



## Silence about encounters with dying among healthcare professionals in a society that 'de-tabooises' death

Ellen Ramvi\* and Birgitta Haga Gripsrud

\*Corresponding author: University of Stavanger, Norway

Email: [ellen.ramvi@uis.no](mailto:ellen.ramvi@uis.no)

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### Abstract

*Background:* Empirical studies on healthcare personnel indicate that professionals' experiences with dying and death become silenced and unutterable within the healthcare service.

*Aim:* To explore and interpret silence about encounters with death and dying among healthcare professionals in Norway.

*Method:* The method used was theoretical exploration, using a psychosocial approach.

*Findings:* This analysis reveals complex interrelations and two-way dynamics between subject-worlds, sociocultural and societal worlds when it comes to dealing with death and dying at work. A performance culture saturates these worlds, and may be implicated in silencing death within the healthcare institutions of the Norwegian welfare state.

*Conclusions:* This article suggests that silence about death and dying among healthcare professionals is indicative of crucial emerging and unresolved tensions in the neoliberal episteme, accompanied and reinforced by the ineluctable basic conditions of life and intrapsychic defence against threats towards the self.

*Implications for practice:*

- Silence about death and dying presents a serious challenge for dying patients and next of kin. Healthcare professionals should be enabled to acknowledge their thoughts and emotions about death in order to be able to support and contain patients and next of kin
- Learning activities such as peer support and supervision can help the processing of difficult psychological content and allow for emotional aspects of professionals' work to be acknowledged and thought about in a way that encourages reflective and sound practice
- Clinical managers should address whether performance pressures induce shameful feelings in staff, who may believe that by providing appropriate levels of care they are compromising productivity. Shame in turn, may undermine professionals' emotional wellbeing and ability to continue to provide attuned and adequate care for dying patients
- Creative approaches to facilitate reflection on this difficult topic could be encouraged by introducing death as a cultural trope (for example, by the symbolic use of art, literature, music) into clinical contexts

**Keywords:** Death and dying, communication, social defence, healthcare professionals, shame, psychosocial approach

### **Introduction: unwrapping a paradox**

As members of a research group in Norway that focuses on professional relationships in welfare professions, this article's authors have been involved with several studies of how working with death and with dying people affects healthcare professionals. Through research interest on professionals' experiences with death and dying the authors have witnessed the emergence of an apparent paradox: on the one hand, there seems to be an ongoing sociocultural de-tabooisation of death in Norwegian society, while on the other, research (Pollestad, 2015; Ådland and Ramvi, 2016; Moen, 2016) repeatedly indicates how professionals' experiences with death and dying are frequently silenced and not speakable in the healthcare services. This recurrent finding is confirmed by the sparse national and international literature on the topic. Therefore, this article will explore, through a psychosocial approach, how this silence can be understood. It will start by expanding on the paradox mentioned above.

#### *Death and dying – a dissolved taboo?*

Through significant advances in medicine and improvements in social health, death has increasingly become an 'exceptional event' in the developed world, rather than a fateful and unpredictable occurrence of daily life (Ariès, 1976, 1981; Kellehear, 2007; Laqueur, 2015). This coincides with a change of settings: death and end-of-life care has moved from the home to institutions for care and treatment (Kaasa, 2008). In his classic study, Philippe Ariès (1976; 1981) identified death in modernity as invisible and banished, characterised by secrecy, denial and taboo – a medical event governed by professionals and hidden away in such institutions. In late modern Western societies, it appears not much has changed: death is still referred to by some as the last taboo, and most of us do not know much about dying (Jacobsen, 2001). Death has, in some ways, become a 'novelty' event in our lives (Ariès, 1981, p 560). Referring to a Nordic context, the Danish sociologist Michael Hviid Jacobsen (2001) claims we do not easily relate to death and find it hard to talk about.

In contrast to this dominant cultural narrative of our time in a part of the world where death is identified as unknowable and unusual, in recent years we have seen some striking developments towards a public de-tabooisation of death: death has become an emerging cultural trope. This article will illustrate this, through examples from a Norwegian context. A crucial event in this national context came with the 2010 publication of a book entitled *Death, shall we dance?* (Fuggeli, 2010, author translation). Its author Per Fuggeli is a Norwegian professor of social medicine and a prominent public figure, who happens to be living with a terminal cancer diagnosis. Fuggeli claims that in life we push death away from us into a prison of forbidden words. He says that although the zeitgeist generally invites openness and honesty about many difficult facets of life, death is not invited into this open landscape – it is, in correspondence with Ariès' claim, the last taboo. The book was well received in Norway and, perhaps strikingly, given its direct confrontation with this final taboo, Fuggeli's contribution was not ignored as an unpleasant reminder of a collectively dreaded reality. Instead, he was heralded as a taboo-breaker for having initiated what was felt to be an important public debate. He was subsequently awarded a prestigious national prize for freedom of speech in 2013, as Norwegian society welcomed his intervention and appeared to acknowledge that death is a subject we can no longer afford to ignore.

Despite his observations on death, Ariès also noted how attitudes towards death tend to be static but that 'at certain moments, changes occur, usually slow and unnoticed, but sometimes... more rapid and perceptible' (1976, p 1). This article speculates on whether now is such a moment, with Fuggeli's book perhaps acting as a precursor to a significant social change concerning death. In support of this speculation, Christensen and Sandvik (2014) indicate that in the 21st century, death as a silent, introverted and private phenomenon has become subject to significant social changes influenced by globalisation, individualisation and social media. Hegle (2014) concurs that death is indeed no longer the great unmentionable; her analysis of contemporary Norwegian culture places death as the subject of a great deal of attention. TV, news and social media provide new opportunities to 'tackle', think about

and mourn death in a manner unknown to previous generations. Walter (*in* Kofod and Brinkmann, 2017, p 5) refers to contemporary Western grief culture and points out how it is characterised by ‘an interplay between public provision and private experience’. Mourning may become a public event: the media provide us with intimate insight into celebrities’ deaths; funerals are documented through video, to be replayed; and websites feature digital memorial protocols, mourning support groups and advice on funeral planning. In Norway, several blogs have appeared thematising death, including one by the father of a dying seven-year-old (2013, [tinyurl.com/pappa-engel](http://tinyurl.com/pappa-engel)). His Facebook profile attracted 90,000 followers, who commented on his posts and sent him messages of support throughout his daughter’s terminal trajectory.

‘Death cafés’ are another remarkable phenomenon in Norwegian society ([dodskafe.no](http://dodskafe.no)). In a death café members of the public are invited to engage in conversation, to enable people to think and talk about end-of-life issues. Likewise, ‘last aid’ courses – as opposed to ‘first aid’ – have been established to inform people about end-of-life care, with the stated aim of contributing to a public debate about death ([palliativ.org](http://palliativ.org)). The Norwegian Cancer Society has also arranged public debates about death, asserting that death is an important topic for everyone to talk about, as well as curating a photo exhibition entitled ‘Life with Death’. Death has also made its mark on national TV, where the series *The Coffin* ([tinyurl.com/nrk-coffin](http://tinyurl.com/nrk-coffin)) challenged celebrities to direct their own funerals and explore their relationships to death. In another Norwegian TV documentary series called *Friend in Death*, ([tinyurl.com/nrk-friend](http://tinyurl.com/nrk-friend)), the presenter was on a quest to find out how to be a good friend to someone who has lost a loved one.

How can we understand this almost playful engagement with death as entertainment? Perhaps Laqueur (2015, p 27) is onto something when he suggests that in the postmetaphysical age we still comfort ourselves by ‘[keeping] the dead present, however tenuously’. Walter (*in* Dalgaard, 2010) mentions similar reconfigurations of death as ‘the dissolved taboo’ – disintegrating because it is undermined by a more expressive counterculture, which emphasises openness and expression of feelings and dread rather than their suppression. As indicated above, there appears to be a cultural tendency in Norway that may support this hypothesis. However, this article will proceed to juxtapose and problematise ‘the new openness’ (Österlind et al., 2011) around death in Norwegian culture through examples from a far more confined representational space in the institutional settings where health professionals regularly care for the dying and thus experience ‘death at work’ (Moen, 2016).

#### *Death as a silent subject among healthcare personnel?*

National strategy documents identify death and care for the dying as one of the most significant challenges for healthcare services in Norway (Ministry of Health and Care Services, 2012-13). Healthcare personnel are expected to be professional in encounters with dying and death. Numerous authors have focused on the necessity of openness and communication about death between healthcare professionals and dying patients and their families (for example, Dalgaard, 2010; Gjerberg et al., 2010; McCourt et al., 2013; Nyatanga, 2013; Robinson et al., 2014). In their literature study, Gustafsson and Malmlöf (2012) identify how patients face great difficulties in talking to their relatives about their fears regarding death. In these situations, it is crucial for patients and relatives that the nursing staff are able to facilitate and enable such difficult conversations. In this context, providing professional care for dying patients and their families, would require what Trier (2016, p 49) refers to as a capacity for ‘courageous presence’. However, a stark contrast to this courageous presence is provided by Sæteren (2011), who describes a Norwegian care context where ‘there are few conversations concerning the patient’s existential situation and prospective death’ between nurses, patients and their families (p 34, author translation). Sæteren concludes that talking about death in healthcare is still subject to taboo – not as a general topic – ‘but when it comes to the story of “my own death” there appears to be limited space, even when one is seriously ill, for talking about the inevitable’ (p 35, author translation). Some studies indicate that there is a need for more professional training in how to talk about death and dying with patients and their families, while others make links between the capacity to communicate

to patients about death and healthcare professionals' capacity to reflect on the prospect of their own death. For example, Nyatanga (2013, p 421) acknowledges that when it comes to death and dying, we as healthcare professionals 'need to be comfortable ourselves first in talking about it'. Similar concerns have been raised when it comes to nursing education. Hardeland (2009) has studied how Norwegian nursing students are prepared for going into palliative care, and concludes there is a lack of attention given to students' own experiences, their attitudes to death and how they relate to their own death anxiety.

Despite the urgency of this topic for professionals, the research literature on how healthcare professionals talk to each other about experiences of dying and death at work is sparse. There are some exceptions – for example, Österlind et al. (2011) describe how in Swedish nursing homes 'death was held at bay, and the emotions experienced by the staff when an old person died, were ignored' (2011, p 538). Death experiences were also reported to be silent among nurses in Norwegian home care (Ådland and Ramvi, 2016) and in hospital (Pollestad, 2015). Nurses in home care referred only to superficial small talk about death at work, with one saying: 'We don't really tend to go into great depth, because it's just a part of the job' (Ådland and Ramvi, 2016, p 53). In his study of healthcare personnel's (nurses, physicians and chaplains) experiences with death at work, Moen (2016) found they had limited opportunities to communicate their feelings around and experiences of death. Interestingly, findings from an Asian context mirror this situation. Chang and Tin's (2012) study finds that 'support from the workplace is still limited for helping professionals who do death work. For example, supervision is often administrative, and there are no regular meetings or activities scheduled to deal with the stress of hospice staff in Hong Kong' (p 909). As will be indicated, this description is equally valid in the Norwegian context.

It was curious to discover that there is so little research on communication about death among healthcare professionals, and that the few studies that do address this research deficit have found, as indicated above, that healthcare professionals do not really talk to each other about experiences with death at work. Thus, the apparent cultural de-tabooisation of death identified as a prominent new feature in the Norwegian public sphere is hard to discern among those whose professional task it is to work with dying people in the healthcare sector. This is somewhat puzzling – one might expect that healthcare professionals would welcome openness around death, as an integral and challenging aspect of their daily work. One might even expect healthcare professionals to be at the forefront of an exposition and de-tabooisation of death, yet this has clearly not been the case. Hence, the research question to be pursued further in this article is, how can we understand that healthcare professionals do not talk about experiences of death at work? This article will explore this theoretically through a psychosocial approach.

#### *Methodological approach*

This article uses a psychosocially informed theoretical lens to examine the phenomenon in question. Psychosocial approaches have emerged, particularly over the past 20 years (Walkerline, 2008) to address a disciplinary gap between sociology and psychology. Psychosocial studies are frequently motivated by a desire to understand how the human being's 'inner' conscious and unconscious psychological world forms and is formed by the 'outer' societal world, and vice versa (Froggett, 2002; Lundgaard Andersen and Dybbroe, 2011; Ramvi, 2011). Hence, a psychosocial approach typically attempts to describe, interpret and understand connections between intra- and interpersonal, institutional, cultural, and societal dimensions of experience. According to Cooper and Lousada (2005, p 2) psychoanalytic theory and concepts, often considered integral tools in a psychosocial approach, can make 'a vital contribution [to] the understanding of modern welfare'. The authors further argue that there is a need to integrate emotional experience both in scientific approaches to research healthcare and in welfare policy and practice: 'Integrated thinking and analysis cannot be achieved without a link between the rational and the emotional, and between the rational and the irrational' (Cooper and Lousada, 2005, p 3).

In the following, this article applies the psychosocial approach according to this progression: first it discusses the intra- and interpersonal dimension of experience, pointing to some basic conditions for human life, of which death is a crucial one. The article shows how the psychic (from psychoanalysis, meaning psychical, psychological, mental) processes of projection, introjection and containment continually shape human experience, intersubjectivity and the capacity to think throughout life. Then the institutional dimension is discussed, as the arena within which healthcare professionals operate with their personal and professional capacity to care. Considered next is a societal dimension, which imposes or perpetuates certain restrictions on healthcare institutions and the healthcare professionals working in them. Regulation mechanisms in the institutional framing are identified as well as conditions for healthcare professionals to voice their experience of working with death within this frame. Finally, to wrap up the research question, the article concludes by drawing together societal, personal and institutional strands as mutually constitutive components of the explanation for why healthcare professionals do not talk about death at work, despite being citizens in Norwegian society which, through an emerging field of cultural representations, reveals an increasing curiosity about death.

### **The intra- and interpersonal dimension: a given and a relational framework for self**

The foremost, but also threatening, characteristic of being human is that we are determined and driven by something non-willed (Vetlesen and Stänicke, 1999). This notion stands in stark contrast to the dominant late modern mindset, where humans are frequently imagined as capable of self-interpretation and understanding, of being in charge of themselves. However, the non-willed aspect of human subjectivity is considered by Vetlesen and Stänicke (1999, p 236 ) as an undeniable part of the ineluctable basic conditions of life: vulnerability, mortality, the fragility of relations, dependency and existential loneliness. Within this given framework for life, every human being develops a self through their relationship to primary caregivers. This relational framework for the development of self was described by psychoanalyst Wilfred R. Bion as 'container-contained' (1962). Through his conceptual framework he provided an image for the emotional qualities and experiences that must be present in the early dyad so that thinking and understanding may subsequently develop in the infant. Bion suggested that at the most primitive level, the anxieties of the infant are associated with death, fear of annihilation – a 'nameless dread' (Bion, 1962, p 96). The infant is dependent on a capacity to split off such unbearable feelings. Typically, in a container-contained relationship the caregiver becomes the recipient for the infant's split and projected feelings, welcomes this and ponders over it before responding to the child in a way that enables the child to take back, or introject, its feelings in a more 'digested' and bearable form. Through responding creatively and feeding back an understanding to the child, the caregiver functions as a container for the child. The infant internalises a caregiver who has the capacity to receive and transform anxiety and frustration, and the caregiver shows the infant that it is possible to bear pain through thinking, to 'contain' or accommodate one's feelings. To contain one's feelings is thus the opposite of splitting. As a concept container-contained thus symbolises the experience of being taken care of and taking care of, emotionally.

Experiences of primary relationships are part of every human being, and continue to inform us throughout life as we find a place in society as citizens. What is crucial to the discussion here of health professionals' communication about death, is that unconscious intersubjectivity continues throughout life as we learn to use ourselves and others as containers to help us think about what is hard to bear. However, splitting – our earliest defensive strategy – also continues to accompany us throughout life as an unconscious defensive strategy when threats to the self are too difficult to contain.

### **The institutional dimension: the public healthcare service and conditions for healthcare professionals' communication of death**

This article's psychosocial analysis now moves on to the context of public health service, where healthcare professionals face working with death on a daily basis; it explores how the professional's relation to death affects, and is dynamically affected by, the personal and institutional – and how the institutional in turn affects, and is affected by, the professional and personal.

### *Witnessing death involves strong emotions*

To provide insight into experiences from the clinic, this article draws on unpublished data produced in one of the studies emerging from the authors' research group (Pollestad, 2015), where the first author (ER) has supervised a masters project. Permission has been granted by the masters student (Kathrine Pollestad) to use the data in the context of this paper. Six nurses from medical wards in a Norwegian hospital were interviewed about their experience of witnessing death and encountering dying patients and their families. The nurses' stories illuminated the strong emotional impact these experiences had on them as professionals, clarifying how personal the professional experience of death and dying is. However, as it turns out, these personal experiences were practically silenced in the healthcare work context. One nurse said she thought about the death of patients when she came home, and pointed out that there is 'no space or time to talk about it at work'. This turned out to be a repeating story. Another nurse described her first experience of a patient with cardiac arrest, a young woman. The nurse had felt beside herself, helpless, deficient and unable to contribute to the care. She said:

*'When I came to work the day after and had slept badly during the night, there was nobody in the management who asked – or talked to me... [about it].'*

None of the nurses interviewed referred to routines for talking about their personal experiences of death on the ward, whether they were novices or experienced nurses. Another nurse illustrated how difficult this area of experience can be to give voice to at all:

*'I feel in a way it's an "out of yourself" experience. I don't know – it is a peculiar situation to be in. I sort of don't feel that I'm myself but almost in another person, who is going to tell next of kin what has happened.'*

Feeling 'out of yourself' here suggests a psychic experience that pushes the very margins of the nurse's conscious perception. Sæteren (2011) refers to this sort of experience as an 'anxiety of suffering', which appears to lack a language. Moen's (2016) interview study on professionals in end-of-life care found that a conflicted sense of responsibility and guilt ran across the cases – because there was shame related to death work and/or that there was a lack of words for it (p 292). The danger of absence of expression and reflection is, this article would suggest, that when difficult emotional experiences are not allowed to be symbolised or become the subject of acknowledgement and reflection, then the professional's experiences cannot be 'digested' (contained) and so cannot be thought about and learned from (Bion, 1962). This could have severe and detrimental consequences for professional end-of-life care practice. However, through the psychosocial approach this article would suggest that the phenomenon of silence described above extends beyond individual practice. The authors pursue this by exploring conditions for communication about death among healthcare professionals at the institutional level in light of the theory on social defence systems.

### *Social defence*

The concept of a social defence system (Jaques, 1955; Menzies-Lyth, 1959) is based on the assumption that an organisation may develop different types of social structures and cultures to alleviate the emotional tensions of employees. In other words, the social defence system accounts for how organisations may provide protection against mental pain. In her groundbreaking study, Menzies-Lyth (1959) identified how a social defence system in a UK hospital resulted from an unconscious collusion between nurses to protect themselves against the anxiety, guilt, doubt and tensions that arose through their work with patients. Drawing on object relations theory, she identified how nurses protected themselves from unpleasant feelings through splitting and projection (see the discussion on container-contained above). Unpleasant feelings were projected into the social structure and culture in the workplace. Menzies-Lyth made it clear, however, that she did not believe the (nursing) organisation as an institute carried out this defence – in that psychic defence can only be carried out by individuals. She identified behaviour as the connection between the individual's mental defence and the institutional practices. One of her main findings was that the presence of a social defence system in the hospital was counterproductive to developing the nurse-patient relationship.

Could the silenced or absent conversation about death between healthcare professionals in the clinic be the result of such a social defence system? If healthcare personnel and healthcare institutions, through their practices, cultures, structures and norms, play down the experience of, or need to reflect on, mental pain associated with and connected to working with dying and death, this multilayered avoidance strategy could be interpreted as an expression of a social defence. The consequence is that instead of being helped to acknowledge death as a threatening or disturbing work reality, nurses are rather 'helped' by the social defence system to keep their personal experiences of a patient's death at bay.

In a psychosocial approach the institutional and personal, as described above, are also interlinked with wider societal contexts and discourses. Hence this article will now discuss how healthcare professionals' silence around dying and death may also relate to a neoliberal societal governance regime that may indeed be seen to encourage or reinforce social defence within institutions.

### **The societal dimension: reinforcement of social defence in institutions through a neoliberal governance regime**

Personal and institutional aspects of death at work have now been outlined. However, in order to develop this psychosocial analysis more fully, wider societal dimensions must now be taken into account in the exploration of professional cultures and experiences of death and dying. The authors will demonstrate how a societal dimension may influence conditions for talking about death and dying among healthcare professionals, by reference to the continuous demand for greater efficiency and better performance in Nordic healthcare policy and services. Good healthcare is a pillar of Norwegian welfare society and public support for welfare provision remains high (Bergh and Bjørnskov, 2011). Nevertheless, an extensive modernisation of the welfare sector has taken place across Nordic countries since the late 1980s (Lundgaard Andersen, 2016), with the gradual introduction of the New Public Management paradigm also in Norway (Hood and Jackson, 1991). Subsequently, pseudomarket structures have been introduced in the public services, establishing the corporate priorities of efficiency and profit-economy, with target-driven work processes and outcome measurements. Against this backdrop, it is perhaps not surprising that, in the context of death and dying, time and staffing levels have been identified as pressing concerns in nurses' encounters with dying patients (Robinson et al., 2014; Kongsuwan et al., 2016). In our illustrative study (Pollestad, 2015), dying patients were felt to 'disturb' the time allocations and workload distribution in the ward, presenting a painful priority dilemma between colleagues. As one nurse said:

*'You may have many patients. It is overcrowded, cramped, and the alarms are calling and there are few people on the ward, and then you may have a patient dying'* (Pollestad, 2015).

Death, in this context, is an inconvenient incident, disturbing the usual but hectic order of care production.

According to Cooper and Lousada (2005) marketisation and commodification of healthcare and social care systems can lead to new 'structures of feeling', referring to Raymond Williams' original concept (Orrom and Williams, 1954), interconnecting personal experience and the social world. For example, Layton (2009) has indicated how citizens in neoliberal societies tend to reject their vulnerability. Hoggett (2017) takes this one step further, claiming vulnerability in all its forms becomes personally and socially denigrated, something to be ashamed of. Critics have noted how the welfare state writes off responsibility for 'containing' anxiety and 'holding' the vulnerable and the needy, with the effect that dependency becomes increasingly shameful' (Rachael Peltz in Layton, 2009). Henriksen (2010) has termed this phenomenon 'vulnerability shame'. Consequently, we see the contours of a split discourse in neoliberal societies where, on the one hand, independence and production are the most celebrated human qualities, while on the other, human dependency and frailty have become feared and shameful (Österlind et al., 2011). How death figures in this neoliberal governance regime is thus something of a mystery, as it is both prolific culturally and denigrated professionally and institutionally.

In Norway, implementation of New Public Management policies and practices have led to a 'harnessing [of] professional autonomy' to meet neoliberal demands for performance, already prominent in other traditional welfare states, such as the UK's (Hoggett, 2017, p 3). This has been accompanied by a general discursive shift that includes profound changes to the language of healthcare work, the most obvious of which is that self-reflection in the professional role appears to have become a secondary concern, in the face of pressure to prioritise production and cost-coding, performance, quality and risk assessment, quotas and targets, and waiting lists. Examples of this change in the field of palliative care in Norway are 'standard for palliation', 'treatment guidelines for palliation', 'symptom control' and 'palliator'. Nurses are taught to use various tools to assess patients' pain and symptoms in palliative care, for example ESAS (Bruera et al., 1991) or MOBID-2, (Husebo et al., 2007). This instrumentalising vocabulary is representative of a discourse that does not appear to accommodate the basic ethical values and challenges of care for dying patients – essentially a non-standardisable trajectory with a 'non-outcome'. In neoliberal policy discourse, development is frequently defined as increased efficiency, which in turn has been linked to increased anxiety, defensiveness and ambivalence in healthcare professionals (Froggett et al., 2015; Lundgaard Andersen, 2016). Consequentially, professionals are largely left to manage themselves, their own emotions and ethical dilemmas when working with dying people, within a system that operates on technical-rational, economic and politically driven imperatives.

#### *A spiral of increased shame*

Being a part of a social defence system protects against individual responsibility and personalisation of individuals' work (Menzies-Lyth, 1959). However, the social defence system has requirements regarding discipline, control and subordination. Thus, individual healthcare personnel can feel frustrated at work while simultaneously being protected by a social defence. There is a price to pay for this protection. The following salient quote came from a nurse who talks about a patient's death in the hospital:

*'But when it relates to the whole [process] from when they come in to when they die, I don't think it's a good experience. You [as a nurse] are not allowed to be the person you imagined yourself to be, in a way you don't go home with a good feeling, you really don't'* (Pollestad, 2015).

In studies of relational workers (Ramvi and Davies, 2010; Ramvi, 2011, 2015), this sentiment is often encountered – healthcare and welfare professionals feel that, through work praxis, they have become persons they did not want to be. That could mean that the same social defence system that 'protects' these professionals also 'forces' them to behave and act in ways that go against their professional ideal (referred to above as a 'price to be paid'). A consequence of an inability to live up to one's ideals can be feelings of shame (Mang and Martell, 1982, p 142), which, in the context of this discussion, is likely to be reinforced by the performance culture dictated by a neoliberal governance regime. Implicit in such a culture is an expectation of control in all areas of work and life (Hoggett, 2017). Therefore, any loss of control is likely to trigger shameful feelings of failure and imperfection. In situations with dying patients, strong emotions may surface unexpectedly; to healthcare personnel their own vulnerability may suddenly become apparent to themselves. They may worry that this vulnerability will be revealed to the patient, next of kin or – perhaps even worse – to colleagues. Shame can also be attached to a professional's resulting inability to provide care for the dying. This may relate to wanting to escape from the death scene, to avoid the dying patient, to feeling glad to be alive rather than dying (Moen, 2016), or to being more concerned about one's own feelings than the patient's (Ramvi, 2011). The shame of such perceived inadequacy can reinforce a social defence; the social defence system can lead to a self-reinforcing downward spiral where increased shame leads to enhanced need for the social defence which in turn leads to enhanced shame. In the inner world of healthcare personnel there is a need for protection from mental pain (an inevitable side-effect from daily work with suffering and vulnerable persons), while in the outside world there is a need for efficiency and performance. Silence about the personal experience of being confronted with death at work serves both purposes: strong emotions are held at bay, saving time by not being allowed expression or processing, and healthcare



professionals avoid the shame of exposing their vulnerability in the workplace. This article suggests, following the authors' psychosocial approach to the topic, that the silence about death is a result of 'external' factors (societal, institutional, cultural) that interweave with and reinforce the social defence system that originates from the 'internal' world of the professional subject.

### **A psychosocial understanding of silence around death and dying**

This article has questioned and explored why Norwegian healthcare professionals do not communicate about personal experiences with death at work. It has identified in this a striking contrast to an emerging sociocultural trend in Norwegian society to de-tabooise death. The authors approached the research question psychosocially, outlining how ineluctable basic conditions frame our lives and how, from infancy to death, we rely on others to make sense of ourselves and our experiences. This psychosocial exploration continued by interpreting the silence among healthcare professionals surrounding death as an unconscious function of social defence mechanisms against anxiety, tied to threats against their own existence and fear of blame associated with professional (mal)practice and feelings of inadequacy. The authors identified how interrelations between procedures and practices in healthcare institutions, and structural and discursive conditions appear to prevent healthcare professionals from airing personal experiences around death at work, and how the same factors protect healthcare professionals from addressing their vulnerability in the face of death. The social defence around death fits seamlessly within the wider neoliberal governance regime in society, which in healthcare manifests itself in performance-based and outcome-oriented systems where there is little provision for addressing the emotional experiences that go hand in hand with demanding relational care work. Within this discourse, emotional reactions to work have become generally undesirable: the unintended and latent dysfunctions of practice (Lundgaard Andersen and Dybbroe, 2016), making it difficult for the professional to rely on others to help make sense of themselves and their experiences.

In summary, through a theoretically informed psychosocial analysis the authors have arrived at a possible understanding of why healthcare personnel are silent about experiences with death at work, despite an emergent culture of greater openness around death in Norwegian society. Although the analyses are rooted in a Norwegian context, they may well prompt interest or even recognition in other national contexts and the authors would welcome further research to explore possible similarities and differences. Silences among healthcare professionals who work with dying and death are highly indicative of crucial emerging tensions in the neoliberal discursive episteme as the dominant system of thought and knowledge in our time. These unresolved tensions and silences are accompanied and reinforced by the ineluctable basic conditions of life and intrapsychic defence against threats towards the self.

### **Implications for practice**

Healthcare institutions should find ways to accommodate staff's stressful experiences and the complex emotional demands they face. Healthcare professionals should be enabled to care for each other as colleagues, to make sense of themselves and their experiences, so that their ability to care for patients and their next of kin in end-of-life care may be restored. When the emotional aspects of this work are glossed over or ignored because they are too disturbing to deal with, it may have negative impacts on the way care is delivered (Holman, 2008). Learning activities such as peer support, and supervision of healthcare professionals could be implemented to help process difficult psychological content and allow for emotional aspects of work to be acknowledged and reflected on. The authors would argue that are sound reasons for introducing death as an emerging societal-cultural trope (for example, by the symbolic use of art, literature, music) into clinical contexts. This would be in line with Norwegian White Paper 29 (Ministry of Health and Care Services, 2012-13), which recommends arts and culture as means to developing interdisciplinary methods and approaches in the care services, with the aim of stimulating mind and body through activation of thoughts and emotions. Although it may be difficult to engage with the discomfort of putting emotions and experiences of death into words, other forms of symbolisation may be accommodated by a more open institutional culture where challenging aspects

of care for dying patients are not silenced. This may in turn dynamically inform cultural engagements with death in new ways. Perhaps then our personal, professional and social lives may open up to, and be renewed and enriched by the real and existential aspects of death, and the undesired feelings it often gives rise to may lead to psychic growth.

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**Ellen Ramvi** (PhD, MSc BN), Associate Professor, Faculty of Health Sciences, University of Stavanger, Stavanger, Norway.

**Birgitta Haga Gripsrud** (PhD, MA, BA Hons), Postdoctoral Fellow, Faculty of Health Sciences, University of Stavanger, Stavanger, Norway.