far-away witness? Or is there potential harm to sufferers because of the risk of a dehumanizing portrayal? Such considerations and ethical and moral challenges are explored by Luc Boltanski (1999), whose point of departure is the work of Hannah Arendt (1963). Such lines of exploration have since been followed and expanded upon by Lilie Chouliaraki (2006) and others within the social sciences.

In the context of health care, digital equipment and other technological advancements play increasingly prominent roles in mediating patient encounters, where suffering is inherently present (Dempsey et al., 2014). Suffering, conveyed visually or verbally, can be powerful, and attending to it in health care could enrich outcomes for both patients and providers (Del Gglio, 2020). The greater use of digital communications in healthcare practice could mean that providers increasingly relate and respond to the suffering of patients at a distance (Ali et al., 2022). Surprisingly, though, research on distant suffering is absent from the healthcare sciences literature.

In a scoping review looking at the use of digital technologies to deliver compassionate mental health care by Kemp and colleagues, a number of intervention studies were identified as serving a direct goal of responding to suffering through an online intervention (Kemp et al., 2020). Yet, no studies identified in that review focused on distant suffering, per se, such as with an aim of improving recognition or awareness of suffering when it presents through digital technology, or exploring how recognition of suffering is impacted by a mediating role of technology. Rather, that review successfully identified approaches to facilitate compassionate interactions between patients and providers.

The potential for an important role of distant suffering in health care has driven a pressing need for this explorative inquiry. Insights from distant suffering could provide valuable learning for health communications as well as interpersonal communications. The aim of this work is to investigate conceptualizations of distant suffering in research articles, to illuminate aspects that may hold relevance for health care. By forming a greater understanding of distant suffering and describing how such knowledge may be used within health care, this study aims to uncover areas for further investigation of the concept, that may inform research and improve healthcare practice.

2. Methods

2.1. Methodological approach

The present study uses the concept analysis methodology to examine the concept of distant suffering and explore its relevance for the caring sciences. The method was used to synthesize existing views of the concept in existent literature in order to characterize the concept for use within a new discipline (Toftthagen and Fagerstrom, 2010). Rodgers’ evolutionary concept analysis method (Rodgers, 1989) was chosen for this study. Rodgers’ method allows particular consideration of how context influences the nature of concepts, and recognizes that concepts evolve alongside intra-professional and social factors. Concepts are seen as not static (Toulmin, 1972), but may cyclically develop or change over time.

For these reasons, Rodgers’ method was chosen for exploring the dynamic concept of distant suffering, which may continue to evolve as technology’s role in health care and daily life evolves. This method is inductive and proceeds over seven steps that are iterative, and not necessarily sequential. The seven steps taken were to: 1) Identify the concept of interest, any surrogate terms and uses of the concept in literature; 2) identify the appropriate sample for data collection; 3) collect the data; 4) analyze the data to identify characteristics of the concept; 5) identify references to the concept, its antecedents and consequences; 6) identify any related concepts; and 7) identify implications that may guide further development of the concept (see Table 1).

Table 1
Steps of Rodgers’ evolutionary method for concept analysis.

| 1. Name the concept of interest. Identify surrogate terms and uses of the concept in existent literature. |
| 2. Select an appropriate realm (sample) for data collection |
| 3. Collect relevant data to identify the attributes of the concept and the contextual basis, interdisciplinary and socio-cultural variations |
| 4. Identify attributes, or defining characteristics, of the concept |
| 5. Identify references, antecedents, and consequences of the concept |
| 6. Identify other concepts that are related to the concept of interest and exemplar, if available |
| 7. Identify implications, that may inform development or guide further theorization of the concept |
2.2. Data sources and sample

The data sources for the concept analysis were chosen to be peer-reviewed articles in academic journals. Searches were conducted by the corresponding author within the databases of Web of Science, Medline, CINAHL and PsycInfo in March 2022. The search strategy comprised the terms “distant suffering” or “mediated suffering” with quotation marks. This search strategy was limited to those two terms to ensure results focused on the specific topic of distant suffering, while recognizing the surrogate term of “mediated suffering” may also bring relevant and informative results. A search of these terms in Web of Science returned 94 records. EBSCO Host was used to search peer-review articles in PsycInfo, CINAHL and Medline and returned 12 records: one article indexed within Medline, zero within CINAHL, and 11 indexed in PsycInfo (see Fig. 1, PRISMA flow chart). The title and abstracts were reviewed. Ten duplicate records, three editorial works and five book reviews were removed to ensure the present study would be grounded in evidence from peer-reviewed literature. Works published earlier than 2012 were eliminated to ensure relevance within rapidly changing technological landscape following which, 75 records remained. Included articles, all of which were in the social sciences, were selected to reflect Rodgers’ (2000) recommendation of including 20% of the total population of data sources or a minimum of 30 articles. Records were further reduced to 30 articles to be included. To do this, records were arranged in order of the highest number of citations. This step sought to identify papers which might be most impactful and thus referenced most in subsequent literature. The top 35% of the articles most often cited were selected for inclusion, amounting to 26 articles, each with nine or more citations. Finally, four recent publications were retained from the search results from authors not already included. This aimed to ensure diverse and current perspectives (see Fig. 1 and Supplementary material Table 1).

2.3. Coding and synthesizing of data

The full text publications were uploaded into the NVivo software. Data were coded for the following a priori codes, reflecting the aspects to be identified according to Rodgers’ (1989) evolutionary method: attributes, surrogate or related terms, antecedents, consequences, and uses of the concept. Coded data were exported to tables in Microsoft Excel (2018) and code summaries were created to organize, synthesize and summarize the data extracted. The initial analysis was completed by author JA, and reviewing and discussion of the summary syntheses were conducted by all authors to reach consensus for each area of findings. While this concept analysis included only articles published within the past 10 years, earlier original sources are cited below, where appropriate.

3. Findings

3.1. Attributes

From this analysis, three unique defining attributes were identified to characterize instances of distant suffering: mediated far-away suffering, the “recognizer”, and a moderator. Notably, though, many features...
are based on suppositions and theoretical extrapolations with little empirical evidence (Orgad and Seu, 2014).

3.1.1. Mediated far-away suffering

Distant suffering comes about in any number of forms, and can be new and surprising, or can be expected occurrences that may have happened previously (Kotísová, 2017). For distant suffering to occur, it is essential for far-away suffering to be observed or otherwise perceived. This suffering can occur in conjunction with dramatic events such as warfare, violence, or atrocities (Zhang and Luther, 2019) and is often tied to a moment of crisis (Kyriakidou, 2014). The suffering is not direct, nor proximal. Rather, this suffering takes place at a distance, and it is mediated, meaning it is conveyed through a medium.

This element of “mediation” was found to be a necessary characteristic of distant suffering in this context. The mediation happens simultaneously with viewing or perceiving the suffering, as the suffering is conveyed through media such as digital technology or texts (Kyriakidou, 2014). The mediation is what forms the character of the suffering witnessed, as emotionally or morally or politically compelling (Kyriakidou, 2014). The mediation situates the recipient, or one who recognizes the suffering, in a “relationship” with the sufferer (Kyriakidou, 2014). Mediation creates physical space or a never-ending distance between the sufferer and viewer. This is fundamental to the situation of distant suffering, in that the viewer is “sheltered” from the exact exposures and is never “in the same situation as the unfortunate” (Boltanski, 1999, p. 153). The medium shapes the experience (Frosh, 2016; Orgad and Seu, 2014), with modern technology, like virtual reality, furthering an illusion of non-mediation (Nash, 2017).

3.1.2. The “recognizer”

When mediated distant suffering occurs, there is a “recognizer,” meaning the recipient or audience who recognizes the distant suffering through the mediated distant encounter. The recognizer of distant suffering may witness or bear witness (Kyriakidou, 2014), to the sufferer(s) depicted (Orgad and Seu, 2014). A Western middle-class audience is part of the stereotypical portrayals in this role (Ong, 2012; Scott, 2014), witnessing mass humanitarian suffering with indifference. The recognizers themselves do not have a direct personal experience of human suffering (von Engelhardt and Jansz, 2014; Zhang and Luther, 2019). The encounter with mediated distant suffering is not merely an observing or perceiving of far-away distress or horror, though, but connotes a reception of suffering or engagement of the witness (Scott, 2014). The recognizer may feel they are “there with the sufferer” in experiences of immersive 360 degree-video or virtual reality (Nash, 2017; Van Damme et al., 2019). Recognizers may also feel embodied presence when witnessing a harrowing film, experiencing physical sensations while “being there” (Ahva and Hellman, 2015, p. 675).

Media “witnessing” means viewers are brought, via images and sounds, into a relationship with what is encountered (Peters, 2001). There are also further implications of this witnessing act. In addition to this emotional and sensory experience, there may also be the action of bearing witness, or describing it, and also an inward experience of witnessing (Peters, 2001). The witness of suffering may instead experience no response or reaction. The act of witnessing includes juridical, historical, religious, scientific (Peters, 2001) and socio-political (Hesford, 2011) considerations, while bearing witness connotes active moral engagement with suffering (Tait, 2011).

3.1.3. A moderator

Distant suffering in media may feature the role of a moderator, or gatekeeper, like an editor, journalist, photographer or producer, who chooses the suffering others are exposed to and/or how it is presented (Zhang and Luther, 2019). This moderator may select which representations (Orgad and Seu, 2014) or symbols (Ahva and Hellman, 2015) of distant suffering are shared in media. They may craft how distant suffering is portrayed in a humanitarian magazine, for example, or control how distant suffering is disseminated to viewers during a news broadcast.

The moderator of mediated distant suffering may use strategies to compel audiences, to more effectively allow the suffering to pass through the medium or to bring the audience closer to the suffering (Huiberts and Joyce, 2017) and elicit desired responses (Binder and Jaworsky, 2018; Huiberts and Joyce, 2017; Maier et al., 2016; Mortensen and Trenz, 2016; Watanabe, 2014). A stronger sense of presence helps elicit a moral response (Nash, 2017), more engagement or more empathy (Nash, 2017; Van Damme et al., 2019) though too much can result in distress and distancing (Ahva and Hellman, 2015). Innovations have been used historically in journalism and photography (Curts, 2015) to this end, aiming to help audiences overcome distance, or allow the suffering to pass through the medium (Scott, 2014).

3.2. Antecedents

Antecedents are the circumstances in place which allow for the concept to come about. These are conditions that precede the phenomena, or instances from which the concept can occur (Rodgers, 1989). For this, the essential aspect identified for mediated distant suffering to come about is social norms or culturally-embedded values that allow for shared understandings. These could also be described as exposures or learning from which individuals gain social understanding of expected responses to suffering. Approaches which convey suffering through media and across a distance are effective because of shared understandings between moderators of distant suffering and the “recognizers” who receive it. Recognizers bring a culturally embedded expectation of responding or wanting to act (Kyriakidou, 2014). These are social norms that carry moral and ethical dimensions to encounters with mediated distant suffering (Huiberts and Joyce, 2017; Kyriakidou, 2014; Mortensen and Trenz, 2016; Orgad and Seu, 2014). A shared interpretation of mediated distant suffering encounters, or expectation of response (Mortensen and Trenz, 2016) arises then as a social construct, because of culturally and socially embedded expectations (Yell, 2012) or views of a shared humanity (Joye, 2015) which connotes a sense of connectedness among all human beings. Within the conveying of mediated distant suffering, culturally embedded values are exemplified in aspects such as sacralization of children in images that go on to become iconic (Binder and Jaworsky, 2018). These antecedents are central for both distant suffering and its consequences to come about.

3.3. Consequences

Numerous possible consequences were identified to emerge from mediated distant suffering encounters. They may include a response, or no response. First and foremost, consequences arise within the socially and culturally constructed normative background described above.

Witnessing distant suffering may carry a moral imperative (Frosh, 2016) for viewers to act. Responses, as such, may arise with expected moral obligations, not only to one who is presently suffering, but to future survivors, or to honor those who suffered in the past (Frosh, 2016). Notably, there is no “right” moral response, nor is a moral response necessarily the “right” response, and responses may emerge from emotional rather than rational reasoning (Huiberts and Joyce, 2017). But, according to Boltanski (1999), viewers are all “moral spectators” and face such moral obligations (Sontag, 2003). A moral response can be so minimal as a “whisper in one’s mind” (Boltanski, 1999, p. 20). Whatever the moral response, if any, it is determined by individual morality within a larger socio-cultural context (Orgad and Seu, 2014). The potential for any response, in fact, can be seen as embedded within the conditions of a larger collective (Mortensen and Trenz, 2016).

3.3.1. Emotional responses of understanding

Conveying suffering via media may be carried out expressly because of the potential for a response, and can be problematic when there is a
lack of response (Orgad and Seu, 2014). The recognizer or viewer is rather then a “voyeur” (Sontag, 2003). Media can help recognizers imagine the reality of what distant others face, and help recognizers take a stance (Zhang and Luther, 2019). Suffering conveyed in media can compel action (Balabanova, 2019), and such actions can include an outpouring of aid (Orgad and Seu, 2014), and messaging for political action (Binder and Jaworsky, 2018; Horsti, 2013; Ong, 2015).

Empathy is a response described as the audience’s emotional sense of care (Huiberts and Joyce, 2017), and can come about when one gains understanding of another’s plight, or a recognizer relates to the sufferer’s pain (Kyriakidou, 2014). Empathy involves a “non-evaluative” (Käpylä and Kennedy, 2014) sharing of another’s affective state (Huiberts and Joyce, 2017). An empathic witness does not turn away, but witnesses and acknowledges the suffering, and engages as such, recognizing the significance of the experience (Frosh, 2016). Empathy could suggest a narcissistic assumption that one could feel in the same way as the recipient of the empathy (Kyriakidou, 2014). Not all agree though, and empathy is also said to go beyond identifying with the sufferer and reflects a universal ethics or cosmopolitanism (Orgad and Seu, 2014).

Sympathy can be a sense of understanding (von Engelhardt, 2015) and acknowledging difficulties encountered by those suffering and a moral desire to help. It is close to compassion (Käpylä and Kennedy, 2014) but, more of a rational or reasoned process (Huiberts and Joyce, 2017), trying to understand another’s difficulties, rather than experience the emotions of another. It can be a way to respond in a caring manner even when empathy is difficult (Huiberts and Joyce, 2017). This could be carried out by the recognizer in looking for familiarity of the sufferer’s circumstance to relate to (Huiberts and Joyce, 2017), but lacks the engagement found in a compassionate response.

For compassion to arise, there must be serious misfortune or marked suffering of another, and this other is not blamed (proportionally) for the suffering they face (Käpylä and Kennedy, 2014). They are rather worthy of compassion (Orgad and Seu, 2014). The compassion-giver finds some similarity (Mortensen and Trenz, 2016) or alignment with the sufferer or their fate. Compassion is perceived as a form of engagement (Kyriakidou, 2014) and implies action is needed without regard to what action (Käpylä and Kennedy, 2014). Some see compassion as an instinctive or involuntary reaction to “co-suffering” (Arendt, 1963), when encountering others who are facing pain or distress (Crisp, 2008). Compassion and such response, however, are socially constructed, and said to be dependent on recognizers’ emotional identities (Käpylä and Kennedy, 2014).

3.2. Inaction and indifference

Consequences of mediated distant suffering can include inaction, indifference and even enjoyment (Scott, 2014). Indifference can present as lacking emotional response or lack even “thinking” about distant others, particularly if a distant sufferer is dehumanized (Scott, 2014). Disengagement can also result from emotional distress of exposure to distant suffering (Ahva and Hellman, 2015) and recognizers may then act to minimize the witnessing experience to shield its intensity or immediacy (Scott, 2014). If distant sufferers are perceived as uneducated or to lack agency to affect change in their lives, recognizers may also be discouraged from taking action (Scott, 2014). Recognizers feeling they themselves lack agency to respond may use this feeling of powerlessness to justify why they do not bother to help (Huiberts and Joyce, 2017). Another form of inaction also arises in the form of “slacktivism” or a most minimal level of political engagement (Christensen, 2011). This is action taken not as a response to the suffering witnessed, but to impress one’s friends (e.g., on social media) (Morozov, 2011).

3.3. Spectatorship, the iconic, and the ironic

The recognizer in the role of a spectator or voyeur is not necessarily one who takes pleasure in ogling others’ pain, but one who takes no obligation to respond with emotion, better yet action toward relief (Orgad and Seu, 2014). This recognizer may even feel a connection with other fellow recognizers, rather than the distant sufferer (Balabanova, 2019). The distant spectacle of suffering becomes a commodity, as voyeurs consume “terror without danger, pity without duty” (Peters, 2001, p. 721). They may contemplate but do not rise to the aid of the distant sufferer.

Spectatorship can include responses that are emotional, political, or reflexive. There are also moral aspects of spectatorship guided by public opinion. This can be observed in iconography of distant images, which depends on socially imposed mechanisms. The “moral” aspect, and its reinforcement through reflexivity can be seen, for example, practiced by social media users in observing iconic images and then sharing emotions or opinions or facts (Mortensen and Trenz, 2016).

The ironic spectators (Choulilaraki, 2013) maintain a view of the distant sufferer from a position of self-centeredness (or how the suffering relates to them, makes them feel) and not in solidarity with sufferers or with a sense of responsibility or care (Huiberts and Joyce, 2017). The victim’s suffering becomes that of the spectator (by proxy), which they then describe to others (Mortensen and Trenz, 2016). Emotional demands of viewing can prompt this (Ahva and Hellman, 2015), and it results in nothing said or learned about the distant sufferer or their situation, only about the spectator (Boltanski, 1999).

3.4. Surrogate and related terms

3.4.1. Surrogate terms

Distant suffering and mediated suffering can be found in near synonymous usage. Distant suffering implies suffering is mediated, but also connotes geographic, physical, or other barriers that preclude direct interactions with the sufferer. Mediated suffering, as a term and field of
research, includes emphasis on the media and its impacts rather than distance. The focus of the present analysis on “distant suffering” demonstrates an emphasis on the role of geography rather than technology (Ong, 2012).

Distant suffering is different from trauma studies, though both fields consider an ethical focus on how pain is represented and how texts bear witness. From earlier works in this field, and with the entanglement of media within the concept of distant suffering, the concept brings “Western” witnesses who are socially and culturally estranged from non-Western sufferers, and critically, who are estranged from suffering themselves (Ong, 2012).

3.4.2. Related terms

3.4.2.1. Cosmopolitanism. Cosmopolitanism can be conceptualized as global compassion, or a moral concern or sense of responsibility for distant strangers (Höijer, 2004). It is defined as an epistemological shift embracing human interconnectedness, an internal globalization or true “global outlook” (Yell, 2012, p. 410). For example, a cosmopolitan news cast would not report “local” and “foreign” news as separate (Yell, 2012). In this worldview, global concerns take an everyday role in people’s moral lifeworlds. It should be aspired to, but with caution for its risk of connoting a prescribed normativity, and notably it remains a theorized ideal.

3.4.2.2. Self-represented witnessing. Self-represented witnessing arises when one’s own agony or trauma is communicated with one’s own words, via one’s own technology (Rae et al., 2018). In the case of social media, a witness can respond and directly communicate with the agent conveying the distant suffering, and who may also be the distant sufferer (Rae et al., 2018).

3.4.2.3. Domestication. Domestication in media is when the global news is made relevant for local audiences by framing these international events in a particular way for a domestic viewership (Clausen, 2004). In the present circumstance, it is practiced to bring the audience closer to distant suffering (Huiberts and Joyce, 2017) by crafting emotional proximity for the recognizer, usually in the form of relevance to the viewer’s home country (Joye, 2015). Proximity can also emerge in membership to one’s in-group, cultural similarities, geographical proximity, or sense of shared experience (Huiberts and Joyce, 2017). An example of this is when foreign news is made to seem more relevant to local viewers (Huiberts and Joyce, 2017; Joyce, 2015) by including an account of the event by someone who looks like the audience, or a celebrity, because a recognizer is more capable of empathizing when they feel more connected to the distant suffering (Huiberts and Joyce, 2017).

3.5. Uses of the concept

Distant suffering is used for conveying information, like reporting on crises by professionals (Zhang and Luther, 2019) or citizen eyewitnessing (Ahva and Hellman, 2015), or to provide digital testimony of atrocities (Frosh, 2016). Distant suffering can be used to elicit a response, and with immediacy (Ahva and Hellman, 2015). This response can be an emotional response, aiming to shock or elicit empathy or sympathy (Zhang and Luther, 2019). It can also be used to create understanding in the way of displaying vulnerability, or to humanize or give voice to the voiceless (Zhang and Luther, 2019), or give a social or moral or political frame to a situation (Frosh, 2016). Distant suffering can be used to emphasize, even quantify, the suffering (Zhang and Luther, 2019) of a distant other, which may be suffering that can motivate a response like political or moral engagement (Horsitivity, 2013) or actions like charity and giving aid (Orgad and Seu, 2014).

Distant suffering is also described in circumstances such as when a self-absorbed witness may face only fleeting concern, but truly is indifferent to the suffering of far-away others (Orgad and Seu, 2014; Scott, 2014). A model case of this could be a “humanitarian tragedy” (Binder and Jaworsky, 2018, p. 7). It may include a simplified brief or even stereotyping view of an “other” (Joye, 2010), and above all, may sensitize how victims or crises are presented. Such instances may be presented frequently in media at one time, and then fade out of popular interest. Examples like this include the aftermath of the 2004 tsunami in Southeast Asia, or the 2010 earthquake in Haiti (Driessens et al., 2012), or when the image of 3-year old Aylan Kurdi washed up dead on a Turkish beach brought attention to the Syrian crisis to the extent that no other reporting had done previously (Maier et al., 2016).

Precise examples of witnessing suffering in media also include modern examples in the use of social media, where any who are willing can observe suffering on these platforms (Rae et al., 2018). These “digital witnesses” can connect, engage with others about what they witness, compel others to take action to halt suffering, and share such actions with other social media users (Rae et al., 2018).

A historical example can be found in the case of Hawthorne, a journalist who was sent to famine-stricken India in 1897 to witness and bring back descriptions of the dreadful plague and starvation there for American readers (Curtis, 2015). Photographs taken were thought to better convey the horrific realities to the readership of The Cosmopolitan, a popular literary magazine at this time. Hawthorne doubted readers would respond to faraway suffering with action, empathy or aid, but they sent letters and donations (Curtis, 2015).

4. Discussion

This concept analysis of distant suffering sought to uncover how mediated distant suffering is conceptualized in peer-reviewed research and explore the relevance of distant suffering for healthcare sciences. Distant suffering is described within fields of media and communications, cultural studies, political science, and in studies in experimental and social psychology. It appears absent from healthcare research, despite the prominent roles of both suffering and technology in patient care.

Discourse on distant suffering emphasizes a moral critique on the ethical use of images featuring suffering, or the dubious responses of audiences when they see it. Boltanski, who coined the term, describes distant suffering as examining the problem of how media portrayals of sufferers can generate viewers to care for these faraway others (Yell, 2012). In distant suffering, an importance is levied on this judgment toward the “other”, the sufferer, and thoughts or actions of those who recognize this faraway suffering. The responses taken, and the influences which define a relationship to “the other” are how morality and humanity are supposedly defined (Scott, 2014). The fact that the suffering of some warrants more attention than the suffering of others is particularly troubling for academics (Joye, 2015).

4.1. Conceptual considerations

Distant suffering arose as an academic inquiry first focused on humanitarian suffering and response to it from persons far away (Orgad and Seu, 2014). These inquiries typically investigated how media entities construct images of the vulnerable (Zhang and Luther, 2019) which in turn dictate knowledge and perceptions of the faraway sufferers. In one way, distant suffering is described as squeezing in all the details of a complicated truth others face (Kotíšová, 2017). But, what also emerges, is that distant suffering is a symbolic representation, or an “immersive storytelling” (Van Damme et al., 2019, p. 2055) inviting recognizers to feel emotions for others (Chouliarakis, 2006). It is tagged as a question of esthetics, not necessarily the psychology of viewers (Chouliarakis, 2006), to do what they do with this knowledge (Kotíšová, 2017).

4.2. Mediation

Mediation is one unique attribute of distant suffering that distinguishes it from witnessing other forms of suffering. Mediation carries
suffering over distance or time, and the medium transforms or recalibrates the social experience. It is in this transcending of space, or this interface, that meaning is produced (Ong, 2012) and in which the paradoxes arising in distant suffering are framed: “media simultaneously establishes and undermines the immediacy of the sufferer” (Choulilarki, 2006, p. 37). The mediation itself is said to enable cosmopolitanism, or drive greater audience involvement (Van Damme et al., 2019). Critiques can easily problematize this mediation, then, and the problem of the suffering itself gets ignored. While mediation plays a critical role in distant suffering, blaming the medium may be used to help relieve pressure on recognizers to respond (von Engelhardt and Jansz, 2014) and justly inaction to relieve the suffering.

Forms of suffering of relevance for health care may also exist where the suffering is distant, meaning physically not proximal, but is not conveyed through media, but could still impact one who recognizes this suffering. As well, suffering that has taken place in the past, could also be considered “distant” for the recognizer, and could be additional areas of research of relevance in this context. Internalized presentations of distant suffering that is not mediated could include, for example, homesickness, which has implications for health and health care. While the relationship of many factors concerning distant suffering remains unexplored in health care, reflections from this analysis gleam a number of considerations that may prove of interest or relevance for future healthcare research.

4.3. Moderating distant suffering in health care

When distant suffering is conveyed, examples of moderators are aplenty within fields of communications, where editors and producers may craft how suffering is conveyed. Within health care, similar roles could be envisioned as carried out by technicians and clinic staff or by caregivers, determining how suffering of a patient is conveyed through a medium, by controlling sound or video transmission on equipment. The role of a self-representing witness could also be envisioned in the healthcare context, where a patient is also a moderator, crafting how their suffering is conveyed to a healthcare provider.

The growing use of health care via the internet, mobile apps, other forms of telehealth, and digital technology in care could provide greater exposures to distant suffering for clinicians, as well as demand by patients to convey suffering via media. In addition, patients and caregivers may increasingly be exposed to distant suffering and its implications via healthcare related exposures, but also in the use of digital media, use of social media or news apps in everyday life. As the use of these technologies snowballs, the potential for a detrimental cumulative impact from exposure to mediated distant suffering remains unknown. These aspects may present avenues for further research, to understand if or how moderators alter distant suffering in health care and to investigate possible implications. This may also allow avenues for potential research on how suffering is conveyed through media to improve telehealth care for patients, improve providers’ provision of telehealth care, or to study how distant suffering can be moderated to disperse, shield, or limit exposures and thus reduce risk for undesirable consequences. Such research may also lend insights to improve interpersonal communications in health care, guiding providers to communicate with patients in ways that most effectively convey health risks, or which best motivate behavioral change for health promotion.

4.4. Shared understandings

Social- and culturally-embedded values were identified as an antecedent, or circumstance that precedes the occurrence of distant suffering, and notably, the only antecedent described in this analysis. Shared understandings were crucial to the socially-bound circumstances that allow distant suffering to arise: defining who is a “sufferer” and giving rise to a recognizer. Distant suffering, as such, demands some shared interpretation or response (Mortensen and Trenz, 2016) or socially constructed truths (Ahva and Hellman, 2015) for it to come about.

In distant suffering, we find images, such as the photograph of Aylan Kurdi. But, images only have meaning in the socially-constructed frame (Käpylä and Kennedy, 2014). A shared understanding worldwide made such response to a single image possible. The picture never tells the whole story, such as in the case of Aylan Kurdi, or the photograph taken in the Vietnam war of the young girl, Kim Phuc, severely burned following a napalm attack (Grice, 2012). The whole story isn’t told when the suffering is conveyed in these images. It is only in that these become iconic, and the spectators or recognizers, as expected, then seek a fuller narrative (Binder and Jaworsky, 2018).

In health care, shared understandings, socially- or culturally-determined behaviors or responses to suffering, may be embedded within healthcare practice, just as medical diagnoses and other aspects of care can reflect “clinical culture”. Formal education, experience, training, and even practice guidelines, also play roles in care, yet all to some extent reflect social and cultural influences. Particularly when relating to suffering, social influences, and characteristics of patients or healthcare providers may determine how suffering is defined or recognized. Further exploration of mediated distant suffering and its response in the healthcare setting may uncover valuable insights of how clinicians as “professional recognizers” recognize and respond to mediated distant suffering in the healthcare setting. Such characterizations could improve interpersonal communications, or in training providers to care for emotional or physical needs. Healthcare sciences may benefit from further research to understand if mediated distant suffering provokes greater or lessened emotional engagement when encountered or witnessed by healthcare providers acting in a professional capacity, for example. This could be of immense value to inform healthcare practice and better understand mediated suffering in increasingly technologically-mediated clinical settings.

4.5. Moral duties and distant response

Responses to distant suffering are not automatic and not necessarily predictable (Höijer, 2004). The cause of the suffering may determine the response (Ong, 2012) or not. As this analysis has uncovered, numerous considerations can play into how distant suffering is conveyed, how it is received, and the response, if any. Influential aspects lie with the sufferer and circumstance, with the mediator and what is conveyed, as well as with the audience. All recognizers of distant suffering are ethically obliged “moral spectators” (Boltanski, 1999). Healthcare providers practice under a code of ethics that may influence perceived professional duty to respond to suffering and how. Whatever the moral response, or if any, it is determined by an individual’s morality within a larger socio-cultural context (Orgad and Seu, 2014).

However, the more “distant” sufferers are, the more difficult it is to convey moral responsibility to the recognizer of mediated distant suffering (Nash, 2017). The act of domestticating is carried out so a far-away sufferer better resembles the intended recognizer or their setting. While this closeness is said to provoke a sense of care for the distant sufferer, it is also asserted that a sense of “otherness” of the sufferer can motivate a response (Nash, 2017). A distance in mediated suffering removes personal connection, which can allow reﬂexivity and detached judgment, and allow cosmopolitanism to emerge (Choulilarki, 2006). When applied to a healthcare context, such aspects of perceived distance or connection with the sufferer may be relevant for understanding responses elicited in healthcare practice.

4.6. Ironic spectatorship and other risks

If one becomes too immersed in distant suffering, also called an “improper distance”, this can result in ironic morality and a focus on the self. This is when the viewer’s own experience is elevated above the suffering of others (Choulilarki, 2013). One can imagine this
occurring if exposed to something particularly troubling, and the recognizer worries more about their own exposure than the circumstances of the sufferer. Affective involvement, as such, may indulge the audience with intense emotions, but then impair their ability to act, and render the witnessing obsolete in effect (Kotíšová, 2017; Kyriakidou, 2014)

Compassion fatigue arises in media studies and describes numbing or desensitization from repeated exposures to distant suffering. It is a concept not without criticism and doubts of its existence (Maоз and Frosh, 2020). Notably, it is seen as a blunted and apathetic response to distant suffering, and not, as the name suggests, a result of over-compasion. Compassion fatigue in the health context is suggested to emerge among care providers as a result of prolonged or repeated empathic or emotional engagement in encounters with suffering, not merely a response to witnessing suffering. In the healthcare setting, it is seen as a secondary trauma among health professionals who experience heightened, untenable sensitivity to the exposure (Orgad and Seu, 2014) and it can result in apathy and exhaustion, which are serious in the professional clinical setting.

Cynicism could be considered a similarly grave risk in the healthcare context. It likely serves as a protective mechanism to shield those exposed to jarring or traumatic exposures. People find ways to distance themselves from the suffering they see (Kyriakidou, 2014; Ong, 2012). But, suppressing of one’s emotions in lieu of cynicism to cope may be a threat to professionalism (Kotíšová, 2017). In many professional circumstances, an immediate and emotional response to affective exposures is not permissible. Work demands and being “in the thick of the crisis situation” may create a circumstance that allows professionals to postpone their response while serving in their role, only for emotions to burst forth once removed from the direct crisis (Kotíšová, 2017). It remains unknown if responses to emotional encounters are inhibited or postponed for healthcare professionals when these encounters with sufferers are distant, or if there may be implications like moral distress if providers are exposed to distant suffering but constrained from responding as they would like. In distant encounters with suffering, mediation introduces a situation that is challenging, yet fundamental for health care to address. Technology allows healthcare providers to meet with patients who are beyond the walls of the clinic. But, mediation does not allow for technological hands to reach beyond the clinic in order to respond (Bauman, 2001), which may challenge moral conscience and impact professional practice.

4.7. Limitations

This study was limited to include only articles published in the past 10 years to ensure relevance to the current use of technology. As such, this study may not reflect fully on the historical development of the concept. In addition, this study is based on literature searches using focused terms. This was designed to ensure inclusion of only the most relevant literature from which initial theoretical discussion in the healthcare sciences could be launched. A future study designed to include broader aspects of mediated witnessing or encounters with suffering may further expand the discussion.

No peer-reviewed articles were identified within the healthcare sciences, and few empirical studies were found. This anticipated dearth of evidence prompted this study to be undertaken, yet presents important limitations. An understanding of the role of distant suffering for health or health care remains incomplete. Meaningful conclusions to inform healthcare research and practice. Use of telehealth, mobile apps and other technology in health care, as well as the prominent role of social media and digital technology in daily life, could mean healthcare providers and other individuals are increasingly exposed to mediated distant suffering with the increasing global use of these technologies.

Distant suffering in health care may bring negative implications for patients and providers. The presence of distant suffering means patients are separated from providers physically, but may also psychologically or emotionally distance providers from the individuals they are providing care for. It is possible this leads to consequences such as pity, cynicism, or indifference of professionals, with negative implications for health care. It remains unknown if distant suffering in healthcare encounters will bring about positive implications for care through lessened affective engagement with patients who are suffering. As the implications and consequences of distant suffering exposures remain little explored in the healthcare sciences, opportunities for further research abound.

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Data availability

Data sharing is not applicable to this article as no new data were created or analyzed in this study.

Declaration of Competing Interest

None.

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