

# Silences in palliative care-the primacy of human presence

## Abstract

Our world is very noisy. It's the shrill sound of deafening music, the unbearable screams of hysterical people, is the constant aggression to our ears coming from mobile commercial advertising, and finally, there is a foreign conspiracy, under various forms of protest, against the need for peace and stillness. The world must think. We need, everyone, to hear more. Life calls for silence and reflection. Respect the patient's silence implicit a deep respect for his personality, a sublime professional act that demonstrate the ethic of the health professional. It is, probably, in the moment of serene acceptance of death, that haunt the quiet periods of silence. The patient no longer wants explanations, is mind grasps the great truth. At such moments the health professionals should not abandon the patient. They must maintain this silence, a understanding glance, the gentle touch of hands. They must establish a better dialogue, never a empty set of words. Caring is also carefully listening, being present, sharing the silence, complicity; be challenged by the lack of words. It's welcoming. This article is based on a narrative review of the literature related with the therapeutic use of silence in end-of-life care.

**Keywords:** palliative care, death, communication, silence, presence, human

Volume 2 Issue 3 - 2018

Paula Sapeta,<sup>1</sup> Ângela Simões<sup>2</sup>

<sup>1</sup>Phd, Master in Sociology, Instituto Politécnico de Castelo Branco, Portugal

<sup>2</sup>Phd, Master in Palliative Care, Instituto Politécnico de Castelo Branco, Portugal

**Correspondence:** Ângela Simões, Nurse Specialist in Medical-Surgical Nursing, Master in Palliative Care, PhD in Nursing, Nurse in Palliative Care Hospital Support and Consultation Team-ULS Castelo Branco, Adjunct Professor, Escola Superior de Saúde Dr. Lopes Dias, Instituto Politécnico de Castelo Branco, Campus da Talagueira, Avenida do Empresário, 6000-767 Castelo Branco, Portugal, Tel (+351)-272-340-560, Email [angela.simoes@gmail.com](mailto:angela.simoes@gmail.com)

**Received:** June 01, 2017 | **Published:** June 06, 2018

## Introduction

Silence reminds us of the dialogue with life, and makes us hear many profoundly beneficial sounds; that are muffled by the neurotic and unhealthy sound of everyday life. In silence we can hear the voice of our own interiority. Our claims are revealed in the sound of agonizing guilt, restless spirit, deep sorrow, the "silent" agony of a bad night's sleep, or not sleep at all. It is in silence that we learn to hear the voice of the heart, and develop a silently dialogue, sometimes difficult, but healthy, with ourselves. It is in silence, too, that we dialogue with life, through the people around us and nature that nurtures us. The silence is, inherently a provocative dialogue, and invariably raises many sounds hitherto unnoticed. The ears assaulted by the noise of day-to-day, do not get, for themselves, the sound that emerges from the needy eyes and beggars gestures of the patients around us. There are things that can only be grasped and understood in silence. *"The silence becomes a lookout for our intimacy. Who is not afraid to be near this viewpoint so high?"*<sup>1</sup>

Before the word "silence" everything gets quiet. Anything, but the curiosity to find it in the middle of words and sounds. The answers follow in the chronology of time devoted to each of our conversations, but it is up to each of us to reveal in the word of others what in us do not shut up. Speech and silence are dependent and defined through the other. There is no speech without silence like there would be no silence without speech, just a universal meaningless, emptiness. According to Foucault the lack, the unsaid, the unspoken determines and defines the very existence of what is said, of the enunciative field. What is present in the words and the sience of the patient is defined by what is not. Sharing the unspoken is a invitation to step into the unusual world of the patients, between words, where the time between a visit and another leads us gently to the one that follows it. The singularity, expressed the multiple possibilities that the silence evokes. What we

heard here, also awakens in us the chance to live it - in the extent possible for each one - not as a goal, but especially as a path. Port to the unsayable, Silence, invites us to find in the dissonant voices, the silence within us.

Our tendency as professionals willing to help is often translated by an intrinsic need to act, provide answers, say something, as if everything could or should be answered. *"Somewhat ... We have low tolerance to the silence of others. On the other hand we have no time or much desire to listen."*<sup>1</sup> In palliative care the patients require of the professionals who care for them, listening skills, in order to see recognized the singular importance of his person. But listening is not just ear carefully, requires education and training in recognizing the importance of the other. Listening is an active and voluntary process in order to truly understand the sounds and the silence.<sup>2</sup> Silence always occurs within a context, as a multi-faceted and multi-functional phenomenon.<sup>3,4</sup> So is acknowledged as a complex phenomenon, more than simply an absence of speech. Silence implies voice. It does not equal muteness, it is not the absence of sound our speech.

Jacob<sup>5</sup> argues that silence is not opposed to verbal language. Establishes a circle of language that is only possible if we keep quiet. Distinguishes two types of silence during the interaction of communication: opening and closing. The first means that you need to listen to be able to talk. These silences of opening are charged against a silence of finishing, the order of intuitive understanding and that makes all the discourse development. If understanding is funded by listening, all the talk is always on the background of silence. *"Listen to others and feel what they really want to communicate requires a change of registration, the use of a different «language»"*<sup>1</sup> Actively listening to the patient is silence the inner voice that has an absolute need to respond all with words. According Lazure, cited by Querido,<sup>6</sup> be attentive to silence is listening to what the other lives deeper.

## Tearing down the “wall of silence”

There are silences, when someone crosses the final phase of life, that are not beneficial, that should be overturned. According to Wiesel, quoted by Jacob, there are silences cold and hard, which divide, deny, judge.<sup>5</sup> The silence is fundamental to communication but should not be used as a shield against difficult questions. Thus, the silence can be used as an escape. According to Sciacca, cited by Serra,<sup>7</sup> futile and meaningless words are hollow, are just voice. Equally a pointless silence is a “naked” silence. Likewise, Dauenhauer, quoted by the same author, argues that silence is not absence of audible sound, because the therapeutically silent necessarily involves an active conscience.<sup>7</sup> Following this line of thought, in palliative care can not be allowed the omission of information, silence conspiracy and quiet trails, all the annihilating forms of silence in the communication. According to Amorós, cited by Serra *“The dumb want to speak but can not, the one that is quiet can speak but do not want, and it is, precisely the nature of voluntary choice that makes the silence so significant.”*<sup>7</sup> According to Twycross, if we do not talk to patients, we not prevent the inevitable to happens. We must be honest with ourselves and wonder if our silences protect the patient or protects us from an embarrassing situation by not knowing how to handle it.<sup>8</sup>

## The silence in the environment

According to Bergold is common to hear complaints about the difficulty of sleeping at night in a hospital, for many reasons: interruptions for therapeutics administration, lights, sound of footsteps, strange noises, conversation and laughter. The author advances an explanation for this “neglected” attitude by professionals. Perhaps this attempt to keep the noise is a need to dispel the silence and fear.<sup>9</sup> *“Man fears the absence of sound as he fears the absence of life ... the final silence is death.”*<sup>9</sup> Scientific tests cited by Bergold, reveal that even brief periods of loud conversation are enough to affect the nervous system and cause constrictions in much of the circulatory system. Palliative care professionals should be redoubled care with judicious use of sound. Dealing with individual and specific patients suffering from multiple losses, in an everyday attempt to transcend, it’s important to choose the sound that surrounds them. Choose the way of caring: noise and unpleasant sounds, music that the patient like or simply silence. Decide which sounds exists in our work environment is to choose between being careful or practice “sloppiness.” When we entered the room of someone who approaches death the silence feels at once, which differs markedly from the bustle outside. *“The matter of silence exists, sometimes insists, and always longs to be said, rightly, in the fullness of meaning that can be heard.”*<sup>10</sup> This silence invites us to enter in to the patient world. *“The silence shared with someone who has wings in the heart and is ready to leave is contemplative. Words are not necessary, because who says goodbye says it all, without saying nothing.”*<sup>10</sup>

## The therapeutic silent

The essence of the work with others is to be present as a living being. What matters is a human being with another human being, recognizing the other person as another person. If the patient make eye contact he need to see honesty and presence. He may not look. But if he does he need to see it. Maybe he see some anxiety, some insecurity that we own, I have learned that is normal. I do not need to feel emotionally secure and look firm. Only need to be present. There is no given qualification to the kind of person I should be. The only

requirement for a good therapeutic process is the presence. Lozano, cited by Bifulco: *“... just «be with the patient» is an effective form of communication, is what we call the therapeutically silent ...”*<sup>11</sup> There are times, during the relationship established with the patient, that the communication process becomes confusing. I stop, try to go back and empathetic “feel” the patient, understand its interior. *“We must focus our attention on the patient and the environment to reflective listening the silence of the patient”*<sup>12</sup> Leave the formulas, protocols, and look at the patient in the same way that he looks at me. Also important is the ability to empathize with the silence of the patient, as active presence, to convey a true understanding of what he mean. *“The silent person is beyond words.” Prudente,<sup>12</sup> is a “container of words”*<sup>12</sup> There are many characteristic silences during the final phase of life. *“Notice the silence that comes around. It is part of the reason for listening. You hear what the patient wanted to tell you and you answered. Now you have nothing to say and feel the problem. Is not all solved, of course. You have not a clear feel of this - right there - a confusing side. You feel it physically, without no more words”*<sup>14</sup>

There is where we should stand, at this confused point, not trying to fill this space with words, respect the silence and learn from it. *“The silence will speak louder than words ... he substitute the unnecessary and inconvenient phrases”*<sup>11</sup> The acceptance of the limits of empathetic language, the therapeutic silence, accomplishes what the words can’t, respect and non-abandonment.<sup>15</sup> The study made by Durman, regarding the construction of therapeutic relationship for nurses, concludes that the elements identified in this relationship were: reflective listening, use of touch and hold the patient’s hand during the interaction, be sensitive to their feelings and silences, empathy and involvement.<sup>16</sup> When the patient asks about troublesome issues for which we have no answer, silence becomes the only way to communicate. *“About what one can not speak, has to be silent.”*<sup>17</sup> According to Wittgenstein, is not the impotence of talk about what bothers us but recognizing that there will be limits to what can be say, beyond which the silence stretches out her mantle.<sup>17</sup>

Elisabeth Kubler-Ross,<sup>18</sup> in relation to the process of death and dying, when the patient lies between the preparatory stage of depression and acceptance stage, is essential to let the patient verbalize their grief, without encouraging phrases or optimistic conversations. The patient needs to live the losses to grief their life. *“In preparatory grief there is little or no need for words. It’s a feeling that is expressed mutually, translated, in general, by a tender touch in his hand, patted the hair, or just by a quiet “sit alongside”*<sup>18</sup> Altemeyer, quoted by Prudente,<sup>13</sup> argues that one should only speak when what we have to say is more precious than silence. *“The empathic ability translates into a particular sensitivity to identify the emotions of others, understand the situation from the point of view of others and try in yourself the emotions of others”*<sup>16</sup>

But the time will come when we will leave the answer purely empathic and enter into the true field of compassion. Compassion *“a virtuous response that seeks to address the suffering and needs of a person through relational understanding and action.”*<sup>19</sup> In this field silence will become truly therapeutic. From the compassion perspective, silence is not a instrument to be used with a specific set of indications and meanings. Instead *“patients can experience as a profound kind of being with, standing with, and contact in a difficult moment. This kind of silence can nurture a mutual sense of understanding and caring”*<sup>20</sup>

According to Back et al.,<sup>21</sup> for this silence, truly therapeutic, to emerge, it is necessary, that the health professional as the competent of:

- i. Give attention for the purpose of understanding the patient as a whole person.
- ii. Maintain focus and set aside distractions common in clinical settings.
- iii. Clarity of perception free from distortion or bias.

### The silence of those “who care”

After the death of a patient with whom we have established a deep relationship, feels in the whole team the “shock”, regret, nostalgia ... it creates a dome of silence, for minutes, for days. “We looked at each other full of questions that we dare not utter. And so, we protect ourselves from one another with a pathological silence”<sup>10</sup> This silence becomes too heavy to bear. It took me a while to understand that these “walls of silence” could not bring a good result. I learned that after the death of a patient there is always something more to say, so it is essential to work as a team. A team that welcomes its wounded members in times of weakness. That welcomes them in silence. Professionals also need active listening, to be heard by someone who is able to establish an empathic relationship. “With a analyst silent my counselor listened to me and I exorcise the ghost.”<sup>10</sup>

Before entering the room or the house of a patient in the final stages of life, we should prepare ourselves for the caring and sharing that will take place. After the loss of a patient, each professional should reserve for itself a period of withdrawal, inner listening, silence. “The silence allows a pause in the theatre of life. It takes us behind the scenes where the roles are again recalled and updated. After this moment of rest and meeting with our intimacy, we are prepare to get back on the scene”.<sup>1</sup>

### Conclusion

Silence lets us hear the flawless symphony of sounds of nature, manifest in both the lightness of the wind that turns into a breeze that caress the trees, and the flight of birds chirping; in the therapeutic “noise” of the movement of the waves, in the serenity and peace of those who approach the farewell. And, in silence, we discover and delighting in the world. “It is indeed a “be quiet” that characterize the human order, replacing clarity and distinction to the human turmoil and making it possible the action on the rubble of the excitement”<sup>15</sup> According to Ahya et al.,<sup>22</sup> in the context of palliative care, when words have no real sense, when our knowledge hit a great impotence, it is still possible to enter in the complex world where the contact, the look and body language become the only messengers of the deep communication with the other.<sup>22</sup> Sharing this need for silence is provide quality care. Being present in silent with another person who is suffering is recognised as challenging. Which brings us to the breakdown of these moments of extreme deep wealth and ruin the deep relationship that could have established that instant, is the impotence and inability to manage emotions and silences. Several papers describe it as an act of non-abandonment demonstrating willingness to remain in an uncomfortable place.<sup>15,23,24</sup> “But change can be stressful and uncomfortable because it leads to an individual confrontation.”<sup>1</sup>

Tornøe et al.<sup>25</sup> find that being in silence requires a mental shift from ‘doing something for the patient’ to ‘being with the patient’ (p.6) and this demands personal courage. Silence, as presence, is a difficult skill to master, it takes experience, and practise. It involves letting go of ego and a shift of focus from self to other that is integral to compassionate care.<sup>26</sup> It is essential to preserve this silence that is on the verge of extinction in a world that lives in a hurry. The kind of silence that allows us to meditate, contemplate and feel. “The silence that allows us to feel the presence of someone, very close to us, and that, despite the buzz of gestures, listen without talking.”<sup>27-29</sup> This article not seeks to provide answers, but to stimulate discussion, and new research and interpretation. We need to deepen understanding the quality of therapeutic silence as a core element of care. Which, although intangible, will always be fundamental.

### Acknowledgements

None.

### Conflict of interest

The author declares no conflict of interest.

### References

1. <http://terrasdabeira.gmpress.pt>
2. Querido A. Listen in palliative care-where silence is worth a thousand words. *Nursing Journal Lisboa portugal*. 2004;185:24–28.
3. Hill C, Thompson B, Ladany N. Therapist use of silence in therapy: a survey. *J Clin Psychol*. 2003;59(4):513–524.
4. Sabbadini A. Listening to silence. *BJP*. 2004;21(2):229–240.
5. Jacob A. *Introduction to philosophy of language*. Porto, Portuga: Rés-Editora; 1984.
6. Serra R. *The place of silence in the communication process*. Tesis doctoral presented at the University of Salamanca, Department of Classical Philology, French and Hispanic; 2001.
7. Twycross R. *Palliative Care*. Lisbon, Portugal: Climepsi Editors; 2003.
8. Bergold L. Music for care humanization. *Online Brazilian Journal of Nursing*. 2003;2(3).
9. Cunha TC. *The silence in communication*. 2004
10. Teixeira M. The painful silence of those who care. *Journal of Bioethics*. 2002;98:83–87.
11. Bifulco V. *Speaking of death*. 2006.
12. Takaki M, Santana D. Empathy as the essence in the customer care team of nursing for a basic health. *Cogitare Nursing Magazine*. 2004;9:79–83.
13. Prudente G. *Silence is well outside the body and in mind*. 2005.
14. Gendlin E. Steps in the therapeutic process. In: Gendlin ET. *Focusing y Experiential Psychotherapy*. Alemany C Bilbao Publisher; 393–409.
15. Capretto P. Empathy and silence in pastoral care for traumatic grief and loss. *J Relig Health*. 2015;54(1):339–357.
16. Durman S. Nurses build a therapeutically relationship in general hospital. *Cogitare nursing magazine*. *Curitiba*. 2004;9:44–53.
17. Wittgenstein L. *Logical-philosophical*. Lisbon: Calouste Gulbenkian Foundation. 1987.

18. Kubler-Ross E. *About death and dying*. São Paulo: Editora Martins Fontes; 1996.
19. Sinclair S, McClement S, Raffin-Bouchal S, et al. Compassion in Health Care: An Empirical Model. *J Pain Symptom Manage*. 2016;51(2):193–203.
20. Back A. Approaching difficult communication tasks in oncology. *CA Cancer J Clin*. 2005;55(3):164–177.
21. Back A, Bauer-Wu S, Rushton C, et al. Compassionate silence in the patient–clinician encounter: a contemplative approach. *Journal Palliative Medicine*. 2009;12(12):1113–1117.
22. Ahya P. *Challenges in palliative care nursing*. Lusociencia. Loures; 1999.
23. Moriichi S. Re-discovery of silence in pastoral care. *J Pastoral Care Counsel*. 2009;63(1-2):1–6.
24. Savett L. The sounds of silence: exploring lessons about silence, listening, and presence. *Creat Nurs*. 2011;17(4):168–173.
25. Tornøe K, Danbolt L, Kvigne K, et al. The power of consoling presence–hospice nurses’ lived experience with spiritual and existential care for the dying. *BMC Nurs*. 2014;13(25):1–8.
26. Bassett L, Bingley A, Brearley S. Silence as an element of care: A meta-ethnographic review of professional caregivers’ experience in clinical and pastoral settings. *Palliative Medicine*. 2018;32(1):185–194.
27. Sá E. *Make your way to me and let yourself be*. Dafundo: Oficina do Livro; 2002.
28. Himelstein B, Jackson N, Pegram L. The power of silence. *J Clin Oncol*. 2001;19(19): 3996.
29. Stafanelli M. *Communication with patients- theory and teaching*. São Paulo: Robe Editora; 1993.