Spiritual caregiving silence:

an exploration of the phenomenon

and its value in end-of-life care

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Master of Arts in Pastoral Theology

A thesis submitted to Lancaster University in partial fulfilment
of the requirements for the degree of Doctor of Philosophy.
The candidate has already achieved 180 credits for the assessment
of taught modules within the blended learning PhD programme.

December 2016

Faculty of Health and Medicine

Lancaster University

I declare that this thesis is my own work and has not been submitted
for the award of a higher degree elsewhere

Acknowledgments

My thanks go to my academic supervisors Dr Sarah Brearley and Dr Amanda Bingley for their patience, support and sustained belief in my work; to Professor Katherine Froggatt for early tutoring and continued support and encouragement; to Jenny Brine, specialist librarian, whose clear-headed humanity helped me to navigate the mysteries of database searching; to my peers who have journeyed with me on the 2010 PhD Palliative Care programme and who have become firm friends; to the chaplains who participated in this research for giving their time and sharing such rich experience; to Lydia McLean for proof-reading and to my long-suffering husband, Phil, who has listened, waited and shared the birth-pangs as this thesis has unfolded.

Finally, I give thanks to God for his inspiration and constancy, especially when I could not, myself, see the way. In the PhD journey, as in all things, the prayer of Thomas Merton has been a reassuring guide.

> My Lord God, I have no idea where I am going.
> I do not see the road ahead of me.
> I cannot know for certain where it will end.
> Nor do I really know myself, and the fact that
> I think that I am following your will does not mean
> that I am actually doing so.
> But I believe that the desire to please you does
> in fact please you. And I hope I have that desire
> in all that I am doing. I hope that I will never do anything
> apart from that desire. And I know that if I do this
> you will lead me by the right road though I may know
> nothing about it.
> Therefore will I trust you always though I may seem to be lost
> and in the shadow of death. I will not fear, for you are ever with me,
> and you will never leave me to face my perils alone.

> *Thomas Merton, Thoughts in Solitude (1997:81)*

Lynn Bassett, MA Pastoral Theology. *Spiritual Caregiving silence: an exploration of the phenomenon and its value in end of life care*, PhD Palliative Care, December 2016

Abstract

Towards the end of life, silence seems to take increasing prominence in caregiving relationships. A complex phenomenon, silence has been less explored than verbal interventions, yet to be an effective element of care, silence requires skill and practice from professional caregivers.

This research, undertaken in the United Kingdom between 2013 and 2016, sought a deeper understanding of a type of silence that contributes to palliative spiritual care. A two phase phenomenological methodology was adopted, using heuristic inquiry and hermeneutic phenomenology. Data were gathered through self-inquiry and unstructured interviews with 15 palliative care chaplains. A descriptive and hermeneutic analysis facilitated explication of the lived experience to produce an interpretation of the nature, meaning and value of spiritual caregiving silence in end-of-life care.

Spiritual caregiving silence emerges as a way of being with another person, complementary to speech and non-verbal communication, in which the caregiver takes both an active and participative role. It evokes a sense of companionship and connection and creates accompanied space, allowing the other person to be with themselves in a way they may not be able to be alone; this demands a depth of engagement from the caregiver. Silence provides a means of, and medium for, communication beyond the capacity of words and has the potential to enable change, leading to expression and acknowledgment of truth. It offers patients, and their families, opportunities to find acceptance, restoration and peace.

The thesis concludes that spiritual caregiving silence is a person-centred phenomenon that supports the wellbeing of patients at the end of life, and their family members, by drawing on cross-disciplinary knowledge and experience. The interpretive process, illuminated by examples of specialist lived experience, has produced a deeper understanding of the phenomenon that may find resonance with the experience of other caregivers, to stimulate further discussion and inform clinical practice.

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Abbreviations

AHPCC - Association of Hospice and Palliative Care Chaplains

EAPC – European Association for Palliative Care

MeSH – Medical Subject Headings

NHS – National Health Service

UK - United Kingdom

Word count: 39,171

CHAPTER ONE

Introduction: The research in context

This thesis explores silence in the context of spiritual caregiving and in the wider setting of end-of-life care. Thus it seeks understanding of an everyday, but perhaps rarely noticed, phenomenon at the intersection of two specialised areas of health caregiving. Silence, spiritual care and the end of life share a common element of liminality; they mark transitions and are, somehow, 'on the edge' of normal human experience. Outside this particular environment, silence occurs in numerous situations and is also used metaphorically, so it will be helpful to clarify the type of silence that is to be explored.

In order to do this it necessary to explain a little about myself. Between 2001 and 2015, I worked as Catholic chaplain in acute and palliative care settings within the National Health Service (NHS) and in the more generalist role of spiritual care co-ordinator in an independent hospice in the south east of England.

The idea for this research arose following an encounter in early 2011. I had brought Holy Communion to a patient, who was a religious sister, on a care-of-the-elderly ward. The silence of her post-communion prayer evoked in me a deep sense of peace and a profound awareness of the presence of God. It was a notable moment, not because it was unusual or unique, but rather because it resonated with so many other times when I had experienced this type of silence in my role as chaplain; it awoke in me the desire to understand more deeply the nature of this silence which seemed, of itself, to have the capacity to minister spiritual care.

Thus, the focus of my research has been on a type of silence described as 'spiritual caregiving silence' defined, for the purposes of this thesis, as silence which occurs, or is used, within a professional caregiving relationship with the intention of supporting the spiritual wellbeing of the person being cared for. It is a type of silence that is recognised as offering a positive contribution to care and encouraged in spiritual caregiving practice but, perhaps, it is less well understood than the spoken word.

My personal desire for understanding was complemented by the realisation that opportunities for silence may be diminishing in a westernised culture which has become increasingly focused on activity, communication and information. Aldous Huxley wrote of the 20th century, "all the resources of our miraculous technology have been thrown into the current assault against silence" (in Lane, 2006:29). Jesuit priest, Hughes (1985:97) offers an explanation:

> We are so afraid of silence that we chase ourselves from one event to the next in order not have to spend a moment alone with ourselves, in order not to have to look at ourselves in the mirror.

In her research into spirituality in palliative care, Stanworth (2004) observed that silence seems to be regarded as something to be filled and is often encountered as something to be avoided and Swift (2014:167), a healthcare chaplain, writes, "In a world full of productive knowledge and solution focused health care it can be hard to argue for the necessity of space and silence".

Writing from the perspective of communication theory, Braman (2007:281) suggests that "we might treat difficulties with silence as miners treated canaries in coal mines,

as early warning signals". She argues that silence, as the field against which communication becomes visible, is sensitive and fragile and needs to be protected as an arena of personal and social choice. This exercise of choice has been illustrated by the increase in public and corporate interest in spiritual and meditative practices (Tischler, 1999; Astrow et al., 2001; Miller et al., 2003) and a growing body of evidence that practice of mindfulness meditation (Kabat-Zinn, 1994), which employs silence as a way of being in the present moment, increases resilience, counteracts physical pain (Burch, 2008; Chiesa and Serretti, 2011) and supports psychological well-being (Miller at al., 1995). Expressing a similar concern to Braman, Benedictine abbot Jamison used the BBC2 television series 'The Monastery' in 2005, to showcase the practice of silence, not only for monks but for lay people too, highlighting both its value and challenges (Jamison, 2006).

In palliative care there are physiological and psychological reasons for increased occurrences of silence. Dame Cicely Saunders (2003:6), founder of the modern palliative care movement, comments, "So much of our communication with people is done without words, but I think it is especially so with the very ill".

Physiological examples of patients' silence include inability to communicate verbally because of disease progression or medical intervention. Silence may also indicate a natural state of withdrawal, shock or isolation. Some situations are beyond the scope of words; then silence and non-verbal communication become the primary means of building rapport between health caregivers and those they care for (Perry, 1996).

Silence is sometimes characterised in a negative way; the term 'a conspiracy of silence' is used to suggest denial of death (Zimmermann and Rodin, 2004) or that

which is left undiscussed in the clinical encounter (Fallowfield et al., 2002; Hudson et al., 2004; Inbadas, 2016). Some clinicians report their fear that silence may provoke an emotional reaction (Emanuel and Lawrence-Librach, 2011) and so silence is avoided; alternatively caregivers may be tempted to fill silences to alleviate their own discomfort (de Caestecker, 2012). Twycross (2002:67) identifies the dual dangers of isolating patients "behind either a wall of words or a wall of silence".

There seems to be little evidence of silence as an element of care. Periods of silence in interactions between patients and caregivers do not lend themselves to documentation in patient notes (Edwards et al., 2010), where the focus is on details of the dialogue, resulting decisions and actions taken (Royal College of Physicians, 2015). Existing knowledge appears to reside mainly in the tacit domain described, by Polanyi (1966), as intuitive understanding that is less easily put into words. Moustakas (1990) suggests that tacit knowledge forms an internal frame of reference which governs behaviour and how experience is interpreted. In a critique of Moustakas' method, Sela-Smith (2002) identifies the risk of a cycle where tacit knowledge, which remains in the subconscious, may be subject to interpretational flaws which are then reflected back, in a flawed response, to the external world. This supports a case for exploration and explication of professional caregivers' tacit understandings of silence as care.

In summary, my reasons for conducting this research were three-fold: to explore tacit knowledge about a type of silence which seems to be spiritual caregiving in nature, to initiate a dialogue about silence in a culture where it is often ignored or

avoided and to consider the value of silence in end-of-life care where occasions of silence may become increasingly prevalent.

1.1 Research design

In common with all research, the aim is to generate knowledge. This is sometimes achieved by proof of a hypothesis, explanation of why something happens or why human beings behave in the way that they do. However, the aim of this research is to gain a deeper understanding of a type of silence that contributes to spiritual caregiving at the end-of-life. It is a phenomenon which does not lend itself to measurement or objective observation but reveals itself to consciousness in the subjective act of lived experience. Palliative care chaplains, who specialise in the provision of spiritual care, provide the human 'lens', through which the phenomenon of spiritual caregiving silence is explored.

The understanding of knowledge which guides this research is drawn from the field of human science. As described by van Manen (1990) human science is concerned with people, how they exist and interact in, and with, the world and the structures of meanings that inform these relationships; it is complementary to the sensory observations of natural science and the societal focus of social science. This philosophical paradigm, and the two phenomenological methods used, will be discussed more fully in Chapter Four.

The research was conducted in the United Kingdom (UK) between March 2013 and September 2016 utilising two phenomenological methodologies in two phases: heuristic inquiry following Clark Moustakas (1990) and hermeneutic phenomenology following Max van Manen (1990). The purpose of Phase One was to explore

experience of the phenomenon of silence from the personal and professional perspectives of myself and three other palliative care chaplains. Phase Two sought specific examples of silence, in spiritual caregiving encounters with patients and their families, from the lived experience of 12 more palliative care chaplains. Data were generated from self-inquiry and unstructured interviews.

1.2 Research question, aim and objectives

The research question asked was: What is the nature, meaning and value of silence in spiritual caregiving at the end-of-life as experienced by palliative care chaplains?'

The aim was to deepen understanding of silence as an element of spiritual caregiving and the objectives were: to explicate existing tacit knowledge, to produce a description and interpretation of the essential qualities of spiritual caregiving silence, and to stimulate reflection and dialogue about the value of silence in palliative spiritual care.

As a subjective approach to the process of deepening knowledge, phenomenology acknowledges and capitalises upon the engagement of researchers, their prior orientation (van Manen, 1990) and personal experience of the phenomenon in question (Moustakas, 1990). In order to ensure transparency, openness to the emergence of new knowledge and rigour in the research process, it is important for researchers, not only to conduct the research from a perspective of self-awareness but also, to make clear their own position, background and potential biases as the process of understanding unfolds.

1.3 Background of the researcher

As introduced above, I am a Roman Catholic Christian who worked for 14 years in healthcare chaplaincy. During this time, I had many experiences of silence, and the feelings it evoked in me, during encounters with patients and their families. I wanted, not to explain the phenomenon but, to understand it better. In addition there was a persistent curiosity which questioned whether a deeper practice of silence in my own spiritual life would enhance the experience of the people I encountered in my professional role as chaplain and spiritual caregiver.

In parallel to this was my interest in silence as a way of personal prayer. I had followed the guidance of contemplatives such as Trappist monk Thomas Merton and Benedictine John Main, more or less faithfully, for over 20 years. I found that my practice of setting aside 20 minutes for silent prayer in the morning somehow had a good effect on the way the day progressed. I was also aware of how elusive this time is, how often it is filled with distractions and how easily it is sacrificed to, seemingly, more urgent priorities. In summary, in both my personal spirituality and my professional experience, I believe that silence is important. I have held this position in awareness throughout the research process. However, the primary purpose of the thesis is, not to confirm the importance of silence, but to gain deeper understanding of its role in spiritual care.

1.4 Contribution to knowledge

This work intends to add to the body of knowledge about spiritual caregiving: it answers a call for research into chaplaincy and spiritual care practice and particularly at the end of life; it builds upon the work of other healthcare researchers who have

explored aspects of spirituality and spiritual care as an integral part of palliative caregiving. In addition, it offers a contribution to the cross-disciplinary interest in the phenomenon of silence in human interaction which spans communication theory, the psychological disciplines, education and the humanities.

1.5 Thesis structure

The thesis comprises eight chapters which describe the context and conduct of the research and the conclusions drawn. Chapter Two explains the background to the research. It includes three major sections that focus on, firstly, the research setting of palliative care explaining its principles and purpose and the relationship between palliative and end-of-life care. Pertinent to this research is the understanding that palliative care is interdisciplinary and holistic in intent, caring for the whole person, including spiritual needs, and that care is extended beyond the patient to the whole family unit.

Secondly, the research context of spiritual caregiving is addressed: a working definition is given for a palliative care context, with an explanation of who offers spiritual care. The role of chaplains is discussed. The concepts of care, conversation and a contemplative approach are considered.

Finally the phenomenon of silence is introduced, drawing on relevant existing knowledge from the perspectives of human interaction, therapeutic relationships, religion and spirituality.

Chapter Three describes a review of the literature undertaken in March 2015. This was systematic in approach and searched for professional experience of 'caregiving

silence', using the following working definition: silences which occur in interactions between professional caregivers and their patients or clients in end-of-life and other clinical and pastoral settings with the intention of providing care. Literature was retrieved from psychological disciplines, palliative care and chaplaincy. A lines-of-argument approach, following Noblit and Hare (1988), facilitated synthesis of disparate cases and findings to develop an interpretation of existing knowledge. This supports the case for the progress of this research.

Chapter Four addresses the philosophical paradigm, the phenomenological methodology and the heuristic inquiry and hermeneutic phenomenological methods employed. Chapters Five and Six report the findings from phases One and Two of the research respectively. Silence emerges as a way of being with another person which evokes a sense of companionship and connection and acts as a medium for communication beyond the capacity of the spoken word. It is shown to have the potential to enable change, understood as a new perspective that emerges through the provision of caregiving space and time; change may be realised in the expression of emotion or a truth which helps another person towards acceptance, restoration and peace.

In Chapter Seven the findings are discussed in the light of existing literature. The essential quality of spiritual caregiving silence, as a way of being with another person, works in close cooperation with speech and non-verbal communication. It is interpreted as having multiple modes; central to this is the notion that silence is both external to and an interior disposition of the caregiver. Being with another person in caregiving silence offers non-intrusive companionship, allowing that person an

opportunity to be with them self in a way that they may not be able to be alone. In this way, spiritual caregiving silence has been observed to be beneficial to patient care.

In the concluding Chapter Eight, key points of the thesis are summarised. Qualities of spiritual care are identified as intrinsic to spiritual caregiving silence. Spiritual caregiving silence includes types of silence used and practiced in wider palliative caregiving and other disciplines but, like spiritual care itself, it is distinct in purpose and practice. Spiritual caregiving silence, as a way of being, involves an active intention to be silent on the part of the caregiver *and* a willingness to participate in the external silence of the caregiving encounter. It involves risk and discomfort and demands self-awareness, discernment and openness to the possibility of change but these challenges are outweighed by the spiritual caregiving intention to stay with the other person and the perceived value to patient care. Limitations to the scope of this research and opportunities for future research are identified.

As a phenomenological approach, the thesis does not offer definitive answers but aims to stimulate conversation about the experience and value of silence in spiritual caregiving.

CHAPTER TWO

Background: Palliative spiritual caregiving and the phenomenon of silence

This chapter presents the background to the empirical research. The setting is palliative care in the UK, at the beginning of the 21st century, where society has become increasingly multi-faith and multi-cultural whilst traditional religious practice has declined. This chapter outlines three areas of relevance to this research: palliative care, spiritual care and the phenomenon of silence. In addition, the meaning of care as a key concept, conversation as the occasion in which spiritual caregiving takes place and a contemplative approach to silence are addressed.

2.1 Palliative care

Modern palliative care, developed by Saunders in the latter part of the 20th century to improve care for the dying, has evolved, in the UK, into specialist multi-disciplinary care for people with life-limiting illnesses from the point of diagnosis (Leadership Alliance for the Care of Dying People, 2014). Palliative care is distinguished from other medical disciplines by a shift in attention from cure to palliation, a term derived from the Latin *pallium* meaning cloak, where the aim is to moderate pain and other distressing symptoms. In addition, palliative care has a focus on quality of life, helping patients to live actively for as long as possible (World Health Organisation, 2016). Palliative care is centred upon the person being cared for. In her book, *Watch with me,* Saunders (2003:7-8) describes the caregiver role of watching with patients:

> Our most important foundation for St Christopher's is the hope that in watching we should learn not only how to free patients from pain and distress, how to understand them and never let them down, but also how to be silent, how to listen, how to just be there.

This patient focus calls for a caregiver disposition of 'being with' the other person rather than 'doing for' (Saunders, 2003); it acknowledges the value of human relationship as healing (Sulmasy, 2002) and the importance of listening to the person and their story (NHS England, 2013). Silence is a prerequisite for listening (Savett, 2011) and silence is identified as a component of compassionate nursing (Buchanan-Barker and Barker, 2004).

Of particular pertinence to this research is the foundational principle that palliative care is 'holistic'; it is concerned with caring for the whole person. Saunders' approach incorporates physical, psychological, social and spiritual dimensions (Cobb, 2001), thus palliative care is grounded in an inter-disciplinary and biopsychosocial-spiritual model of care (Sulmasy, 2002) for patients and their whole family unit (Ferrell and Baird, 2012). Hence, this research explores chaplains' experience of silence in encounters with patients and family members. These encounters may have taken place in a hospice in-patient ward or in a unit attended by home-based patients for the day, variously described as day care, day services or day therapy.

A lack of clarity about the terms palliative and end-of-life was highlighted in the discussions which surrounded the demise of the Liverpool Care Pathway (LCP) in 2013. NHS Choices (2016) offers this guidance:

End of life care is support for people who are in the last months or years of their life … End of life care includes palliative care … Palliative care isn't just for the end of life. You may receive palliative care earlier in your illness while you are still receiving other therapies to treat your condition.

The focus of this thesis is on the silences that occur in end-of-life encounters within the broader definition of palliative care; this is based upon my interest in the way that, as death approaches, physiological and psychological conditions may impact upon the nature of conversations for patients and their family members.

Data are drawn from hospice settings, which Froggatt (1997) identifies as liminal spaces that hold the threshold between life and death. In this she draws on the 'rites of passage' model, described by van Gennep (1960), which explains the limen as a transitional stage, between separation and re-incorporation, in common life-cycle events. Crossing the threshold into this transitional place, and phase, may raise existential questions about meaning, purpose and transcendence; these are attributed to the spiritual domain of care.

2.2 Spiritual care

Spirituality addresses and expresses matters of the human spirit; Blanton (2011:136) notes that "both in Hebrew (*ruach*) and Greek (*pneuma*) the word "spirit" means breath". Thus, spirituality is a natural dimension of life; it is also bound up in the relationship with self, others and with creation (NHS Scotland, 2009). The spiritual aspect of personhood seeks meaning and purpose in life and transcendence of the current circumstance; this can foster hope (Speck, 2005; Puchalski and Romer, 2005; Nolan, 2012).

Whilst Eastern spirituality is associated with religious practice, contemporary Western European spirituality has emerged as a broader construct that embraces the increasingly secular composition of society and includes existential and value based beliefs. This is the setting in which this thesis is grounded and, as such, findings cannot be assumed to be transferrable to end-of-life care in other cultures. This is also the case for the phenomenon of silence, understanding of which is susceptible to contextual and cultural influences.

There is no single definition of spirituality but the Spiritual Care Taskforce of the European Association for Palliative Care (EAPC) has produced a working definition to inform ongoing research:

> Spirituality is the dynamic dimension of human life that relates to the way persons (individual and community) experience, express and/or seek meaning, purpose and transcendence, and the way they connect to the moment, to self, to others, to nature, to the significant and/or the sacred (EAPC, 2014).

Spiritual care is the professional caregiving response to spiritual need. In the guidance issued by NHS Scotland (2009:1), where spiritual care is an integral part of health care provision, spiritual care is defined as:

> That care which recognises and responds to the needs of the human spirit when faced with trauma, ill health or sadness and can include the need for meaning, for self-worth, to express oneself, for faith support, perhaps for rites or prayer or sacraments, or simply for a sensitive listener. Spiritual care begins with encouraging human contact in compassionate relationships, and moves in whatever direction need requires.

Of note, in this definition, is the final phrase; spiritual care is primarily concerned with process rather than a predetermined objective; it is not usually approached with a prior agenda (Nolan, 2012). A meta-study of qualitative research into spiritual care at the end-of-life, finds that spiritual care is "*the manner in which care is given*" (Edwards et al., 2010:762, original italics); this resonates with the assertion of Sulmasy that, "the professional's role is to facilitate this spiritual stirring, not to administer it" (2002:30). Thus spiritual care offers an affirming relationship that enables the person themselves to respond to their spiritual needs (Edwards et al., 2010). Like palliative care, spiritual care is person-centred and usually given in a one-to-one relationship (NHS Education for Scotland, 2008). Within chaplaincy, generalised outcomes have been identified as "healing, alleviating suffering, and helping others to feel more at peace" (Handzo et al., 2014:46).

Spiritual care is within the remit of all members of the palliative healthcare team at the level of individual ability (Marie Cure Cancer Care, 2003), and a survey in the UK (McSherry, 2011) demonstrates that nurses consider spirituality and spiritual care to be a fundamental aspect of nursing care, but spiritual care is acknowledged as the responsibility and specialism of chaplains (Puchalski and Ferrell, 2011; Association of Hospice and Palliative Care Chaplains (AHPCC), 2013). It is for this reason, and for homogeneity, that I have chosen to focus on the lived experience of chaplains in this research.

2.2.1 The role of the chaplain

The title chaplain is derived from the Latin *capella*, meaning cape. Christian tradition tells that St Martin of Tours (316-397 AD), moved by compassion for a beggar at the gate of Amiens, divided his military cloak (*cappa*) in two and gave half to the man. That night, Martin dreamed of Christ wearing the half cloak that he had shared and, in the morning, his cloak was miraculously restored. The King of France took the miraculous cloak to war and military chaplains (*cappellani*) were custodians of the relic (Catholic online, 2016). Thus chaplaincy is rooted in the threefold tradition of imitating the compassion and charity of Martin, recognising Christ in others and being the presence of the church in the field of secular life. Consistent with the practice of pastoral theology described by Hiltner (1958) practical care is privileged over theoretical debate (Todd, 2013).

In addition to the military, there is a tradition of chaplains in prisons, education and healthcare and, more recently, a development of chaplaincy in workplaces and other secular institutions. Of relevance to this research is the establishment of chaplains in Primary Care in the UK, providing a community listening service which has been shown to be supportive to the well-being of both patients and staff (Mowat et al., 2012; Kevern and Hill, 2014).

In the UK chaplains have been part of the NHS since its inception in 1948 (Autton, 1968; Orchard 2000). Appointed on the basis of bed occupancy by religion, they were usually Christian priests who administered the rites, rituals and pastoral care of the Church. In response to changing needs and societal demographics, contemporary chaplaincy encompasses a wider remit of care for spiritual and existential need.

Chaplains' responsibilities extend, beyond care for patients and family, to staff and the institution as a whole. In hospices chaplains are regarded as full members of the multi-disciplinary team (AHPCC, 2013). Healthcare chaplains have a dual accountability; they are employed or contracted by the institution to which they minister and authorised by their faith community with which they are expected to be in good standing. A variety of job titles describe their role of spiritual, pastoral and religious care provision but the title 'chaplain' is generally accepted as representative (NHS Scotland 2009); this is the term adopted in this thesis.

In early research into chaplaincy in the UK, Orchard (2000:94) suggests that a defining characteristic is its two dimensional nature, holding together the "seen and the unseen; material and spiritual; human and supernatural"; Cobb (2015:4) describes the chaplain's role as at "the intersection of worldly and transcendent realities" and Mullally (2002:9) notes that it is "on the edge" of both institution and faith community. Chaplains retain a reputation for confidentiality and trust which stems from the priestly confessional seal (Coates, 2010). They are expected to support their own spiritual development, reflecting theologically and philosophically on their practice and maintaining a spiritual discipline (NHS Education for Scotland, 2008).

Chaplains perform a broad and varied role (Mowat, 2008) but the focus of this research is on pastoral encounters with patients and/or their family members, thus silence in religious services, group therapy, or in the care of staff and volunteers is not explored. Chaplains respond to referrals but often their visits are opportunistic;

unlike therapists, there is no programme of treatment, encounters may be one-off or continue over months or years.

Chaplains are identified as having a ministry of presence (Puchalski, 2002; Edwards et al., 2010; Nolan, 2012) with an emphasis on listening (Mowat and Swinton, 2005). Listening enables a person to tell their story; in research with chaplaincy volunteers, active listening has been found to generate wellbeing by offering patients control, choice and empowerment (Manzano et al., 2015). However silence, as a quality of listening, has not been explicitly addressed in the above research.

As chaplains become more closely integrated members of the professional healthcare team, the need for evidence of outcomes and value has become increasingly important. The field is little researched and existing research focuses largely on what chaplains do (Orchard, 2000; Mowat, 2008). Following work to produce a published body of case studies (Fitchett, 2011; Fitchett and Nolan, 2015), Handzo et al. (2014) have called for an outcome orientated approach to chaplaincy, and chaplaincy research, beginning with practice-based evidence which values chaplains' tacit knowledge. To this end, this thesis aims to contribute a deeper understanding of chaplains' experience of silence.

2.3 Concepts of care, conversation and contemplation

Three key concepts emerged from the exploration of spiritual care: the notion of care itself, the occasion of conversation within which spiritual care encounters often take place and a contemplative approach which grounds my own understanding of spiritual care and of the conduct of this research.

The centrality of care is emphasised in both the palliative care setting and spiritual care context for this research. The common themes of 'cape' and 'cloak' in chaplaincy and palliative care underline the person-centred focus on comfort, healing and human relationship. For chaplains the purpose of care is accompaniment (Nolan, 2012) and *Being There* expounded by Speck (1988).

From the perspective of Heidegger (2010), care is the existential meaning of being-in-the-world; Heidegger implies that care is not so much task related, as in the act of taking care of something or someone, but is more a matter of concern for a situation or person. This definition is consistent with aims of pastoral activity, described by Hiltner (1958:18) as "tender and solicitous concern" and Saunders' (2003) understanding that care is concerned with 'being with' rather than 'doing for'.

In his introduction to hermeneutic phenomenology, van Manen (1990:58) extrapolates from the meaning of care as sorrow, "So in caring for another person I relieve the other of "care" in the sense of troubles, worries, or anxiety". It is a perspective which emphasises the participatory nature of care, given in a place of shared humanity, which exposes the caregiver to vulnerability which can be uncomfortable (Sinclair et al., 2012) but, at the same time, rewarding. Hanrath (2002:18), a chaplain-researcher from the Netherlands, found:

> For patient and spiritual caregiver the satisfaction came from such basic
> things as people paying attention, having time to listen, time to have a chat,
> or just be there.

Spiritual care is often given in an occasion of conversation. From the Latin *conversari* meaning "to keep company (with)" (Oxford Dictionaries, 2016), conversation has a

more informal turn than dialogue or discourse. Seventeenth century Castilian usage, which offers an insight into the style of conversation that influenced the development of Ignatian spiritual direction, describes "a gentle encounter … a communication between friends" (Arana, 2005).

The term, spiritual conversation, has been adopted more widely in contemporary spiritual healthcare to denote a type of interaction which may flow from the taking of a spiritual history and result in a conversation about the way a person relates to and makes sense of the world. The aims are to understand the patient more fully (Puchalski and Romer, 2005) and to offer accompanied space where they may rediscover their own value and meaning (Sulmasy, 2002). Thus, spiritual conversation is concerned with developing inter-personal relationship.

There is some evidence of the limitations of speech in literature which describes spiritual care conversations: for example, Kacperek (1997), a nurse, found that her relationship with patients was enhanced when she lost her voice. The research of Sinclair et al. with healthcare professionals working at the end of life, finds that a reliance on verbal communication may inhibit spiritual care. They note that:

> A number of participants felt that verbal communication had equal potential to harm in the provision of spiritual care, especially when comprised of superficial clichés and hollow scripts of comfort. Participants indicated that their words had the potential to stifle the flow of patient driven and therapeutic conversations (Sinclair et al., 2012:322).

Acknowledging the limitation of verbal interventions, spiritual caregiving has been described as a contemplative practice (Clayton, 2013). This approach to care has

implications for both caregiving practice and the paradigm within which this practice

is researched. This thesis draws on the argument of Braman who proposes a

contemplative construction of reality to complement the theory of social

construction; she notes similarities but also differences and describes contemplative

construction of knowledge as:

> That which takes place through silent contemplative practices by individuals
> (...) the contemplative construction of reality focuses on the individual's
> sense of his or her body in a natural environment; it begins with the breath of
> one individual, alone, and can lead outwards beyond the social to include, for
> many, a spiritual dimension. It is not that the individual is removed from
> society, but that the individual is reconnected with the larger universe within
> which we all reside. Communication is the means by which reality
> construction takes place, and silence serves as architecture, enabler, and
> stimulant (Braman, 2007:284-5).

Thus, a contemplative construction offers an epistemological environment for

research into spiritual care. Drawing on Braman's construction, Figure 1 illustrates

how spirituality includes, but also transcends, the boundaries of the social world;

inwardly, it begins in embodied self and outwardly it looks to the transcendent
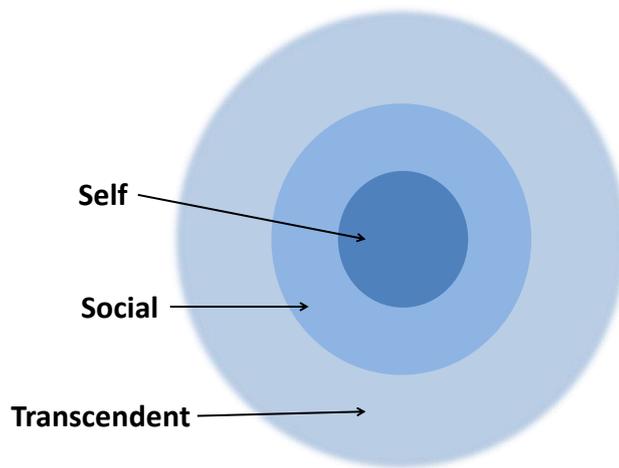
dimension.

Figure 1. Dimensions of spirituality

From a Christian perspective, contemplation is the highest expression of spiritual and intellectual life (Merton, 1999), described by Gregory the Great in the sixth century as "resting in God" (Contemplative Outreach, 2016). The contemplative state is one which is not achieved so much by will as understood as gift (Merton, 1999); the pray-er becomes lost in a state of rapt listening (Keating, 2012) so that self and external world are, for a moment, forgotten.

Religious traditions make two points: contemplation is not an end in itself; rather the contemplative life leads to love of God's truth (Merton, 1976). Secondly, the contemplative state is transient (Egan, 1984); there is an imperative to return to the world, to realise the fruits of contemplation in action. In this cycle, Rohr draws a distinction between action, born out of contemplation, and activism suggesting that activists "might *have* the answer, but they are not *themselves* the answer" (Rohr, 2016 – original italics). A contemplative approach places 'being' before 'doing'.

The temptation of activism is recognised by children's hospice chaplain, Clayton (2013). As a prerequisite to care, he emphasises the importance of a prior condition of interior space for chaplains suggesting that:

> Contemplative practices of prayer and meditation encourage us to relinquish habitual ways of knowing and travel deeper into the emptiness of silence (…) in order that we might face the emptiness of death with others (2013:44).

For Clayton, contemplative practice creates the "inner space and stability (…) [that] can be translated into the creation of external therapeutic space for others" (2013:48).

2.4 Silence

In communication silence has been found to be multi-modal, complex and elusive (Ollin, 2008); from a psychological perspective it is described as "a complex psychic state that cannot be easily classified or systematised" (Zeligs, 1960:411). It is recognised as carrying more meaning than the dictionary definition of an absence of sound or speech suggests (Saville-Troike, 1995; Jaworski, 1997), rather it is experienced as a full and active presence (Scott and Lester, 1998) which can only be understood in the context in which it arises (Knutson & Kristiansen, 2015). According to Zeligs (1960:408), "silence, like thought, permeates all levels of human functioning". The term silence is used metaphorically, to describe white spaces in art and typography, and literally in the pauses in a musical score; these examples illustrate the theory of silence as field (Braman, 2007) against which sound and speech become discernible.

In his musical composition 4'33", Cage (1968) demonstrates how silence enables

sounds, normally unnoticed, to be heard. More commonly, silence is noticed at the

end of a performance; described by Olinick (1982:463) as "silent communion" it is a

silence of appreciation or taking in what has preceded. Cox and Roberts (2007:24),

music therapists working with people at the end of life, attribute a value to this end-

silence, observing how live harp vigils take people "beyond music into a silence that

is deeply spiritual and profoundly comforting".

2.4.1 Silence in human interaction

Bruneau (1973) distinguishes different forms of silence by perception of time; fast-

time silences, such as the pauses between utterances, denote technical silences and

slow-time, attentive silences are used to develop interpersonal relationship. Silence

is acknowledged as an important part of human interaction (Martyres, 1995; Scott

and Lester, 1998; Knutson and Kristiansen, 2015) but it is "often experienced with

discomfort and quickly filled with words" (Martyres, 1995:118).

Kurzon (2007) contributes a typology of silence in social interaction, concluding that

conversational silence is only one type of silence in this field. He makes a distinction

between internal and external silence; whether the cause for silence is found within

the silent person or it is imposed by another person or social norm. This

understanding is echoed in the distinction between being 'silent' and being 'silenced'

made by Fivush (2010), but the typology proposed by Kurzon includes two

assumptions that may distinguish palliative spiritual care interactions from social

interaction: the first is that, in the interaction described by Kurzon, there is a silent

person and another who addresses that person, this seems too limited to encompass

the mutuality of spiritual caregiving; the second is that external silence is understood as imposed; in this sociological approach, there seems to be no allowance for naturally occurring silence.

In his phenomenological interpretation, Merleau-Ponty (1968) describes silence as a background to speech, preceding and succeeding the spoken word, and also closely interwoven with language, giving meaning to utterance. Dauenhauer (1980), in distilling his ontology of silence, does not acknowledge silence outside the context of discourse, however, he does consider silence and discourse to be of equal value, contrary to Hegel and Husserl, given by him as examples of philosophers who prioritise the spoken word. A legacy of modernism perhaps, priority of the spoken word seems to be embedded in Western society. Knutson and Kristiansen (2015:24) note, "When we engage with people we usually expect the spoken word and silence can feel disconcerting and unpleasant".

As communication, silence has been described as having the capacity to convey messages (Saville-Troike, 1995; Kacperek, 1997; Lane et al., 2002) and emotion (Feldman-Stewart et al., 2005). Messages, or content, may be designed to make connection or signify rejection (Scott and Lester, 1998), but silence has been acknowledged as more open to ambiguity than speech (Sharpley et al., 2005); thus messages in silence may be subject to misunderstanding or misinterpretation. Feldman-Stewart et al. (2005) give the example of patients interpreting a professional's silence as disinterest.

Silence also serves a function in information giving, described as, "a deliberate slowing down in order to aid the addressee to understand what has just been said"

(Kurzon, 2007:1673). Silverman et al. (2005:79), teaching communication skills to clinicians, write "most verbal facilitation is ineffective unless it is immediately followed by a non-verbal attentive silence". This function is also applied in information gathering, described by Neimeyer (2001:369) as creating space for the "not yet said"; silence allows the other in the conversation to collect their thoughts and decide what they will say next.

2.4.2 Silence in therapeutic relationships

The role of silence has been debated in psychological disciplines; for instance, Zeligs (1960) explains the early Freudian perspective that patient silence was generally regarded as resistance and unhelpful to the analytic process. However, towards the end of the 20th century, moments of silence during the therapeutic hour were noted as important for communicating psychodynamic information as well as facilitating the therapeutic process (Lane et al., 2002) and this alternative perspective is evident in the person-centred work of Rogers (1961) and the object-relations theory of Winnicott (1971). Zeligs (1960:409) suggests that it is in these moments of deep contact between patient and analyst that attitude becomes important; where "the analyst's silence denotes impatience, boredom, indifference or annoyance, this will surely be seen by the patient and thought of as disapproval, rejection or condemnation" whilst a benevolent attitude will help the silent patient develop self-assurance and self-realisation.

In addition to communicating involvement and engagement, a therapist's silence performs functions of holding and containing, conveying safety and acceptance (Lane et al., 2002). Attentive silence enables understanding and interpretation (Martyres,

1995) and facilitates dialogue and empathy (Wilmer, 1995). In phatic communication, which privileges relationship building, Olinick (1982) identifies an interpersonal mutuality that resolves in a comforting silence. It is recognised that therapeutic silence offers the potential for healing (Zeligs, 1960; Fivush, 2010; Knutson and Kristiansen, 2015).

Sharpley et al. (1997; 2005) have investigated the association between silence and client-perceived rapport in initial counselling interviews finding "significantly higher amounts of silence during minutes rated Very High [sic] in rapport" (2005:149). They conclude that silence is a powerful tool, but they caution students and educators to be aware of the kind of silences which are therapeutic and those which are not, stating that "not all silences are equal" (2005:158).

Dauenhauer (1980) identifies that silence involves risk. The potential for silence to provoke anxiety in both counsellor and client is recognised (Scott and Lester, 1998; Sabbadini, 2004; Knutson and Kristiansen, 2015). Scott and Lester (1998:105) describe, "As the silence grows in length, there is sometimes a compulsion to break it with some utterance - but also a fear in doing so". Knutson and Kristiansen (2015:5) explain, "When we experience silence in a situation where spoken words are part of a highly valued tradition, we encounter silence with bewilderment, especially when silence remains unbroken". They describe feelings of fear and discontent and the perception that silence, as a phenomenon, is uncanny. Sabbadini (2004) links an anxious reaction to the unconscious understanding of silence as a void, nothingness and related to fear of death.

2.4.3 Silence in religion and spirituality

Silence is sought and respected in many world faiths including Hindu and Buddhist traditions and in the mystical traditions of Judaism and Islam (Lane, 2006). The approach of this thesis is grounded in Christian spirituality which has been the predominant influence on the development of spiritual healthcare and is still the religious affiliation of the majority of chaplains in the UK.

In Catholic Christian seminaries, the cultivation of interior silence is regarded as the main task of student formation (Keating, 2012). Keating (2012:308) describes the relationship between interior silence and the external silence which "serve its purposes". Silence has associations with a monastic lifestyle. In chapter six of his Rule, Saint Benedict writes on cherishing silence in the monastery; he reminds the community, "We should remember that speaking and instructing belong to the teacher; the disciple's role is to be silent and listen" (Benedictine Handbook, 2003:26).

In this context silence is both the fruit of inner asceticism and a gift from God; in a reference to listening, Goulding (2003:290) explains, "You listen because your silent waiting on God is an openness to his word". Physically and mentally, it involves a withdrawal from the world but the paradox, identified by Merton (1976), was that in his life of solitude he found a greater sense of engagement with, and love for, all humanity.

Silence is also associated with Christian mystical traditions; the author of '*The Cloud of Unknowing*' suggests that the "most godlike knowledge of God is that which is known by unknowing" (in MacCulloch, 2013). Pseudo-Dionysius writing in the fifth or

sixth century (Stanford, 2014) discerned God's presence in silence; for him, the objective of the spiritual life was to clear aside the obstacles which stand in the way of resting in God's silence (Carafna, 2004). MacCulloch (2013) explains that an apophatic, or negative way of knowing, acknowledges the inability of language to capture the divine. Where words lose their adequacy, silence remains; translated into contemporary palliative caregiving, silence is "part of a vocabulary of spirit" (Stanworth, 2004:80)

From the perspective of spiritual direction, where the purpose is to accompany another person on their spiritual journey, Lunn (2009) notes two kinds of silence. The first is 'communicative' where no words are heard but body language and nuances may be noticed. The second is the silence of 'no-voice', it is a silence of waiting and she describes this as a deeply theological act, "It is an act of self-emptying, *kenosis,* which involves putting aside one's thoughts, feelings and desires in order to fully attend to the other" (Lunn, 2009:225).

Spiritual care, as defined earlier in this chapter, includes elements of religious practice, spiritual direction, therapy and social interaction and is distinguished by its particular role in contemporary healthcare. In sharing silence with another person, health caregivers bring the practice of silence into the patient encounter. Literature suggests that to be effectively silent with another it is necessary for the caregiver to be comfortable with silence themselves (Cassidy, 1988). Wright (2006) suggests that this demands a personal spiritual practice and Stanworth (2004:220) confirms the value of this from her own research experience:

If you get into the habit of maintaining even a short period of silence each day you will feel less perturbed when you are invited to share the silence of another.

It has been suggested that a regular meditative spiritual practice for all caregiving staff offers benefits for themselves and the patients they care for (Wright, 2006; Wong, 2013). There are some reports of the value of incorporating meditative or contemplative practice into caregiving encounters (Brown-Saltzman, 1997; Blanton, 2007; Lord, 2010) but there is little exploration into the subject of silence as an element of wider spiritual caregiving.

In summary, silence has been noted to be of value in human interaction, therapeutic and spiritual practice; it is also recognised as ambiguous, open to misinterpretation and a source of discomfort and anxiety. My thesis is that a better understanding of silence, on the part of caregivers, may serve to alleviate, or transcend, the natural anxiety that silence provokes in themselves and those they care for, in turn, enabling more comfortable silences in patient encounters. This may offer benefits in terms of patient care and wellbeing. A primary route to understanding may be through experience of silence in practice; this is the aim of this research.

2.5 Conclusion

This chapter has presented the setting of palliative end-of-life care, the context of spiritual care, and the phenomenon of silence. Palliative spiritual care has been described as holistic and person-centred, with an emphasis on process and care rather than outcome or cure, illustrated by the image of cape and cloak. The liminal space, offered in hospices, enables a transition in the rite of passage (van Gennep,

1960) from life and death, supported by attention to the spiritual-relational domains of self, others, the natural world and that which transcends space-time reality. Within this the caregiver is regarded as an accompanying presence; the role is not so much to provide a solution as to make space for the other person to interpret their own meaning and find their own way.

There is little empirical evidence for silence as an element of spiritual care, but philosophical debate and accounts of experience in palliative end-of-life settings point to a relationship between silence and holistic wellbeing. The literature review, which follows, seeks experience of a type of silence which offers care in a wider field of inter-personal relationships.

CHAPTER THREE

Literature Review: Existing understanding of silence in caregiving contexts

The purpose of the literature review was to search for and synthesise published papers which report experience of caregiving silence in interactions between professional caregivers and their patients or clients in clinical or pastoral settings. A systematic search process was undertaken in order to maximise the potential to retrieve relevant work across caregiving disciplines. This was followed by a conceptual and interpretive approach to data extraction and synthesis, informed by meta-ethnography (Noblit and Hare, 1988), to produce an interpretation of existing understanding of silence as an element of care.

The review question asked was: How do people in professional caregiving roles describe their experience of silence, as an expression of care, in interactions with patients or clients?

3.1 Method

Meta-ethnography is considered by Popay et al. (2006) to be the pre-eminent approach in qualitative synthesis offering an interpretive method for synthesising disparate data from individual case studies (Pope et al., 2007). It is congruent with the epistemological position of this research and accommodates the heterogeneous, cross-disciplinary and self-reflective nature of the material in this review, which has been drawn from different psychological disciplines and pastoral care and is

presented as reported research, personal reflections and clinical cases that are

neither suited to direct comparison nor report significant disagreement.

Where disparate papers report findings from their own perspective, Noblit and Hare

(1988) propose a lines-of-argument synthesis. It is a two-step process that first

compares themes and concepts across studies, clustering similar findings and noting

differences and, then, draws together the main arguments of each paper to frame a

new line-of-argument. The aim is "to discover a 'whole' among a set of parts" (Noblit

and Hare, 1988:63) which may contribute a greater understanding of the area of

interest for a particular audience.

3.1.1 Search strategy

The search was undertaken in March 2015. The search strategy used in PsycINFO is

attached in Appendix 1. It was adapted for the following cross-disciplinary databases:

Academic Search Complete, AMED, CINAHL, Medline, Index to Theses, International

Bibliography of the Social Sciences and ProQuest Digital Dissertations. Appendix 2

shows the number of results in each database and the numbers of exclusions in the

initial screening process. Search terms are detailed in Table 1. No date range was

applied; some databases and journals provided their own defaults.

Table 1. Search terms used in systematic literature review

Main search areas	Search terms (PyscINFO database 15/03/2015)
Silence	silence OR silence [MeSH term]
	AND
Discipline	therapeutic processes [MeSH term] OR therapeutic environment [MeSH term] OR psychotherapeutic processes [MeSH term] OR psychotherapeutic counselling OR palliative care [MeSH term] OR meditation [MeSH term] OR spirituality [MeSH term] OR pastoral counselling [MeSH term] OR therap* [title /abstract] OR counsel* [title/abstract]
	AND
Patients	patients [MeSH term] OR geriatric patients [MeSH term] OR hospitalised patients [MeSH term] OR medical patients [MeSH term]OR outpatients [MeSH term] OR psychiatric patients [MeSH term] OR surgical patients [MeSH term] OR terminally ill patients [MeSH term] OR clients [MeSH term] OR patient* [title /abstract] OR client [title /abstract] OR therap [title /abstract]
	AND
Language	English

Indexes of the following discipline-specific journals were searched by hand for material relating to spiritual and pastoral care: Journal of Health Care Chaplaincy (US), Journal of Health Care Chaplaincy (UK), Scottish Journal of Healthcare Chaplaincy, Journal of Religion and Health, Journal for the Study of Spirituality, Practical Theology. The search was supplemented by citation-tracking and review of reference lists of included articles and a Google Scholar alert for material including the terms 'silence', 'spiritual care' or 'end-of-life'.

Records which addressed the experience of silence, as care, in professional caregiving interactions were retained according to inclusion and exclusion criteria shown in Table 2. After initial screening, records were downloaded to an Excel file and duplicates removed. Eligible articles were assessed by title and abstract and, where they met the inclusion criteria, full text was reviewed.

Table 2. Inclusion and exclusion criteria

Inclusion	Exclusion
English language texts	
Empirical research and articles published in peer-reviewed journals	Book reviews
Reports primary experience of silence from the perspective of the caregiver	Does not include primary experience of silence
Focus on silence	
Silence in a professional caregiving contexts with patient, client or family member	Group therapy Non-caregiving disciplines Inter-professional communication Non-professional care-giving e.g. Family or informal carers
Focus on silence as an element of care including clinical consultation or therapy	Silence that is not an expression of caregiving: • Patient/ client silence • Taboo/ stigma, that which is "not discussed" • "conspiracy of silence", use of silence as power or control Self-care Silence as a part of individual spiritual practice

A 14 point manual data extraction process was used to capture information about the article or study, focus, conceptualisation of silence, main findings and a descriptive summary. An example of a data extraction sheet is included in Appendix 3. This enabled comparison and informed the final selection of articles for inclusion.

Reports of empirical research were appraised for quality using a critical appraisal tool developed by Hawker et al. (2002) for reviews of diverse studies and heterogeneous data. Studies were scored between 10 and 40 points, on each of nine criteria, resulting in a maximum possible score of 360 points.

3.2 Results

Thirty-nine papers were retained for full text review; of these, 16 were identified as meeting the inclusion criteria. Citation tracking identified two further relevant papers. No papers were excluded on grounds of quality because they all contributed themes and primary experience of the phenomenon to the synthesis. Figure 2 describes the flow of the literature search process and Table 3 summarises the final selection of studies and articles for the review.

Identification

Records identified through database screening n=2365

Records identified through hand search n=39

Screening

Records screened, searches merged, duplicates removed n=2404

Excluded n=2073 Duplicates n=40

Title and abstract assessed for eligibility n=291

Articles excluded n=252 non-English (2); book reviews (15); focus not silence (80); not care context (32); not element of care (123)

Eligibility

Full text articles assessed for eligibility n=39

Articles excluded n=23 Focus not silence (3); not care context (1); not element of care (9); no primary experience of care (10)

Included

Eligible studies and articles n=16

Additional articles from citation search n=2

Studies and articles included in meta-ethnographic synthesis n=18

Figure 2. Flow diagram to show literature search process
Source: modified PRISMA flow chart as described by Moher et al. (2009)

Table 3. Studies and articles included in review

Empirical research

Author/ date/ country	Discipline/ Context	Methodology/ design/ sample	Quality assessment (Score out of maximum 360 points)	Focus of study
Barber, T. (2009) UK	Counselling/ Psychotherapeutic setting	Phenomenological Semi-structured interviews; data-driven thematic analysis 7 newly qualified counsellors	350	Therapists' experience of silence
Hill, C. et al. (2003) USA	Psychotherapy	Mailed survey 5 point Likert scales 81 therapists	320	Therapists' use of silence in therapy
Ladany, N. et al. (2004) USA	Psychotherapy	Consensual qualitative approach 12 therapists	300	Therapists' use of silence in therapy
Tornøe, K. et al. (2014) Norway	Hospice nursing	Phenomenological hermeneutical (after Ricoeur) Narrative approach 8 nurses	310	Being with dying people/ alleviating spiritual and existential suffering

Articles and commentary

Author/ date/ country	Discipline/ Context	Reported experience (numbers of reported cases or clinical vignettes)	Theory/philosophical perspective	Focus
Back, A. et al. (2009) USA	Palliative care/ Clinician communication	One	Christian/ Buddhist contemplative traditions Mindfulness	Compassionate silence: a new typology
Bravesmith, A. (2012) UK	Psychoanalysis/ Psychoanalytic dialogue	Two	Jungian approach	Speech and silence as a partnership for creation of meaning
Bunkers, S. (2013) USA	Nursing	One		Silence as bearing witness to life story
Capretto, P. (2014) USA	Pastoral care; hospice chaplaincy. Grief and loss	Two	Attachment/ mourning theory. Freudian analysis and Christian tradition.	Silence as a therapeutic tool in bereavement care
Denham-Vaughan, J., Edmond, V. (2010) New Zealand	Gestalt psychotherapy	Two	Theory of presence: Buber, Sartre	Hypothesis: Attending to silence is a figure-ground reversal resulting in interconnectedness
Harris, A. (2004) UK	Person-centred therapy	One	Rogers	The power of silence in the therapeutic relationship

Hill, M. (2004) USA	Psychoanalysis	Two (One patient)	Freud Lacan: empty and full speech Buddhism	Compares silence in psychoanalysis with Buddhist meditation; use of silence as practice in therapy
Himelstein, B. et al. (2003) USA	Paediatric palliative care/ Consultation with patient's mother	One		Practicing the art of silent presence
King, K. (1995) USA	Nursing/ Home healthcare	Two	Communication: Saville-Troike	Nurses' use of silence
Moriichi, S. (2009) USA	Pastoral Care/ Nursing home	Two	Clinical Pastoral Education (CPE) Eastern culture Christianity	Proposes a counter-cultural adjustment to the perception of silence
Rajski, P. (2003) Canada	Psychology/ therapy	One	Contemplative Christian spirituality	Contemplative prayer informed silence in therapy
Sabbadini, A. (2004) UK	Psychoanalysis	Two		The function of silence in the psychoanalytic encounter
Savett, L. (2011) USA	Medical education	One		The importance and practice of deliberate silence for healthcare professionals
Wilmer, H. (1995) USA	Psychoanalysis	Four	Jungian approach	Deep communication when analyst and analysand are both "listening into" the silence

3.2.1 Location, methodology and philosophy

Articles are drawn from the disciplines of palliative care and nursing (n=6), pastoral care (n=2) and psychotherapy and counselling (n=10). The majority (n=14) offer first-hand professional experience of the type of silence sought. With the exception of Barber's (2009) MA dissertation, articles were published in peer reviewed journals, primarily in the USA and Canada (n=12). The majority (n=16) were published after the year 2000.

Four articles report empirical research. Of these, three are located in psychotherapy (Hill et al., 2003; Ladany et al., 2004; Barber, 2009); two (Hill et al., 2003; Ladany et al., 2004) are closely linked exploring why therapists use silence. Barber (2009) also draws on the work of Ladany et al. (2004) taking a phenomenological and thematic approach to analyse therapists' experience of silence, from the perspective of both therapist and client, within the therapeutic setting. In the field of palliative care, Tornøe et al. (2014) adopt a phenomenological approach to explore hospice nurses' experience of consoling presence; silence emerges as a result, not the focus, of the research.

The prevailingly qualitative methodologies reflect the nature of inquiry into experience. Consistent with qualitative research design, aside from the survey mailed to 81 therapists, (Hill et al., 2003), samples were small (range: 7-12). Methods are clearly reported and all four papers report the experience of participants.

Whilst little reported empirical research was found, the remaining 14 articles provide data for synthesis in the form of reflection on personal experience. No predominant theory emerges but each article draws on scholarship from its own discipline and

more generally from the fields of psychology, communication and spiritual traditions. The breadth of influence illustrates the heterogeneity of the selected material.

3.3 Data synthesis and interpretation

In the first step of the meta-ethnographic process, which compared themes and concepts across the selected papers, three areas of focus were identified: the relationship of silence and speech, the use of silence and the practice of silence. These will be discussed in detail below, following an appraisal of some general understandings of the phenomenon.

Silence is described as multi-faceted (Hill et al., 2003) and multi-functional (Sabbadini, 2004) affording a spectrum of intentions and perceptions which include extremes of experience. Silence does not lend itself to any definitive interpretation, prescription or significance (Ladany et al., 2004; Sabbadini, 2004), but as part of human communication, it occurs within a context (King, 1995) and a relationship (Barber, 2009; Tornøe et al., 2014).

Used well, silence can lead to therapeutically rich moments (King, 1995; Hill et al., 2003; Himelstein et al., 2003). Positive experiences of silence are described as comfortable, affirming and safe (Hill, 2004; Back et al., 2009) but silence may also be received as awkward (Back et al., 2009), embarrassing (Denham-Vaughan and Edmond, 2010), frustrating or frightening (Bravesmith, 2012). Bunkers (2013:7), a nurse, describes silence as "a double edged-sword", a powerful force for connection or rejection; either way it can "touch the deepest emotion" (Barber, 2009:54). The quality of caregiving silence, sought in this review, is described in these contexts as therapeutic silence (Back et al., 2009; Barber, 2009; Capretto, 2014; King, 1995).

The connection between silence and anxiety, highlighted in Chapter Two, is borne out in research findings (Hill et al., 2003; Ladany et al., 2004); when anxious, some therapists use more silence, some less (Ladany et al., 2004). Anxiety may lead to too many words and too little silence (Harris, 2004; Barber, 2009; Denham-Vaughan and Edmond, 2010), but too much silence has also been identified as a source of anxiety in both therapy (Hill et al., 2003; Bravesmith, 2012) and healthcare (King, 1995; Back et al., 2009). Bravesmith (2012:26) describes her aim for an "optimal pause"; King (1995) suggests a well-timed silence of ideal length.

3.3.1 Focus One: The relationship of silence and speech

All papers discuss silence in the context of a conversation. Understood and used skilfully, silence presents not as absence of speech (Bravesmith, 2012; Capretto, 2014), but as an active presence, the ground from which speech arises or "a container of words" (Sabbadini, 2004:229). In the patterns of silence and speech, described as language (Bravesmith, 2012), humans connect and meaning is created (Bunkers, 2013). Bravesmith (2012), invoking Jungian theory, conceptualises the partnership between silence and speech as a union of opposites in which there is the potential for new and holistic meaning to arise.

In relation to speech, types of silence are described as pause, a way of listening and attending, and a way of communicating that is beyond words. Lastly, and relevant to the experiences of anxiety noted above, the question of responsibility for the silence is addressed.

Silence, as pause, is noted in the research of Ladany et al. (2004) as a quality of relationship and presence. In both therapy and nursing care silent pauses allow the

conversation to slow down, conveying respect (Barber, 2009) and reverence (Bunkers, 2013). Savett (2011:170) explains, "if silence is interrupted too soon, one may fracture the narrative and miss important information". Bravesmith (2012) suggests that sometimes the story is still in the process of creation; this may need time, space and a listener. Similarly, Savett (2011) and Bunkers (2013), writing to inform the practice of nurses, introduce a concept of waiting for the story to be told to completion. Quoting Cooper-White (2007), Capretto (2014:356) explains that listening in silence is neither passive nor neutral but rather the practice of "profound respect for the complexity that might emerge from the not-yet-known-or-knowable".

Savett (2011:169) asserts, "To listen one has to be silent". In therapy, Bravesmith (2012) describes productive silence which allows the patient time, through semi-communicative chatter, to gain personal insight and to build the trust necessary for a significant disclosure to be articulated. Seemingly empty speech may be a pre-cursor to the creation of new meaning (Hill, 2004; Barber, 2009; Denham-Vaughan and Edmond, 2010). A silent listener bears witness to life-story and offers relational space "for the narrative to unfold" (Bunkers, 2013:9).

Attending means listening, not only to clients' words but also to their silences (Wilmer, 1995; Sabbadini, 2004; Barber, 2009). Jungian analyst, Wilmer, suggests that deepest communication takes place when analyst and analysand are engaged in the psychoanalytic process of 'listening in' to the silence of the other. Gestalt theory describes this as a 'figure-ground reversal'; whereby silence, normally the ground of conversation, becomes the figure or focus (Denham-Vaughan and Edmond, 2010).

Beyond words, Denham-Vaughan and Edmond (2010:16) assert that "the deepest level of connection may only be possible in total stillness and silence"; here words may only serve as interruption (Harris, 2004; Denham-Vaughan and Edmond, 2010; Bravesmith, 2012). This is illustrated by Capretto, a chaplain working with trauma in bereavement. In his clinical example of supporting a woman by the bedside of her dying mother, Capretto, (2014:354) notes that it was when he "stopped talking and let the moment be", that she was released to find a way forward; he claims that therapeutic silence accomplishes something that cannot be fully actualised in speech noting a quality of theological wholeness which includes both respect and non-abandonment. Tornøe et al. (2014) report that palliative care nurses recognise a similar quality of silence in care of the dying; they conclude that there comes a time when it is too late for words, when words lose all meaning.

Acknowledging the ambiguity of silence, several authors consider responsibility for the wellbeing of the patient. Back et al. (2009) emphasise that the effects of silence in the clinical encounter are largely the responsibility of the clinician. This is recognised in therapy (Harris, 2004; Sabbadini, 2004; Barber, 2009) and nursing (King, 1995; Savett, 2011). Where the intention of the caregiver is for patient wellbeing (Hill et al., 2003) every silence presents a decision; wise decisions not to speak are described as purposeful (King, 1995), intentional or deliberate (Savett, 2011).

3.3.2 Focus Two: The use of silence

All papers refer to the use of silence. Life experience (Barber, 2009), culture (Moriichi, 2009), professional philosophy (Hill et al., 2003) and personality of the

caregiver (King, 1995; Wilmer, 1995; Moriichi, 2009) are all factors which may influence decisions about when and how to use silence. This is discussed further below together with reflections on training and practice. In addition several papers, including Himelstein et al. (2003), Back et al. (2009) and Capretto (2014), support the interpretation of Barber (2009) that use, alone, is not enough.

Ladany et al. (2004) find a range of client focused reasons why therapists use silence in therapy; some convey a quality of themselves, such as understanding, empathy, respect, others are supportive in quality, including holding, nurturing, facilitating reflection or giving the client permission to be themselves. A third category attends to the therapeutic space, honouring what has been said and providing the conditions that facilitate therapeutic work.

Hill (2004) proposes a different use of silence, comparing the psychoanalytic aim of transformation with the Buddha's quest for enlightenment. He describes silence of the body as "letting go of ego" (Hill, 2004:29) and a gateway to transcendence.

Ladany et al. (2004:7) conclude that "no specific recommendations can be made in terms of when to use silence" amplified by Hill et al. (2003:514), "Clinically, it does not make sense that more or less silence would necessarily be good; rather it makes sense that silence could have many different impacts depending on timing and client need". However it is generally agreed that, in psychotherapy, a strong therapeutic alliance is a pre-requisite for the use of silence (Hill et al., 2003; Ladany et al., 2004; Sabbadini, 2004). It is not advised to use silence early in the therapeutic relationship (Hill et al., 2003; Ladany et al., 2004; Bravesmith, 2012), with clients who are

disturbed (Hill et al., 2003) or have poor past experience of silence (Wilmer, 1995; Ladany et al., 2004; Barber, 2009).

There is acknowledgment that effective use of silence requires training and practice but Hill et al. (2003) and Ladany et al. (2004) find that there is little formal training in the use of silence in psychotherapeutic practice. Therapists attribute growing confidence largely to their own clinical and supervision experience which offer different perspectives on the experience (Barber, 2009). Hill et al. (2003:521) conclude, "It could be that graduate programmes are not doing enough to teach therapists how to use silence or it could be that silence is an advanced skill that can only be learned through clinical experience". In pastoral care, Moriichi (2009) and Capretto (2014) note that training may focus more on what to say. Across disciplines it is agreed that to become skilled at listening to silence, being comfortable with silence and being silent effectively takes skill and practise (King, 1995; Wilmer, 1995; Back, 2009; Moriichi, 2009; Savett, 2011). Thus there is general understanding that silence is more than a skill to be learned (Back et al., 2009) or a formulaic tool to be used (Capretto, 2014).

Barber's (2009) suggestion that, beyond use, silence is an experience to be entered into by both caregiver and client, is demonstrated by Himelstein et al. (2003) who describe how the palliative care team remained in silence with the anguish of a mother in order to allow her the time she needed to begin to assimilate the reality of her child's dying. To be healing and restorative, silence demands "authentic presence and a willingness to remain open" (Denham-Vaughan and Edmond, 2010:16).

3.3.3 Focus Three: The practice of silence

Thirteen papers refer to silence as practice; this may be the explicit introduction of a meditative process during therapy (Rajski, 2003; Hill, 2004), or the more implicit use of mindfulness techniques (Back et al., 2009). It may be a recommendation to adopt a personal spiritual practice (King, 1995; Savett, 2011) or simply to still oneself sufficiently to be fully present (Bunkers, 2013).

Silent presence is described as a quality of being fully in the here-and-now, being present to embodied self (Denham-Vaughan & Edmond, 2010) and being there for the other, described by Tornøe et al. (2014) as a deeply personal and relational practice. Shared silence leads to deeper connection, between the individuals involved (Barber, 2009) but also to something more, described as the transcendent which, depending on personal spirituality, may be the presence of God within the relationship (Moriichi, 2009), the recognition of a divine spark in self and other (Rajski, 2003) or a "profound inter-connectedness with all that is" (Denham-Vaughan and Edmond, 2010:5).

Silence has the potential to provide a transitional medium (Capretto, 2014). Caregiver and cared-for meet as human beings in a liminal space; the tool is not silence but the caregiver him or herself (Savett, 2011; Tornøe et al., 2014), used to nurture a mutual sense of understanding and care (Back et al., 2009; Denham-Vaughan and Edmond, 2010). Being with another in silence is described as an act of non-abandonment (Wilmer, 1995; Moriichi, 2009; Savett, 2011; Capretto, 2014), demonstrating willingness to remain even in an uncomfortable place (Himelstein et al., 2003; Harris, 2004; Back, 2009; Bravesmith, 2012; Capretto, 2014). Where speech

or interruption might indicate rejection (Harris, 2004), silent presence is enabling (Himelstein et al., 2003) allowing space and time for the other (Harris, 2004; Hill, 2004; Moriichi, 2009). Capretto (2014) goes further to suggest that silence in the presence of another facilitates processing work that cannot be effected in isolation.

Being silent with another, especially another who is suffering, is recognised as not easy (King, 1995; Himelstein et al., 2003; Back et al., 2009; Denham Vaughan & Edmond, 2010; Capretto, 2014; Tornøe et al., 2014). It may be hard to maintain attention (Bravesmith, 2012), it may be tempting to interject with words (Sabbadini, 2004), it may be uncomfortable, or even distressing as the pain of the other is shared (Himelstein et al., 2003; Harris, 2004; Sabbadini, 2004; Back et al., 2009) but these encounters are described as privileged (Himelstein et al., 2003) and rewarding (King, 1995; Tornøe et al., 2014).

Echoing Saunders' (2003) experience, Tornøe et al. (2014:6) found that "embracing silence together with the patient, demanded a mental shift from 'doing something for the patient' to focusing on 'being with the patient'" and this demands personal courage (Denham Vaughan and Edmond, 2010; Capretto, 2014; Tornøe et al., 2014).

Beyond useful and helpful (Ladany et al., 2004; Barber, 2009), beneficial (King, 1995; Back et al., 2009; Bunkers, 2013;) and empowering (Himelstein et al., 2003), silence has been observed to effect transformation (Wilmer, 1995; Rajski, 2003; Harris, 2004; Capretto, 2014) fostering a connection that goes beyond the power of words (King, 1995; Denham Vaughan and Edmond, 2010; Moriichi, 2009; Capretto, 2014) and with the potential to relieve spiritual and existential suffering (Tornøe, 2014:8).

Sabbadini (2004:239) concludes "perhaps staying with our patients' and our own silences for a little longer is the one unambiguous recommendation I can make".

3.3.4 Interpreted line-of-argument

The second step of a lines-of-argument synthesis, according to Noblit and Hare (1988), is to interpret a new line-of-argument from the main arguments of the selected papers and informed by the synthesis above. Table 4 summarises the lines-of-argument from each paper according to the three areas of focus outlined above.

Table 4. Summary of lines-of-argument in selected papers

Relationship of silence and speech	Use of silence	Practice of silence
Silence aids speech to integrity (Bravesmith, 2012) Silence is the acceptance of the limits of empathetic language and differentiation of psychic differences offering theological wholeness (Capretto, 2014) Attending to silence is a figure-ground reversal resulting in interconnectedness (Denham-Vaughan and Edmond, 2010) The dominant discourse in person centred therapy may distract therapists from non-verbal interventions and silence (Harris, 2004) Silence is complementary to speech, "a container of words" (Sabbadini, 2004)	A useful phenomenon which becomes more comfortable with experience (Barber, 2009) Therapists use silence to enhance the therapeutic relationship (Hill et al., 2003) Silence is often uncomfortable but when used purposefully can aid effective communication (King, 1995) Silence is multi-functional and has multiple conceptions. It is used for different interests (Ladany et al., 2004)	Compassionate silence enables a kind of communication that fosters healing (Back et al., 2009) Silence is bearing witness to life story (Bunkers, 2013) Silence, like meditation, is a letting go of ego (Hill, 2004) Silent presence is an empowering but difficult skill to master (Himelstein et al., 2003) A "counter cultural" adjustment in the perception of silence is needed (Moriichi, 2009) Silence is the royal way to discovering God. Finding the divine particle in self and client changes therapy (Rajski 2003) Silence is necessary for listening (Savett, 2011) Silence with another has a powerful consoling effect (Tornøe et al., 2014) Listening in to the silence of the other fosters deep communication (Wilmer, 1995)

My new line-of-argument suggests that silence is an aid to therapeutic communication. Silence works in partnership with speech (Sabbadini, 2004; Bravesmith, 2012) enabling deep communication beyond the limits of language, as listening (Savett, 2011), bearing witness (Bunkers, 2013), empathy (Capretto, 2014) and consoling presence (Tornøe et al., 2014); this fosters healing (Back et al., 2009).

Silence is multifunctional (Ladany et al., 2004), used for multiple intentions and evoking multiple perceptions. It has the potential to enhance the therapeutic relationship (Hill et al., 2003) being empowering (Himelstein et al., 2003) and transformative (Rajski, 2003).

Silence, as presence, is a difficult skill to master (King, 1995; Himelstein et al., 2003); it takes experience (Hill et al., 2003; Ladany et al., 2004; Sabbadini, 2004; Barber, 2009) and practice (King, 1995; Wilmer, 1995; Back et al., 2009; Savett, 2011). It involves letting go of ego (Hill, 2004) and a shift of focus from self to other that is integral to compassionate care (Back et al., 2009).

It is perhaps because silence can be anxiety provoking, difficult or uncomfortable, and because of the priority of speech in Western culture, that caregivers find themselves using too many words. However there is a shared perception in all the selected papers that silence is of value; this is articulated in a call for the practice of silence (King, 1995; Rajski, 2003; Hill, 2004; Back et al., 2009; Savett, 2011), a figure-ground reversal in listening to silence (Denham Vaughan and Edmond, 2010) and a counter-cultural adjustment to the perception of silence (Moriichi, 2009) in therapeutic relationships. This may require reappraisal of the dominant discourse in

person centred patient care (Harris, 2004) and consideration in caregiver training

(Hill et al., 2003; Moriichi, 2009).

3.4 Conclusion

This review sought reports of experience of silence in encounters between

professional caregivers and their patients or clients in clinical or pastoral settings. A

lines-of-argument synthesis offers one interpretation of the material; as an

interpretation it seeks, not to provide answers but to stimulate discussion (Noblit

and Hare, 1988).

The major line of argument, presented above, concludes that silence is an important

element in inter-personal communication and that silence particularly lends itself to

the spiritual and existential dimension of communication where words may fail.

Following this line suggests that the practice of silence may be an important element

of care at the end of life, where speech may be compromised and spiritual care is

recognised as important. Yet silence is acknowledged as a difficult skill to learn and

may, itself, be silenced by the dominant discourse on words. No research into silence

in spiritual care at the end of life has been found. Thus this review highlights a gap in

knowledge which may be addressed by empirical exploration into specialist lived

experience of silence in spiritual care.

Chapter Four sets out a methodology through which silence, as an element of

spiritual care, can be explored and interpreted with the aim of gaining greater

understanding of this complex phenomenon and stimulating further discussion.

CHAPTER FOUR

Methodology: A phenomenological approach

The previous chapters have introduced the phenomenon of silence, the research

context of palliative spiritual care and the purpose of this research, which is to

deepen understanding of silence as an element of spiritual caregiving by exploring

the lived experience of palliative care chaplains.

This chapter introduces the methodology and methods chosen for the conduct of the

empirical research. Methodology describes the approach; methods are the specific

tools used. Underpinning these is a philosophical paradigm that addresses questions

of ontology and epistemology, the nature of reality and how knowledge can be

known (Guba and Lincoln, 1994; Snape & Spencer, 2003). A good fit between the

subject and research question, methodology and paradigm, leads to relevant

methods and ensures congruence and cohesion (Silverman, 2010) and contributes to

trustworthiness and confidence (Finlay, 2008).

Because this research seeks to deepen understanding of spiritual caregiving silence

by exploring questions of nature, meaning and value in the lived experience of

palliative care chaplains, a phenomenological approach is proposed.

4.1 Philosophical paradigm

Van Manen (1990) explains phenomenology as a human science research approach.

Human science was developed by Wilhelm Dilthey (1883) as a middle way between

positivist explanations of the natural sciences, abstract concepts of metaphysics and

the economic focus of the historical school. Dilthey argues that, in human science, experience is contextualized by consciousness. He uses the term "facts of consciousness" (Dilthey, 1883) to describe understanding, given in inner experience, as a reflexive approach to the exploration of reality. Following Dilthey, Edmund Husserl, who, as Pascal (2010) notes, is regarded as the founding father of phenomenology, offers an alternative to positivism as a foundation for knowledge and truth (Husserl, 1970) by drawing upon human experience in the everyday 'lifeworld', described as "the original, pre-reflexive, pre-theoretical attitude" (van Manen, 1990:7).

Thus phenomenology is the study of how things appear to human consciousness (Finlay, 2009). Descriptive in process, it uses language to illuminate the human experience (Giorgi, 1985; van Manen, 1990). Research is approached with an air of curiosity, openness and freedom from theory or framework (Finlay, 2009); the researcher enters into a dialogue with the phenomenon in question, to explore the nature of its being (Smythe et al., 2008). The process involves concentrated focus, described by Moustakas (1990) as 'intentionality', a direction of attention, towards phenomena encountered in everyday life. For Husserl (1962), the aim was to uncover the essence of the thing-in-itself.

Martin Heidegger, Husserl's pupil, introduced an ontological approach centered on the notion of being. His concept of *Dasein*, translated as "there-being" (Encyclopedia Britannica, 2014) expresses the uniqueness of human being and the situatedness of that being in the world. From Heidegger's perspective, understanding and interpretation are inherent qualities of human being; they are not only a conscious

process of acquiring knowledge but already inherent in the act of experiencing (Finlay, 2009).

In Heideggerian phenomenology the subjectivity of the researcher is acknowledged; the researcher engages actively in the process of understanding, and brings to the research a history of interpreted experience. Gadamer (1976) suggests that the purpose is, not to objectify the phenomenon, but to identify and accept the unique viewpoint of self by bringing into focus personal and prior understandings and assumptions. This is achieved through 'reflexivity', described by Etherington (2004) as the ongoing cycle of self-understanding, changed in the light of experience and, then, interpreted by the developing self. In this research, reflexivity involved a continuous process of hermeneutic reflection, using self-dialogue and journaling, enriched by conversations with others, engagement with existing literature and my own primary data.

Hermeneutics is the study of the theory of interpretation. Originating in biblical scholarship, hermeneutics describes a circle of dialogue between author, text and reader that illuminates original meaning, and seeks resonance with the reader's own experience. In his hermeneutic turn, Heidegger extended the term 'text' to any human action or situation (van Manen, 1990; Hoy, 1993). Thus the hermeneutic process is essentially a dialogue between self and the world.

In his work *Truth and Method*, Gadamer (1975) introduces and discusses the concept of interpretive horizons (Stanford, 2014); he suggests that the unique perspective that the researcher brings to the subject, and text, is comprised of personal experience, culture and history. This personal horizon, with its subconscious biases

and assumptions, can limit discovery but, when acknowledged reflexively, may allow other horizons to come into view uncovering new and different dimension of meaning (van Manen, 1990). It is from the fusion of these multiple horizons that an interpretation may emerge which strives for truth (Gadamer, 1976).

The philosophy of Heidegger and Gadamer offers concepts that are relevant to this thesis. *Dasein* (Heidegger, 2010) resonates with the quality of 'being there' (Speck, 1988) which characterises spiritual care. The relational quality of being-in-the-world, identified by Heidegger, is reflected in chaplains' understanding that the other person is approached, not through objectivity, but through shared humanity (Nolan, 2012). This is resonant with a relational hermeneutic, which privileges community over text, as noted by Todd (2013) in his research into interactions in Bible-study groups. The notion of horizon (Gadamer, 1976) influenced the design of this research which explores, firstly, the experience of the researcher as personal horizon and, then, the experience of other chaplains to gain a perspective from the fusion of multiple horizons.

4.1.1 Ontology and epistemology

Ontology and epistemology are metaphysical philosophies concerned, respectively, with the study of existence and knowledge. In a research context they offer a range of ways of perceiving and presenting reality and truth (Finlay 2006). Psychologists Braun and Clarke (2013) have described ontology as a continuum between two philosophical polarities of realism and relativism. A realist position assumes that a single reality exists independently of human perception whilst a relativist perspective perceives reality as entirely dependent on human interpretation and knowledge; as

Snape & Spencer (2003:11) argue, social reality is "only knowable through the human mind and through socially constructed meanings" and therefore there are multiple and context-specific realities.

Within the range of these poles, the contemplative construction of reality (Braman, 2007), identified as suited to the subject and context of this research, lends itself to a mid-point on the continuum described as 'critical realism'. Critical realism, echoing the human science perspective of Dilthey (1883), is defined by Braun and Clarke (2013:26) as acknowledging that a "pre-social reality exists but we can only ever partially know it".

Wright (1992:35), a theologian, explains critical realism as realist because it acknowledges "the reality of the thing known as something other than the knower" and critical because it recognises that "the only access we have to this reality lies along the spiralling path of appropriate dialogue between the knower and the thing known". This is consistent with the transcendent dimension within spirituality and my perception of silence as an external reality, as well as a human disposition.

Where a critical realist stance is sometimes understood as a position of objectivity, Heidegger's ontology of being extends the potential for dialogue beyond the relationship between the knower and the thing known. The concept of '*Dasein'* contextualises the knower as being-in-the-world; existing in relationship with self, others, the natural world and the significant or sacred which has been defined as the domain of spirituality (EAPC, 2014). This phenomenological approach emphasises the relational nature of exploring reality (Finlay and Evans, 2009) which, in a tendency

towards relativity, acknowledges the capacity for multiple layers and perceptions of meaning, echoed in the understanding of multiple horizons (Gadamer, 1976).

Figure 3 locates the ontological position adopted for this research, within an adaptation of the continuum presented by Braun and Clarke (2013).

Relativism   **Critical Realism**   **Realism**

| Reality is dependent on the ways we come to know it | A pre-social reality exists but we can only ever partially know it | A pre-social reality exists that we can access through research |

- Multi-layered
- Fluid
- Contextual
- Constructed

- External
- Approachable through dialogue

- Single
- Fixed
- External
- Observable

Ontological position of this research

Reality is:
- External
- Relational through human-being-in-the-world
- Understood through multiple horizons
- Uncovered in the exploration of lived experience

Figure 3. Ontological position of this research
Source: Braun and Clarke (2013:26 Figure 2.1)

This ontological position locates the researcher within the external world of the research in a way which is relational through being-in-the-world (Heidegger, 2010). It acknowledges multiple horizons of perception and seeks to uncover new perspectives on reality through the exploration of lived experience. Thus, this research takes a "subjective-objective" (Heron and Reason, 1997) epistemological approach.

Heron and Reason (1997) argue that experiential knowing arises from meeting with the phenomenon and, therefore, it is participative; this is resonant with the critical realist approach to knowing through dialogue described by Wright (1992), and is supported by the chosen methodologies. As presented by Moustakas (1990) knowledge described as understanding is discovered, not by objective observation, but by engaged immersion of the subjective individual in the phenomenon. He places value on human interpretation and intuition, explaining how the involvement of the researcher in the research process is recognized and capitalized upon to uncover new dimensions of meaning in human experience. Van Manen (1990) assumes an orientation to the phenomenon, that is, I approach this research from the perspective of a palliative care chaplain and a person who has an interest in and experience of silence. This does not mean that findings are of lesser value than knowledge generated in objective, natural science research, rather they are of different value (Braun & Clarke, 2013), and have the potential to contain meaning and convey truths, which make no claim to generalisability, but may have universal application (Moustakas, 1990).

4.2 Methodology

From the many phenomenological approaches that have evolved from the work of Husserl and Heidegger, two were adopted in the design of this research to respond to the research question in a methodologically appropriate way. The two phases and their purpose are outlined in Table Five.

Table 5. Two phase methodology employed in this research

Phase and method	Stages in research	Purpose
Phase One Heuristic Inquiry (Moustakas, 1990)	**Stage One** Self-inquiry into researcher's own experience of silence in two areas: **Stage One, Part One** Silence in researcher's own spirituality **Stage One, Part Two** Silence in researcher's professional practice as a palliative care chaplain **Stage Two** Unstructured interviews explored silence in the personal experience and spiritual care practice of a small sample (n=3-7) of other palliative care chaplains.	To gain insight into researcher's own experience and understanding of the phenomenon of silence, in both personal experience and professional practice, and to explicate tacit knowledge. To verify the researcher's experience and seek other experience in order to broaden the horizon of understanding.
Phase Two Hermeneutic Phenomenology (van Manen, 1990)	Specific examples of silence, encountered in palliative spiritual caregiving were sought from a larger sample (n=8-15) of palliative care chaplains, in conversation-style interviews.	To produce a textural description and interpretation that allows the phenomenon to show itself in ways which deepen understanding.

The purpose of this research was to explore palliative care chaplains' lived experience of silence in spiritual caregiving at the end of life. Van Manen (1990) presents hermeneutic phenomenology in the context of pedagogy but his focus on care translates into the context of palliative spiritual care and his emphasis on the value of silence, within the research process, resonates with the interest of this research.

The subjective-objective and interpretive nature of this inquiry, which uses the researcher as the primary instrument of research (Boyd, 1993), demands a high level of reflexivity (Etherington, 2004). This strong emphasis on researcher involvement

informed the decision to design a preliminary research phase. An entry in my research journal explains:

> As both palliative care chaplain and researcher, I needed to explore my own understanding of silence, in my own 'lifeworld', in the every-day experience of my spiritual life and of my professional world of palliative spiritual care. Only in the light of this expanded self-awareness with recognitions of my own pre-assumptions and hermeneutic horizon (Gadamer, 1976) would I be open to the new dimensions of meaning that may arise from the experience of other palliative care chaplains (Journal 16/01/13).

The research method chosen for this initial phase was heuristic inquiry. Derived from the Greek *heuriskein*, meaning "to discover or find out" (Moustakas, 1990:9), heuristic inquiry focuses on human knowing, exemplified in the *eureka* moment of Archimedes. It is a process of self-inquiry drawing on Moustakas' (1990:15). statement, "the heuristic process is autobiographic, yet with every question that matters personally, there is also a social – perhaps universal – significance".

The heuristic phase follows six stages outlined by Moustakas (1990):

Initial engagement acknowledges the autobiographical source of the question. A central tenet of heuristic inquiry is that the researcher has personal experience of the phenomenon to be explored. Moustakas (1990:13) claims, "the initial data is within me: the challenge is to discover and explicate its nature".

Immersion describes staying fully with the experience of the phenomenon. There is no limitation on the sources of raw material for reflection, self-searching, pursuit of

"intuitive clues of hunches . . . and knowledge within the tacit dimension" (Moustakas, 1990:28).

Incubation is a time of waiting, a retreat from the intense focus of immersion drawing on the understanding of Polanyi, "that discovery does not ordinarily occur in the deliberate mental operations and directed calculated thoughts" (Moustakas, 1990:29).

Illumination marks a change of perception and is dependent upon an attitude of perceptive awareness. Moustakas (1990:29) describes illumination as "a breakthrough into conscious awareness of qualities and a clustering of qualities into themes".

Explication involves examining what has arisen in the form of reflexive writing and self-dialogue. It encourages new understanding and insights to emerge both from the data and from reflection on the data.

Creative synthesis draws together threads and themes to bring the internal frame of reference into view (Kenny, 2012).

Phase One of the research enabled an exploration and evaluation of my personal horizon of understanding of silence expanded by the experience of other palliative care chaplains who participated in the process as 'co-researchers'. Co-researcher is a term used by Moustakas (1990) to emphasise the equality of relationship between participant and researcher; he suggests that interviews take the form of a co-

operative sharing in which both parties may open pathways to the other for deeper understanding of the phenomenon being explored.

In addition, Phase One fostered the cultivation of phenomenological attitude before embarking upon Phase Two which focused specifically on chaplains' experience of silence in spiritual caregiving relationships. Whilst 'phenomenological attitude', described by Boeree (2000) as accepting the inter-subjectivity of self and world and allowing the phenomenon to reveal itself, is introduced at this stage, it is engaged throughout the research process.

In Phase Two a hermeneutic phenomenological approach was employed, defined by van Manen (1990:180) as:

> attentive to both terms of its methodology: it is a descriptive (phenomenological) methodology because it wants to be attentive to how things appear, it wants to let things speak for themselves; it is an interpretive (hermeneutic) methodology because it claims that there are no such things as uninterpreted phenomena.

Hermeneutic phenomenology is a method that focuses on text for both data and analysis. In the act of reading and writing, researchers open themselves to the interpretive process (van Manen, 1990). In this research the initial text took the form of interview transcripts, the process captured chaplains' lived experience in descriptive language and then used written text to interpret essential qualities. Hermeneutic phenomenology has been described by Stirling (2010:40), a healthcare chaplain and researcher, as "a powerful tool to explore the provision of spiritual

care". It offers a method which is sympathetic to spiritual care in intent and process (Swinton and Mowat, 2006).

4.3 Methods

For both phases, the aim was to recruit palliative care chaplains as co-researchers and participants for the following reasons: chaplains are identified as the primary givers of spiritual care with an overall responsibility for service delivery (NICE, 2011); reflective practice is integral to their role (AHPCC, 2003); they present themselves as the primary instrument of care (Nolan, 2012), with no other task or purpose, and thus may be more available for times of silence than other professionals who have competing priorities.

Consistent with qualitative methods, a purposive sampling approach was chosen to recruit a cohesive cohort of information rich participants (Pascal, 2010). In addition to my own self-inquiry, a sample of between 11 and 22 participants was sought across both phases. This reflects sample sizes in other phenomenological doctoral research (see Mason, 2010) and aimed to strike a balance between collecting sufficient data to produce meaningful findings and pragmatic decisions about time and resources for in-depth analysis. To contextualise this sample size: whilst the number of palliative care chaplains in the UK is not known, the Association of Hospice and Palliative Care Chaplains' (AHPCC) had 162 members at the time of writing this thesis (Rattenbury, pers. comm. 30/09/2016), thus the proposed sample represents approximately ten per cent of the Association membership.

Chaplains were recruited through the AHPCC. Criteria for inclusion were that participants should be currently in post as a palliative care chaplain and have at least

one year's experience in end-of-life spiritual caregiving. The aim was also to attempt to achieve an overall balance between male and female.

4.3.1 Phase One: Heuristic inquiry

Phase One of the research involved two stages; Stage One utilised self-inquiry to explore my own experience of silence in personal spirituality and in my professional practice as a palliative care chaplain. In Stage Two, I interviewed other palliative care chaplains to broaden my horizon of experience. A process of immersion, incubation, illumination and explication was used throughout this phase following Moustakas' (1990) heuristic inquiry method described in section 4.2 of this chapter.

4.3.1.1 Stage One: Self-inquiry

In order to immerse myself in the phenomenon of silence, in the Christian tradition that has formed my own spiritual practice, I undertook a three day silent retreat, in March 2013, at Worth Abbey in England. This Benedictine monastery was the location for the BBC television series 'The Monastery' that had contributed to my research interest.

To explore silence in my professional practice I reflected on accounts, recorded in my reflective journal, of my experiences of silence in encounters with patients and their family members. Names and other identifying details have been anonymised. In the analysis process I underlined key phrases, which illuminated qualities of silence, distinguishing between descriptions of what happened and the feelings and reactions that were evoked in me. In addition, I explored the notion of 'ownership' of the silence within the caregiving relationship: who initiated and who maintained the

silence. Qualities of silence were extracted and clustered to arrive at emerging themes.

4.3.1.2 Stage Two: The experience of other chaplains

A sample of between three and seven co-researchers was sought. The initial approach was made to regional representatives of the London and South East Regions of the AHPCC using an invitation e-mail with an attached flyer, expression of interest form and participant information sheet (Appendix 4) with a request to circulate to members.

Data collection: Consistent with the heuristic approach, the interview format was unstructured in style (Patton, 1980). The interview focused on two areas: co-researchers' personal experience of silence and their experience of silence in encounters with patients or family members. A topic guide (Appendix 5) was used to provide prompts, where needed, whilst offering flexibility for the conversation to take its own course to encourage individual expression and elucidation. Moustakas (1990) suggests that this dialogic style also allows self-disclosure on the part of the researcher, which has been shown to elicit disclosure from co-researchers. A period of one to two hours was scheduled, with the possibility of a further appointment if needed; Moustakas emphasises the importance of the individual having the opportunity to tell his or her story to a point of natural closing.

Interviews were recorded and transcribed by me as part of the immersion process. Specific information, such as location and names, was anonymised and pseudonyms were ascribed to co-researchers.

Data analysis: Transcripts were read and re-read until the experience as a whole, and its detail, was understood. Phrases that illuminated core qualities of silence were highlighted and extracted, distinguishing between descriptions of silence in the chaplains' personal experience and in their professional practice. The material was set aside for a period of time. On returning to the transcripts, qualities and themes were grouped and a conception of meaning for each individual began to form; this provided the basis for a written 'depiction'. Moustakas (1990:49) describes depictions as a "portrait of each participant's experience"; they retain the original language of the co-researcher and include examples of their experience. A depiction and personal profile was created for each co-researcher. Depictions were checked by co-researchers for accuracy and completeness.

Following Moustakas' approach, I returned to the transcripts and individual depictions for a further period of immersion and incubation in order to produce a composite depiction of the experience of all three participants, highlighting universal qualities and themes while retaining the personality of individual participants by use of their own words.

The final stage in this phase was to produce a creative synthesis, incorporating the whole experience into an "aesthetic rendition of the themes and essential meanings" (Moustakas, 1990:52) which characterise the phenomenon.

4.3.2 Phase Two: Hermeneutic phenomenology

The purpose of this second phase was to gather examples of lived experience of silence in spiritual care giving encounters, from an additional and larger group of

palliative care chaplains, in order to gain a deeper understanding of the essential

qualities of a type of silence which might be described as spiritual caregiving.

A cohort of eight to fifteen palliative care chaplains was sought in an extension of the

recruitment process for Phase One. Small amendments were made to the participant

information pack for which Ethics Committee approval was gained (Appendix 6). An

invitation e-mail, with the participant information pack attached, was sent to

Regional Representatives of the London, South East, East Anglia and Midlands

regions of the AHPCC with a request to circulate to members.

Data collection: Interviews took an unstructured approach starting from an initial

question, "Can you tell me about an experience of silence with a patient, and/or their

relatives, close to the end of their life?" The conversational style interview allowed

participants to recount their own experiences, and what they meant to them, in their

own words providing a richness of data, which might have been constrained by a

structure of questions (Stirling, 2010). Because of the unstructured nature of the

interview, participants were notified of the question in advance so that they had

time to choose an encounter, or encounters, which they could recall in sufficient

detail and depth, including what happened and the feelings they experienced (van

Manen, 1990). Interviews were digitally recorded and transcribed by me to gain early

familiarity with the data.

Data analysis: There is no prescribed method for data analysis in hermeneutic

phenomenological research (Finlay, 2009). However van Manen (1990) suggests

possible approaches to uncovering thematic aspects of a phenomenon. Thematic

aspects do not capture the phenomenon entirely, but serve to provide pointers to

facets of the phenomenon and contribute to a fuller description of the structure of lived experience.

In this research two approaches were adopted. The first is described by van Manen (1990:93) as "wholistic reading" where attention is given to the text as a whole. Individual accounts of spiritual care encounters, within the transcripts, were summarised into short narrative paragraphs. From these, with careful cross-checking with the original transcript, a meaning statement was formulated which attempted to capture the main significance of the caregiving silence described in the account. Formulated meaning statements were clustered and thematic meaning was attributed to each cluster. In turn, thematic meaning clusters were grouped in order to reveal emerging themes. A worked example of the process is included in Appendix 7.

Secondly, a "selective reading approach" (van Manen, 1990:93) was applied to each transcript. Statements or phrases that seemed to be particularly revealing about the phenomenon were highlighted and then extracted. Statements were studied to identify their relevance to the phenomenon in order to formulate thematic meaning. Three questions, drawn from the original research question, guided my approach: What does the statement reveal about the phenomenon of silence? What does the statement reveal about the meaning of silence as an element of caregiving? What does the statement reveal about the perceived value of silence in the encounter?

In the same way as in the wholistic approach, formulated meaning statements were clustered and thematic meaning was attributed to each cluster, then thematic

clusters were grouped to reveal emerging themes. Figure 4 shows the process in both approaches.

	Wholistic approach	Selective approach
Aim	To capture the significance of each account as a whole	To identify statements in each transcript which reveal aspects of the phenomenon from which to formulate thematic meaning
Process 1.	Each account is summarised into a narrative paragraph	Statements are highlighted and extracted
2.	Thematic meaning is formulated for each paragraph or statement	
3.	Meaning statements are clustered and thematic meaning attributed to each cluster. (Cluster of < 5 statements eliminated and meaning statements reallocated)	
4.	Thematic meaning clusters are grouped to reveal emerging themes	

Figure 4. Phase Two data analysis process

Emerging themes from both approaches were compared and combined in conjunction with their thematic meaning clusters to distinguish between incidental and 'essential themes'. Essential themes are defined by van Manen (1990:107, original italics) as those *"which make a phenomenon what it is and without which the phenomenon could not be what it is"*; essential themes provide the substance of the phenomenological text.

As in the heuristic phase, hermeneutic phenomenology requires the researcher to "dwell with the data and interrogate it" (Finlay, 2008:5). It is a process which is both reflective and dialogic (Etherington, 2004; Finlay, 2009) moving, by way of a hermeneutic circle from part to whole and from whole to part. The points on the

hermeneutic circle, at this stage of the analysis, were comprised of the emerging

themes and clusters, the lived experience of the participants and my own reflexive

experience illustrated in Figure 5.

Emerging themes and clusters

Spiritual caregiving silence

Participants' lived experience

Researcher's reflexive experience

Figure 5. The hermeneutic reflective process to discern essential themes of spiritual caregiving silence

The next stage of the analysis was to return to the transcripts to search for material

that elucidated the major emerging themes. In addition it was important to be open

to new themes or perspectives that might emerge from the raw data in the light of

understanding gained through the analysis process. Finally, over-arching themes

were identified which, supported by the emerging themes, provided a matrix to

report findings.

4.4 Ethical considerations

Research was undertaken according to the principles of biomedical ethics including beneficence, non-maleficence, justice and respect for autonomy (Beauchamp and Childress, 1989). The research proposal was submitted to the Lancaster University Ethics Committee together with full details of measures taken to protect participants, the researcher and other third parties during the progress of the research. To this end, any identifying data were removed during transcription; pseudonyms were applied to participants and to persons they described. In addition, measures were put in place for the wellbeing of participants including checking their wellbeing at the end of the interview and providing details of a counselling service if any issues should arise. All participants had the right to withdraw from the research for up to two weeks after the interview. Transcripts were stored in a locked filing cabinet and on a password protected computer. Sensitive data were encrypted. Approval was granted for the research to proceed on 22nd March 2013 (see Appendix 6).

4.5 Quality assurance

In phenomenological inquiry, which takes a contextual and situated approach to research (Denzin & Lincoln, 2000) trustworthiness and resonance are the markers of quality. From a narrative research perspective, Polkinghorne (1983:46) offers four qualities of trustworthiness which are transferable to this phenomenological method; "vividness, accuracy, richness and elegance". A reflexive and transparent approach, clarity of process and quality of data aim to communicate a coherent and

comprehensible thesis. Inclusion of verbatim quotes and participant validation contribute to accuracy.

Both Moustakas (1990) and van Manen (1990) emphasise the commitment, discipline and rigour involved in the research process which is located largely in the person of the researcher. Knowledge is not presented as fact but "is contingent, proportional, emergent, and subject to alternative interpretations" (Finlay, 2009:17). Phenomenology aims to draw the reader into the researcher's discoveries, moving them to recognise the phenomenon from their own experience (Finlay, 2008) and this identification will in turn reinforce trustworthiness and provide further assurance of quality.

In conclusion, the chapter has outlined a philosophical approach which is primarily concerned with how human beings interact with the world. It describes a relational ontological position; reality is understood through being-in-the-world. A participative, subjective-objective epistemology supports deepened understanding through the exploration of lived experience. Two phenomenological methodologies enable this interpretive process through immersion and explication and a reflexive hermeneutic. The methods outlined by Moustakas (1990) and van Manen (1990) provide a way of progressing from context, phenomenon and question to data collection, analysis and the findings which are reported in Chapters Five and Six.

CHAPTER FIVE

Phase One findings: Silence in chaplains' personal and professional experience

The objective of Phase One of this research was to explicate tacit understandings of the phenomenon of silence in palliative care chaplains' personal experience and in their spiritual caregiving practice. It incorporated two stages and Stage One involved two parts, shown in Table 6. As self-inquiry, Stage One focused on silence in my own personal and professional experience. Stage Two sought experience of silence from other palliative care chaplains.

Table 6. Research stages in Phase One

Stage One, Part One	Silence in researcher' own spirituality
Stage One, Part Two	Silence in researcher's spiritual caregiving practice
Stage Two	Silence in co-researchers' personal experience and in their spiritual caregiving practice

In exploring silence in my own spirituality (Stage One: Part One), I identified a disposition of self that linked my experience of silence in personal and professional practice through a sense of interior space that was common to both. It is a space that surfaces in my awareness when I give attention to another, whether that is God or another human being. Finally, I learned that my silence has both purpose and depth. These discoveries contributed the five emergent themes shown on Table 7. In my spiritual caregiving practice (Stage One: Part Two), I identified six other themes that described qualities of silence in encounters with patients and their family members.

These will be discussed in section 5.2 of this chapter and provided a horizon of my understanding of the phenomenon of silence at this stage in the research.

Table 7. Emergent themes in Phase One

Stage One	Part One Silence in researcher's own spirituality	Part Two Silence in researcher's spiritual caregiving practice
	Disposition of self Interior space Attention to other Purpose Depth	Stillness Listening Communication Connection Companionship Witness

Adding the personal and professional experience of three other palliative care chaplains, recruited as co-researchers for Stage Two, expanded this horizon to include other divergent themes presented in section 5.3.

These other chaplains perceived silence to be important, both in their own spirituality and professional practice, confirming to me that the subject was worthy of further research. This chapter describes, in detail, the stages of research and the findings which emerged.

5.1 Stage One, Part One: Silence in my own spirituality

During a silent retreat in March 2013 and in the weeks that followed, three understandings emerged. The first, explained to me by my retreat master, is that silence is not an end in itself; silence must have a purpose. In Benedictine spirituality that purpose is purity of heart (Benedictine Handbook, 2003), drawing on the statement of Christ, "Happy the pure in heart: they shall see God" (Jerusalem Bible, 1968: Matthew 5:8); thus silence is an approach to seeing, or seeking, God.

Extrapolating from this particular understanding, a wider application of 'purposeful silence' might be described as creating, or protecting, a defined time and space for a particular intention. For me, as a chaplain, that intention is to be with another person.

The second understanding arose early in my silent retreat, and presented something of a paradox. Whilst the entry point to understanding a phenomenon is immersion in that phenomenon (Moustakas, 1990), it very quickly became clear to me that I could not immerse myself in silence and, simultaneously, reflect upon my own understanding of the process. A journal extract explains:

> My focus on some outcome, some progress, limits my experience of the silence. It skims over the surface of the project, hoping to join the dots, a to b, (Figure 6) by the shortest available route rather than allowing me to submerge and dive to the depth of that deep, and possibly dangerous place, where I may truly experience something new. (Journal 22/03/2013)
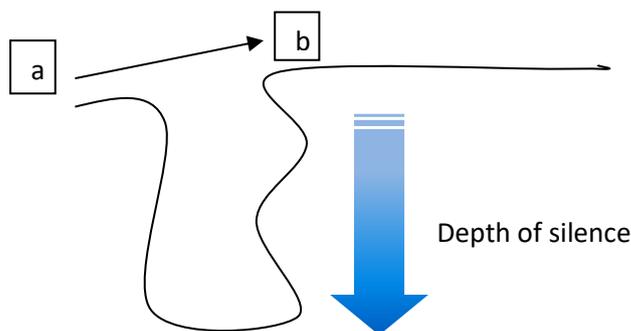
Depth of silence

Figure 6. A diagram to illustrate my understanding of depth of silence

This research experience resonated with my experience as a chaplain which is that to be fully open to whatever may emerge in the encounter, demands a depth of personal silence that is free from agenda and expectation. The same journal entry

notes, "The problem with planning and expecting outcomes in the patient encounter is that it limits my capacity to be fully available to the other."

This understanding suggested a common thread which linked my spiritual caregiving practice, personal spirituality and the hypothesis-free process of phenomenological research.

A distinction began to emerge between purpose as an orientation, or way of being, and purpose as an outcome which implies some expectation of result. My reflection was further complicated by the metaphysical notion that, in the act of observing my silence, the nature of that silence would be changed.

I discovered that silence demands full attention, not attention upon itself but attention on the original purpose of the silence, whether it be to "listen to the silence of God" as described by Merton (in Maitland, 2008:24), or to listen to the silence of another person in an interpersonal encounter.

My third understanding flowed from this: I came to realise that my experience of silence with patients and their family members *felt* the same to me as my experience of silence in prayer. This feeling is best described as a sense of waiting on the other, somehow placing my silence at their service.

In summary, I came to understand my own silence as a disposition of self, which was more than simply a decision not to speak but also as an intention to silence my own thoughts and agendas and to minimise my response to distractions, in order to give time and full attention to the other who is the focus, or purpose, of my silence. In prayerful silence, I enter into an interior space where I wait upon God; as a chaplain,

I draw upon the same interior space when I enter into silence with another person. I was reminded that, in order to be truly and usefully silent with others, I need sufficient time in silence myself.

5.2 Stage One, Part Two: Silence in my spiritual caregiving practice

The second part of this self-inquiry focused on my experience of silence in my professional practice. This was captured in 11 journal entries recorded between March and September 2013, which reflect on silence in encounters with patients and their families. The full text of three accounts is included in Appendix 8. Details of people involved, context and qualities of silence are summarised in Table 8, below.

Table 8. Summary of journal accounts of silence in spiritual caregiving encounters

People encountered (pseudonyms)	Setting and context	Discerned qualities of silence
Paul (deceased) His family	Chapel of rest Following ministry at the time of death	Family silence: shock My silence: waiting, stillness, holding, grounding, solidarity
Sarah (patient) Tony (partner)	Patient's room General conversation, "banter"	My silence: stillness, patient focus
Sarah (patient – as above) * Nurse Jane (nurse)	Patient's room Presence when conversation is not possible Recalled encounter with panicked patient	Sarah's silence: physiological condition My silence: attention Nurse's silence: stillness, compassion, watching, waiting Nurse's silence: stillness
Josie (patient)*	Visits to bedside over a period of weeks. Josie used silence to express anger.	Josie's silence: used as rejection My silence: attention, connection
Henrietta (day care patient)	Day care lounge Silence as absence of conversation	Shared silence: companionship
Maggie (patient)	Patient's room Silence because Maggie cannot speak	Maggie's silence: physiological condition My silence: companionship, uncomfortable, compassion
Tom (son) Julie (daughter)	Quiet Room (chapel) Following the death of their father, Mick	My silence: listening, calm
Grace (patient) David (husband)	Patient's room Following prayer of blessing	Silence in the room: intense
Craig (patient)*	Patient's room Following consultation with doctors	My silence: space, transfer of power
Pat (patient)	Patient's room Pat's slow pace of speech is influenced by weakness and shock	Our silence: gaps and pauses between words
Vilna (unconscious patient) Son Fr Jim (priest)	Patient's room At the time of religious ritual	The silence: thick, heavy, tangible, filled with love

*Full account included in Appendix 8

5.2.1 Ownership of the silence

During analysis, I noticed how the silence moved between the people engaged in the interpersonal relationship. For example, silence was sometimes initiated by one and then maintained by the other. Exploration of this movement, which I describe as 'ownership', helped me to understand to whom, in each reported encounter, the silence belonged (Figure 7). In almost half of the statements, extracted from my journal accounts, which describe qualities of silence (detailed in Appendix 9), I attribute the silence to myself; it is my silence that I was observing or experiencing both during the encounter and afterwards in my reflective journaling. In one account I observed qualities of nurses' caregiving silence.

The second largest category is 'shared silence' when the silence seems to belong to neither party but is shared between the people involved. Patient or relative initiated silence was, largely, determined by distress or physical frailty.

The final category is termed 'silence in the room'; on reflection, I perceive this as my witness to a silence held between the people already there. Thus, in these accounts of spiritual care encounter, silence was always owned by, or held between, one or other person.
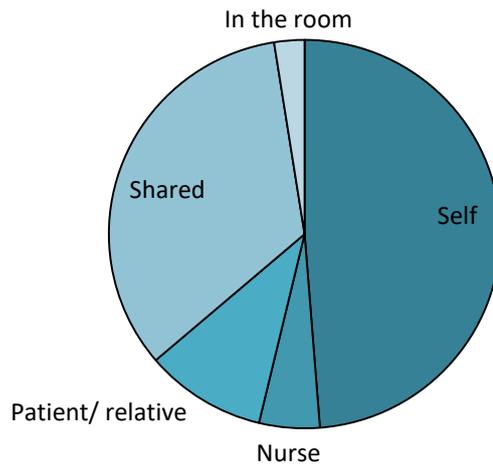
Figure 7. Ownership of silence in spiritual care encounters

5.2.2 Themes of silence

Six themes emerged from the qualities of silence discerned in my accounts: stillness, listening, communication, connection, companionship and witness. These are explored below.

Stillness is experienced as an embodiment of silence, illustrated in my account of sitting with Paul's family after his death. My stillness was a conscious and intentional decision to wait for as long as the family needed. I did not know how long that would be but when Paul's wife made eye-contact and broke the silence to thank me, I knew my silent presence had been long enough. She was ready for me to go, and the family were ready to move on. Until that point, my journal records:

> My silence seems a counterpoint to their sobbing. It feels as if my stillness is somehow holding, or grounding, their grief. It seems very important for me to remain still: one constant in the room.

I also observed this quality of stillness in nurses. For example, sitting with a patient, Sarah, who was unable to speak and in a physically and psychologically low place, I noted how reassured I was by the quiet attentiveness of the nurse, "saying not much, touching her arm lightly, watching and waiting". It reminded me of another occasion when I had watched the stillness of a nurse, Jane, calm a panicked patient:

> Jane didn't say a word, she didn't move, the quality of her stillness was captivating and calming (…) Somehow she absorbed the anguish and the pain.

During another visit with Sarah and her partner Tony, I found myself using silence and stillness to attempt to bring calm into the room. Sensing that the conversation around the bed was out of step with Sarah's condition, I found myself 'stilling', a physical sensation within my body bringing with it a heightened awareness of my physical presence in the room and the importance of my being still; stilling involves silencing both mental and physical activity, and maintaining an intention to speak no more than absolutely necessary. This sense of stilling was counter-intuitive because it was tempting to get caught up in the conversation.

Listening is demonstrated in an encounter with Tom and Julie, whose father Mick had just died; my silence allowed them to pour out their feelings of guilt and unresolved pain. I reflected that my silence was not really a matter of choice, there was rarely space to interject, but I did feel the need to break it to offer reassurance. As explained by Capretto (2014) to be silent or to speak is a discerned pastoral decision and I wondered if I had said too much, whether they were able to hear my attempts at reassurance or whether I should have listened more but, as their anguish diminished, Julie thanked me for being calm.

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My experience has been that a calm presence, however it may feel on the inside, can offer space at a difficult time. I was called to Craig's bedside during ward round; he had hours to live and much to organise. On my arrival, the rest of the team melted away. I felt unsure and instinct told me that, after the hiatus of activity that had preceded, the best I could offer was a little space. I introduced myself using a slow and deliberate pattern of speech, injecting silence between the words. There was a pause, and then Craig began to talk. It felt like handing over the baton. Afterwards I reflected that:

> [The silence] was in the transfer of power, from the healthcare professional to himself, in that fragile moment when we were left alone together amidst a pile of empty chairs. I could have spoilt it, broken it by taking control, or offering a menu of services. Instead I met him where he was in uncertainty and vulnerability. The silence was my acknowledgment that I had nothing to offer.

Communication. With Craig, I noticed that I had used silence as a means of communication; with Pat, my silence allowed him to communicate with me. This encounter illustrates the transfer of emphasis from speech to silence in palliative care conversations. Pat was weak, afraid and in shock. His words came out in gasps and silence constituted the long spaces in between: "… I feel …   just awful …   I can't …   understand   …   how this … has …   happened to me".

The gaps were filled with a sense of anticipation and I found myself hanging on each phrase. Instinctively, I began to mirror his patterns of language, holding the gaps, reducing my own contribution to short, essential phrases, waiting in my own silence,

for him to respond. Silence gave emphasis to the importance of each word; listening, with minimal interruption, allowed his story to be told.

In my own practice, silence is often supported by non-verbal actions: I am aware that sitting down changes the dynamic in the room; just sitting quietly with another person, holding hands, making eye-contact can replace the need for words. When there is no verbal conversation, attention takes on a different perspective. With Sarah, I sought a balance between offering total attention while not seeming to stare:

> I meet her gaze when she turns it upon me but I don't feel comfortable if, every time she opens her eyes, she finds me watching her, so I keep a shifting glance, at approximately forty-five degrees, trying to be a comfortable, attentive, but not intrusive, presence.

I found myself modelling the same silent disposition with Josie, a patient consumed with anger about her situation, who used silence and body language to express herself. She chose not to speak and yet she insisted that I stay with her in her angry silence; I reflected, "It was as if she wanted us to share her pain". I visited Josie for several weeks, sitting in the silence of her rejection, demonstrated by her face directed away from me, arms folded tightly. I tried to maintain an attitude of quiet attending, being there for her and with her, but not forcing my presence upon her.

In the enforced silence I felt uncomfortable, my presence felt futile, I had time to think about other things I could be doing that might be more important or useful. However, slowly, a transformation began to take place, in Josie perhaps, but also in me. I began to see the world with her eyes. In our silence external sounds, such as

disembodied laughter from the nurses' station or the arrival of an unwanted meal, were somehow amplified. My journal records:

> It was as if we shared an ironic joke about the way the rest of the world operated (…) In these wordless encounters I felt a growing connection with Josie, I came to love her.

Connection is highlighted in my encounter with Henrietta, in the Day Care lounge; she is a woman of few words and her condition has made these words fewer. Alone together, we exchanged a few pleasantries and then fell silent. I felt uncomfortable, inadequate, thinking that I should be making entertaining conversation but having none. With Henrietta, I learned something about my own capacity for silence:

> And so we sit, two people who are not good at making conversation, being together. And only now do I see the connection. If she is comfortable to be herself in silence then surely I too must have the humility to be just my silent self too. At a deep level beyond and without words, we are sharing something in common and that is our connection.

More uncomfortable by far was the shared silence I experienced with Maggie. As someone who could no longer speak, silence had become the prevailing experience for Maggie; it felt like a prison and she welcomed me in. As with Henrietta, my experience was that one-sided conversation soon runs dry. I did not know whether she would prefer me to go or stay. In both encounters, I knew that I would prefer to make my excuses and go; activity and productivity are so much easier to do than silence. With Maggie, my awkwardness was increased by the understanding that I

had a choice while she did not. I recognised that, in my discomfort, I may be sharing

something of her feeling of imprisonment. As I sat I wondered:

> If I am sharing this feeling with her, am I beginning to experience compassion
>
> in the literal sense of suffering-with? Is this in any way helpful to her? Is there
>
> a value to this that makes worthwhile the discomfort I feel?

I concluded that to be comfortable with another in silence requires me to be

comfortable in my own silence first.

Companionship involves being with another person where they are. When I sat with

Sarah who also could not speak but cried out in fear and frustration,

"oh,wo,wo,wo,wo,wo … mum, mumumm" there was no possibility of conversation.

My sense of helplessness felt "agonising". The opportunity to offer verbal

reassurance was comforting for me, but did not seem to make any difference to her.

Resonant with the findings of Tornøe et al. (2014), I knew that silence resists the

temptation to console with words.

Witness describes a silence of watching with others reminiscent of the practice

described by Saunders (2003) and noted at the beginning of Chapter Two of this

thesis. With David and Grace I witnessed a different type of silence. On reflection, I

think it was the silence of their deep love for one another, there was a sense of true

companionship and peace. Grace was close to death and I was asked to give a

blessing. After I had said the prayers, the silence felt intense. I can still recall the

tangibility of it:

It rolled across the bed, from him to me, engulfing me and slowing my senses, holding me in the moment. There was nothing more to be said and nothing more needed to do. To speak or move would have been an interruption; to stay was my privilege.

Similarly in a visit to Vilna and her son, the quality of silence seemed thick and tangible; it amplified every small sound in the room. Nobody spoke but my journal states, "the silence reached into a place deep within me and it felt very important to hold it there". Afterwards I reflected:

> The atmosphere in Vilna's room felt sacred, holy, filled with love and this was amplified by the silence; the silence of little common language maybe, the silence of little faith. But for me, God was there in a very tangible and moving way.

At the end of this period of self-inquiry I was able to establish a personal horizon of my understanding of silence, in my own spirituality and in my spiritual caregiving practice, illustrated in Figure 8.
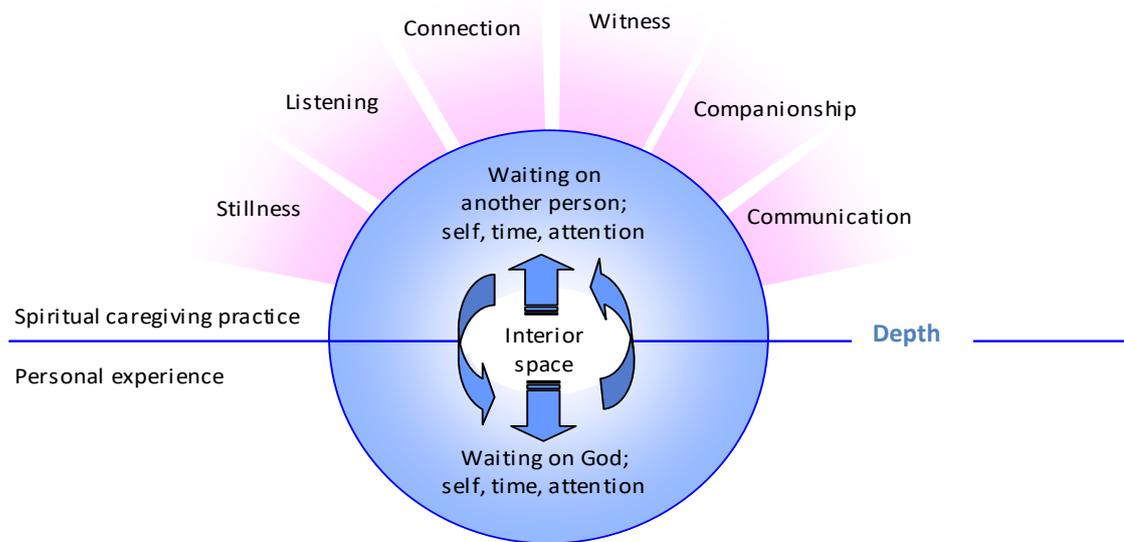
Figure 8. My own horizon of understanding of silence

I had learned that my personal experience of silence was rooted in prayer, understood as waiting on God in a disposition of giving of self, time and attention, and that my experience of silence in my spiritual caregiving practice drew upon that same place in myself and was expressed in the same giving of self, time and attention. Silence seemed to have a dimension of depth; the deeper my personal silence the more available I could be to the other. According to context, this manifested in different ways and therefore illuminated different qualities of silence including stillness, listening, communication, connection, companionship, and witness.

Noticeable in these accounts are my own feelings of helplessness and vulnerability experienced as not knowing what to say, feeling that I have nothing to offer, an uncomfortableness in not-doing and, in shared silences, the beginnings of something that might be recognised as compassion, from the Latin *com-passio*, literally the experience of suffering with another person.

Where caregiving silence is intended to enhance the wellbeing of the other person, the question emerges, is a silence in which I feel uncomfortable, in any way helpful to the other? The answer may be discerned from the understanding that being comfortable with the silence of another is dependent upon the extent to which I can be comfortable with silence myself. In addition, there is a distinction to be made between discomfort with silence and discomfort with the content of the silence. This will be explored in more depth in the discussion in Chapter Seven.

The next section of this chapter draws on the lived experience of three other palliative care chaplains to further explore the relationship of silence in personal experience and professional practice and also to expand my horizon of understanding of a type of silence which may be described as spiritual caregiving.

5.3 Stage Two: Other palliative care chaplains' experience of silence

The purpose of the second stage of Phase One of this research was to seek the experience of others to uncover new themes of the experience of silence. Three palliative care chaplains (two men and one woman, aged between 41-57) consented to participate, as co-researchers, in interviews lasting between 50-76 minutes. Two were employed in independent hospices and one in a private hospital; they had been in post for between six and ten years. All stated that they enjoyed and sought opportunities for personal silence. A table summarising personal profiles, using attributed pseudonyms, is included in Appendix 10.

Following the heuristic method described by Moustakas (1990) and explained in Chapter Four, the transcripts were searched for core qualities of silence. Words or phrases which illustrated facets of the phenomenon were identified and clustered

into themes under two categories drawn from the main foci of the interview: silence in chaplains' own experience and silence in patient or family member encounters (Appendix 11). These themes will be discussed further below. Emerging qualities of silence, common to both categories, described the nature of silence as quiet, peacefulness, space and stillness, the experience of silence as tangible, powerful and profound, the chaplain's role, in silence, of 'being there', presence and waiting and the sense of shared silence as connection and a medium for communication.

An additional thread emerged which linked the two categories suggesting that cultivation of personal silence is part of chaplains' personal practice in order for them to be with people. In common with my own experience, co-researchers identified a need for time in silence before the working day begins and also moments of mindfulness during the working day. One co-researcher suggested that because of their role, chaplains may have a greater awareness of the value of silence than other people.

As suggested by Moustakas (1990), I organised core themes into a written depiction of the experience of silence for each co-researcher, aiming to capture the essence of their experience. A sample depiction is included in Appendix 12. The composite depiction, below, draws together the depictions for all three co-researchers, retaining as many of their own words as possible.

5.3.1 Composite depiction

Silence is important to me, I enjoy quietness and silence. I find silence in the stillness of a church or in the peacefulness of the countryside. Truly silent places are hard to find and I would like more silence in my life.

Silence is notable by its presence and its absence. The opposite of silence is, not sound but, noise. Natural sounds, like birdsong or the wind, seem to enhance my sense of silence, whilst cars and other noise can feel like an intrusion or distraction. But silence is not about being noise free; a silent space may help me to be silent but, with practice, I can find my still centre even amongst the chaos and death of the working day.

Interior silence begins with a state of mind, switching off from everything that's going on around and tuning in to the present moment. There's something about silence that allows me to be with myself in a way that I can't when I'm busy-busy. It evokes awareness of being alive; everything is more immediate and intense. In prayer, silence is where I wait before God and see what it produces. There's a particular quality of connection in silence.

To be able to be with myself is crucial to being able to be with somebody else; especially in spiritual care. The importance of silence has grown alongside my work. At work, people often say that I am a calm person, though I don't always feel that way. As a chaplain I am there, not to fix, or ask a lot of questions, or get to the bottom of why people are distressed, but just to sit alongside. My silence offers the other person time to think, process or say

something they want to say. I try not to presume or assume what is going on for them in this time, but just try to hold it for them because silence offers a space that allows other things to happen.

Being comfortable in silence, with someone else, is founded on relationship and trust. Some people may not want to engage but just sit and think; chaplains have a role in helping them find enough silent time too. Sometimes I am able to hold a silent moment for another person by just holding their hand and being still. At other times, there are just no words to say and, in silence, there is a sense of connection. It is between us and, also, something more than just us; you can almost feel the presence of God. I think the profoundest silence I've witnessed was filled with a tangible sense of love.

Silence can be uncomfortable, especially with someone you don't know. If I am met with silence, I want to get out as quickly as possible. Rejection is hard but you cannot run away, perhaps the time is not right, or the patient is sussing you out. It's always worth going back because something may have changed.

The composite depiction highlights a commonality of co-researchers' experience of silence found in the natural world but also their appreciation of the value of interior silence, as a way of being with self, that they identified as important in spiritual caregiving. Silence is noted as offering space and time to another person that affords a sense of connection. The notion of silence as uncomfortable was prompted in the topic guide (Appendix 5) but the affirmative response from two out of three co-researchers illustrates the impact of this experience for a caregiver. These lived

experiences of silence, which resonate with my own experience, will be explored further in the explication of themes below.

5.3.2 Explication of themes

Table 9 details the eleven themes identified from the data that illuminate qualities of silence in co-researcher's personal experience and spiritual caregiving practice.

Table 9. Themes of silence in co-researchers' personal experience and spiritual care practice

Co-researchers' personal experience of silence	Co-researchers' experience of silence in spiritual care practice
Of the environment – external silence	Therapeutic space
Of the person – an interior disposition	Tool or intervention
Temporal	Connection and rejection
Spatial	Comfortable and uncomfortable
Transcendent	Of the other person
A medium	

These themes demonstrate divergent qualities of silence. Personal experiences reveal silence to be both interior and external to self, temporal and spatial, transcendent and a medium for other things to happen. In patient encounters co-researchers identified silence as a therapeutic space but also used silence as a caregiving tool or intervention. They noted that silence can communicate, both, a sense of connection and rejection and that it can be comfortable and uncomfortable. 'Silence of the other person' related to co-researcher's experience with unconscious patients or after death, and with bereaved relatives who have been silenced by shock; it is, therefore, not regarded as a quality of caregiving silence, nor is the use of silence as rejection.

All co-researchers confirmed that silence is important, to them personally, and also as a resource for their professional practice. Co-researcher Paul identified the growing importance of moments of quiet and stillness as he has evolved spiritually and, co-researcher, Susan spoke of the importance of silence, as time before God, before the working day. All agreed that silence is hard to find and that they would like more.

All three chaplains thought that opportunities for silence may also be important for patients and their family members, as reflective time or to make their own connection with God. Paul noted that the time for talking to stop and silence to come must be right for the patient but concluded that, "silence is an invaluable part of what we offer with people, and if it weren't there a lot would be missing."

Resonant with the explanation of Keating (2012) that, in spiritual formation, exterior silence serves the purposes of interior silence, co-researchers reported that external silence is helpful in finding interior personal space. Experiences of silent retreats were described by Paul as "hugely profitable" and John as "quite liberating" but, John explained, a correlation between external and interior silence cannot be assumed, "If it's externally quiet it doesn't mean to say you're internally quiet".

Reflecting the teaching of spiritual traditions, co-researchers stated that cultivating interior silence is a discipline and an intentional choice. Susan reflected, "I think it's a switching off from everything else and focusing" while Paul suggested that "silence is, perhaps initially, a state of mind and it is from that, that the connection with God comes … I guess the more you practice, maybe … the quicker that might happen."

Co-researchers identified silence as a space which allows things to happen. Paul illustrated this in his preference to precede verbal prayer with silence and all three spoke of the value of silent time after prayer and religious ritual. Paul said, "I'll open my eyes and just look to see where the patient's at and, you know, they're in a lovely place".

It is their own experience of the value of silent space that seems to motivate these chaplains to make opportunities for other people to find stillness for themselves. Reminiscent of the findings of Hill et al. (2003) in psychotherapy, Susan implied that anxiety detracts from silence:

> Family members, naturally, want to keep talking to the patient, talking about the patient (…) I think sometimes more would be gained from just freeing a short time of silence [to] cut the anxiety in the room, to make people feel a bit more peaceful.

She used the term "engineer" to describe her attempts to introduce silence into the caregiving relationship, assisted by touch or holding a hand. Other co-researchers described an intentional use of body language to help create moments of silence. They described the resulting silence as pregnant or expectational but, as spiritual care, John emphasised that there is no presumption about the content of the silence. He explained:

> I'm holding that silence for them, because I'm assuming that there is something going on for them. And then it becomes, like the prayer, a very intimate sharing of silence and we may or may not talk about what's happened in the silence but there's, hopefully, a mutual recognition that there's something, going on there.

Co-researchers noted that silence offers a space for connection with both self and others and John highlighted the importance of this:

> For anybody whose role is to support and work with people spiritually, then if we're not able to be with ourselves we can't be with someone else. If we're afraid to be with ourselves then we're not going to be able to be with someone else who's trying to be with themselves. So I think it's a crucial part of what we do in order to be with other people.

Paul reflected that silence also offers a space for connection with God. He described an occasion in church as one of the most profound experiences of silence he has ever had and described his role as a chaplain to help other people to make that connection. He explained:

> Words can help people make that connection for themselves but silence can do that definitely. So it's being able to just … be still with someone and … you can … very clearly see that connection happening.

Susan described the tangible nature of the other person's connection with God, stating, "you can almost see it, feel it … in the silence".

Co-researchers noted that experience of silence as rejection also evoked intense feelings for them described as awkward, unnerving, and, for Paul, a reminder of how it feels to have silence "being done to you".

All co-researchers recognised that ability to hold a space for another person is grounded in being comfortable with silence oneself; Paul described it as "part of the chaplain's toolbox" to be able to stay in silence and allow whatever is happening for

the other person to happen, without jumping in and filling the silence with words. Equally they stressed the importance of assessing whether the silence is comfortable for the other.

Susan, who has responsibility for bereavement care, explained that the silence of patients and family members can be produced by shock and her response, to be silent with their silence, recognises that they need time and space to take in bad news or the death of a loved one. Paul commented, "In the midst of just awful circumstances and in the midst of grief … before someone's died … what can you say?"

Susan shared a story which demonstrates a patient's need to be silent, "He called a palliative care nurse into his room and asked her sit in silence with him for 15 minutes". Afterwards, he thanked her profusely saying, "that's what I want, just someone to sit with me, to be with me in silence" but the nurse told Susan that she had found it quite difficult. Illustrating a professional need to feel productive, useful or helpful, John admitted that he is not accommodated to sitting, for a protracted period, with someone who's dying. He owned that, "It's partly being observed by colleagues as just sitting with someone who's not conscious and 'what's the point of that?'" In a similar way Paul explained why he finds it hard to take time in the chapel before work, "because there's bells going, and then they come and find you, and you feel you ought to be doing rather than sitting".

5.4 Conclusion

The experiences related by other chaplains supported much of my own experience; themes of connection, stillness and listening were common and enriched the data.

The contribution of co-researchers also served to expand my horizon of understanding adding additional themes to the phenomenon (Figure 9).
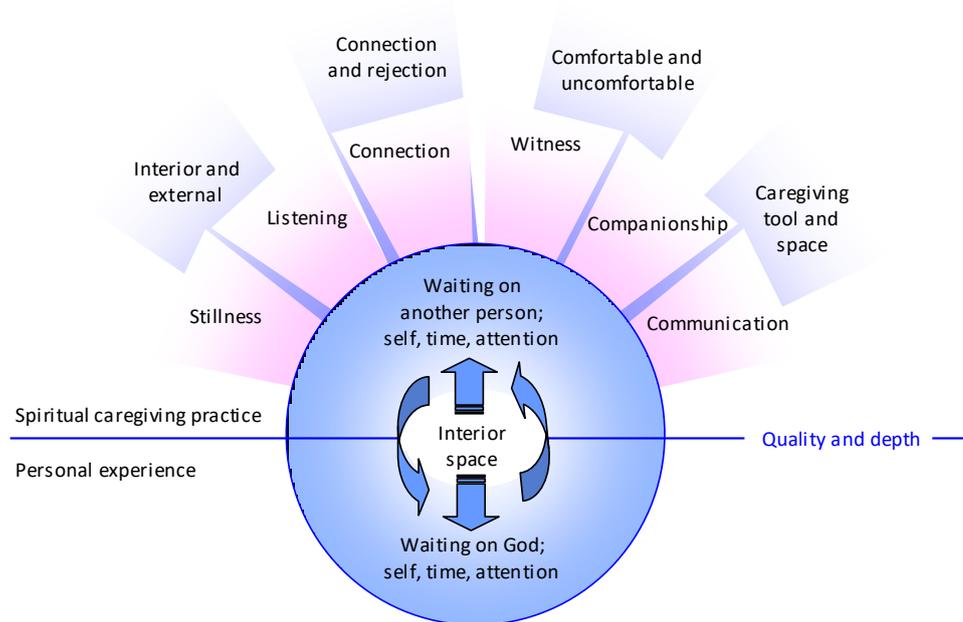

Figure 9. Expanded horizon of understanding of silence as experienced in personal experience and spiritual care

Underlying the above themes of silence is a notion of quality. Co-researchers used analogous words to describe their experience of silence: space, stillness, calm and quiet, but they also noted differences in quality. This resonates with my own discovery that silence has a dimension of depth. Paul differentiated quiet from silence, whilst identifying that the two are connected, and Susan distinguished quiet from "quality silence". All three chaplains noted a particular quality of connection in silence; with oneself, another person or God. This informed my creative synthesis, set out in Appendix 13. As a personal frame of reference this identifies silence as an interior disposition of myself which, in the offering of space and time, enables me to be present to, and connect with, others.

The divergent nature of the explicated themes is notable; silence seems to present at both ends of the spectrum of experience. It can be comfortable and uncomfortable, a means of connection and also rejection. The dual aspects of silence as external and interior, caregiving space and tool seem to be central to the quality of experience that has been revealed and will be explored further in Chapter Seven. First, Chapter Six reports the findings from Phase Two of this research.

CHAPTER SIX

Phase Two findings: Chaplains' experience of silence in spiritual caregiving encounters

This chapter presents the findings of Phase Two of the research which utilised the hermeneutic phenomenological method of van Manen (1990). Following Phase One, which found divergent themes and an underlying notion of quality and depth in palliative care chaplains' experience of silence, this next and final phase sought specific examples of silence in end-of-life spiritual caregiving encounters in order to come to a deeper understanding of the essential qualities of the phenomenon of spiritual caregiving silence in end of life care. Material was provided from unstructured interviews with a second cohort of 12 palliative care chaplains.

In this chapter, findings are presented under the headings of three overarching themes: silence as a way of being with another person, silence as a medium for communication and silence as an enabler of change. First, a summary of participants, data collection and analysis is presented; this was conducted according to the description of methods outlined in Chapter Four.

6.1 Participants, data collection and analysis

Six expressions of interest were received in response to the e-mail invitation sent to AHPCC regional representatives. Six further expressions of interest were received, following a poster presentation outlining the findings of Phase One, at the AHPPC national conference in May 2015. Twelve chaplains (seven men and five women aged

between 41-69 years) met the inclusion criteria and consented to be interviewed. They were all employed in independent hospices in the UK, as chaplain or in another spiritual care leadership role.

A summary of participant profiles shows that the cohort of participants is comparable with the profile of UK hospice chaplains presented by Thomas (2014), (see Appendix 14), whilst reflecting the shift, from a primarily religious focus, to a wider understanding of spirituality in contemporary UK chaplaincy outlined in Chapter Two. The majority of participants are from Christian faith groups or backgrounds, one is Quaker, one is Jewish, two participants described Buddhist interest or practice and one asked to be recorded as "spiritual not religious". The longest serving chaplain interviewed had been in post for 13 years with the majority in post between one and five years.

Interviews, lasting between 41-81 minutes were conducted between March and November 2015. In response to the invitation to tell of their experience of silence in end-of-life spiritual care encounters, participants brought between one and three examples. Typically they chose contrasting stories which illustrated different types of silence. In addition, they shared their general experience in the conversation which followed. In total, 32 accounts of lived experience were collected.

Two approaches to analysis, 'wholistic' and 'selective', following van Manen (1990) and described in Chapter Four, facilitated formulation of thematic meaning and development of emerging themes. A table of summary statements and corresponding formulated meaning phrases for the wholistic approach is attached in

Appendix 15. Appendix 16 contains an example of the process, from transcript to thematic meaning clusters, in the selective approach.

Following the elimination of incidental themes, reorganisation of thematic clusters resulted in 11 emerging themes from which the three overarching themes were developed. A return to the transcripts provided supporting verbatim material and a sample of this is included in Appendix 17. No additional themes were discovered. Table 10 shows the progress from thematic clusters to overarching themes.

Table 10. The progression from thematic clusters to overarching themes

Thematic clusters	Emerging themes	Overarching theme
Silence is a way of being with another when words are inadequate or unnecessary; caregiving silence acknowledges the silence of the other	Silence offers a way of being with another person	Silence as a way of being with another person
Silence in caregivers' and others' spirituality/ situation /experience	Silence as a dimension of the person (spirituality, situation and experience)	
Relationship; being alongside; presence; companionship; empathy; companionable silence is being comfortable in shared silence with another	The role of silence in relationship	
Silence in professional practice; silence as holding space; allowing; offering; honouring; validating (the other or their story); listening ; hearing; attention; waiting; witnessing; confidentiality	Silence as a caregiving intervention	
Shared silence; intimacy; lovers	Shared silence acknowledges common humanity in the presence of another	
Relationship of silence and dialogue; silence in non-verbal communication; spiritual caregiving involves a balance and constant evaluation between silence and words	Spiritual caregiving involves a balance between silence and words	Silence as a medium for communication
Silence is a two way medium of interpersonal communication; Silence in non-verbal communication; leading to a deeper place; something going in	Silence leads to a deeper place	
Silence provides a medium for communication and connection when words are not possible; silence is a way of being with another when words are inadequate	Silence offers a way of being with another when words are not possible, inadequate or unnecessary	
Silence creates a caregiving space; offers space and time to the other; a mode of being present which enables another to stay in a difficult place	Silence creates and offers caregiving time and space	Silence as an enabler of change
Silent listening to story alleviates distress; silence enables self-expression without the use of words; in silence unspoken truths may be heard and understood; silence enables the articulation of truth and a moment of change	Silence enables articulation and expression of truth (with or without words)	
In shared silence a connection is made which transcends the need for words; reconnection	Silence enables connection and reconnection	

6.2 Themes of silence in spiritual caregiving practice

Findings are discussed under the headings of the three overarching themes each supported by the emerging themes which illuminate qualities of a type of silence which can be described as spiritual caregiving.

Findings in Chapter Five conclude that silence not only has divergent qualities but is also imbued with a sense of depth. Figure 10 illustrates how, in this phase, increasing levels of depth of silence are experienced in each of the overarching themes.

SPIRITUAL CAREGIVING SILENCE	A way of being with another person	A medium for communication	An enabler of change
Depth	A dimension of self (disposition) in relationship with the other (companionship)	A balance between silence and words (silence as gaps and pauses)	Creates caregiving space and time
	A caregiving intervention (therapeutic)	Silence leads to a deeper place ('something going on')	Enables the other to stay in a difficult place Enables articulation and expression
	Shared silence and common humanity (intimacy)	Silence as the primary mode of communication (when words are not possible or necessary)	Triggers emotional release Enables connection and reconnection
Observed effects:	Acceptance, restoration, peace		

Figure 10. Themes of spiritual caregiving silence demonstrating increasing depth of experience

6.2.1 Silence as a way of being with another person

The first overarching theme will be explored through four emerging themes: silence as a dimension of self, silence in relationship with others, silence as a caregiving intervention and shared silence, which acknowledges common humanity, and is experienced as intimacy.

A way of being is closely related to the notion of 'being there' which is central to spiritual care (Speck, 1988), and as noted in Chapter Four, this resonates with the situatedness of human being-in-the-world in Heidegger's (2010) concept of *Dasein*. Reminiscent of the understanding of silence as a practice, which emerged in the literature review, participant Jonathan emphasised the priority of a disposition of being silent in his own practice of palliative care chaplaincy, "It's not doing silence, its being silence, being with silence". All participating chaplains identified silence as part of their own disposition, nurtured by their spiritual life and practiced in their spiritual caregiving role which privileges being over doing. James identified a difference between spiritual care and therapy:

> I don't go in with a certain number of questions. I think a therapist …
> professionally, can do that. But I *don't*. So I have to wait and see what they
> bring up, which could be anything and everything. And also to listen, of
> course, that's the other part of silence.

James highlighted the caregiving role of listening; other chaplains interviewed recognised that, complementary to this, is the ability to be with the silence of another person. Steve observed:

Part of the privilege of spiritual care is that we don't require anything of the other person. And, if they require nothing of us, then silence is the shared experience. You're still alongside that person and it is a matter of care through presence.

For other participants, silent caregiving presence included listening to the story of another person, giving time, holding a hand or saying a quiet prayer. Several noted that there is not always a spiritual need to be explored or resolved describing silences, within these encounters, as companionable. During the interview, Alison pictured herself in a typical situation in a patient's room:

It's comfortable … I'm just sitting there, and I'm looking out of the window. I might just say, "There's a beautiful bird out there." And we don't have to talk about it … It's a companionable silence.

Amanda described a series of visits to a lady, June, who did not want to talk. In the interview she recalled her surprise when, before discharge, June thanked her profusely saying how the visits had really helped. Amanda concluded that silence has a quality of honouring:

You say, 'It's ok for you to be however you need to be at this moment in time and I'm not going to put conditions on … making you have a conversation, if that's not right for you.'

The practice of 'just sitting' with another person occurs in all but two of the transcripts; it is described as a way of being which is not only silent but also includes a physical quality of stillness which, does not interrupt but, offers companionable presence. For some participants this has been informed by personal experience of

illness. Julia recalled, "you don't always want to talk about how you're feeling or your illness. But equally, you'll love to have a presence with you".

Findings suggest that being with another person offers companionship, which may alleviate feelings of being alone, but several chaplains expressed awareness of the potential of intrusion into personal space. James suggests that being with someone in a state of attentive silence enables a caregiver "to be present … but not in the way".

Several participants acknowledge that silence is not easy to maintain. James identified the challenge, for his spiritual care volunteers, of going into a patient's room and saying little, but allowing something to emerge; he described a sense of uncertainty and waiting for both patient and caregiver. Alison illustrated this from her own experience:

> Sometimes I do feel that patients wait to see how long we're going to wait with them. Are we really going to listen or are we in and out? There's a pregnant feeling to it. You're not quite sure, 'do I need to say something here or not?'

Alison's comment suggests that waiting in silence, like seemingly superficial conversation identified in psychotherapeutic literature (Bravesmith, 2012) may be a patient's way of testing a caregiver's intention and attention; this is reflected in other accounts which describe how silent listening builds trust.

In silence, Jill suggested, the weight of what is conveyed, and the thoughts behind it, can be absorbed by the listener. Several participants identified their silent wait as

valuing the other and their story. Charles described his first meeting with Bill, who

was trying to come to terms with the shock of his terminal diagnosis. Bill's story

revealed an association between silence and the moment when the consultant

closed his medical file, as if in confirmation that there was no more treatment and no

more to be said. Charles explained that this caused him to be particularly conscious

of his own use silence as he allowed that story to be told:

> When he was trying to make sense of it, there was a silence of me not
> wanting to make sense of it, for him … yet. The silence was to make sure that
> whatever was happening between us was at his level and his pace and his
> language.

Charles and James identified silence as witnessing: recognising the challenge for a

caregiver in admitting "I have nothing to say"; James explained that silence resists

the temptation to rehearse an answer which, may distract from listening and also be

glib or unhelpful. He contrasted this with the natural desire to say something to

"take away their fears, or anxieties or worries or whatever … so they become almost

a cardboard cut-out".

Charles explained the purpose of his silences with Bill:

> The silences were allowing me to give him the space to speak about what
> mattered. The silences were being able to live with the silences that happen
> in life when there isn't an answer.

In addition to listening, the second part of this statement suggests that caregiving
silence acknowledges the possibility of no answers to the questions that arise for
terminally ill patients. Charles emphasised:

> The reason and motivation for my silences were allowing him to say what he
> needed to say and hold him without having any answer. I think it would have
> been intrusive and wrong for me to try and put either my own answer for him
> or [somebody else's answer].

The intentional use of silence in spiritual care encounters may be described as a
caregiving intervention. Simon and Julia spoke of silence as a "powerful tool";
Jonathan, who has training in drama therapy, described use of silence to mirror the
behaviour of the other person, or people, in the room. He explained how the
speechlessness of family members, who may be struggling to find words to describe
their situation, can be reflected back by the caregiver, subtly changed, as "silence-
with-quality". Jonathan reflected, "I think it's about embodiment, it's about being
silent myself in order to bring a comfortable feeling, maybe not silence, into the
room."

Whilst this therapeutic offering of silence has a more active overtone than the
companionable disposition, described above, it is still contingent upon caregivers

being silent themselves. The ability to be silent, and be in silence, seems to create the "comfortable feeling" described by Jonathan which is caregiving and reminiscent of the compassionate typology of silence proposed by Back et al. (2009).

Several participants noted that chaplains are seen to embody silence, reflecting a perception of silence as, not simply a state of mind but, a whole way of being similar to the calm disposition highlighted in Chapter Five. Resonant with my own experience, Alison described her sense of the need to introduce silence, when she is called to the room of a dying person filled with accompanying relatives and the air is charged with anxiety and chatter. In a similar situation, Jonathan described his role as to do the unexpected, to resist the request to give more words, "to break the circle" offering the possibility of a new perspective to emerge.

Tom introduced the concept of "unspokenness", a silencing of self and an economy of words, using only sufficient language to ensure the other person feels safe and accepted. Chris reflected that, for chaplains, unspokenness continues beyond the encounter; the sense of completeness of encounters in silence, combined with the expectation of confidentiality associated with the chaplain's role, means that what occurs in silent encounters is not documented, discussed afterwards, or shared in detail with the multi-disciplinary team; this is noted by others.

Shared silence has a quality of 'being in it together'; central to this is the notion of common humanity which takes precedence over professional status or agenda. Simon shared an excerpt from the book *What is the point of being a Christian* (Radcliffe 2005:207). to demonstrate a quality of mutual presence which Radcliffe defines as "resting in the silence of another for whom one is not just an 'other' but

another 'I'". Participants suggested that when two individuals share silence, they enter into a mutual space in which both have the potential to be changed. Tom alluded to humanistic psychologist Carl Rogers when he explained:

> It's about, your client having a desire for change, and me willing to be part of that change. It needs two people to work together. It's not just that I'm giving to somebody. They're also giving to me. It's not a one way flow.

Echoing the element of risk that Rogers' (1961) identifies in openness to being changed, Charles noted that shared silence at this level is not superficial, saying, "the depth of silence you give to people is paralleled by a depth of commitment as well."

In experiences of deep silence several participants described the quality of connection as intimacy. Alison recalled a "contemplative encounter" with a patient, Peter, intensified by its contrast with a busy external environment; the encounter in silence was characterised by a quality of something happening between the two people engaged. She explained:

> It was like that feeling when two people are in love and there's the whole world going on but … you're in your own little world, and it's all buzzing and then suddenly it breaks and you're back in the group again.

Tom described an experience of intimate silence as dramatic; a silence in which "there is a massive amount going on" confirming his belief that silence is not an "emptiness or void, but filled with meaning". Other accounts illustrate how intimacy transcends the need for spoken words; six participants described situations where silence communicates the unsaid and, in silence, the communication is somehow

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heard, understood and acknowledged. James reflected, "Somebody allows you to see

something very important and all you do is nod your head and say, 'yes, I feel

something'. And that's it".

Jonathan's personal experience, at the bedside of his unconscious, dying

grandmother, was that silence became the medium for communication:

> It was literally very peaceful all around … It was almost, not breaking through
>
> that with words. There was that spiritual breath connection from soul to soul.
>
> I'm sure you can say that about a couple that know each other well; they
>
> don't have to say that they love each other, they know it. It's the energy
>
> between the two. And I believe strongly that there is a soul-to-soul dialogue
>
> that … doesn't use words.

 This has informed his chaplaincy practice and is reflected in the experience of other

participants who suggested that the moment of another human being's dying

transcends the power of words.

6.2.2 Silence as a medium for communication

This second overarching theme considers the relationship between silence and

verbal and non-verbal communication; and highlights an increasing depth of silence

as the emphasis in the encounter shifts away from speech.

Accounts demonstrate silence operating in close collaboration with speech and non-

verbal modes of communication, such as eye-contact and touch, to build

interpersonal relationships. Supporting the conclusion that the use of silence is a felt

decision based on the discerned needs of the moment (Hill et al., 2003), Jonathan

reflected that "words can be intrusive or disruptive. They can also be comforting and

soothing." Recognising that silence can feel awkward to people who are unaccustomed to it, several participants claimed that they are ready to fill silence when needed. Clare, a Quaker, described herself as very comfortable with silence but acknowledged, "I meet very many people who get very uncomfortable if I become too quiet. And I know how to fill silence too. I'm happy to do that if I'm needed to."

Findings suggest that throughout spiritual caregiving encounters, the relationship between silence and speech remains fluid. Participants gave examples of significant conversations which arose from an introductory silence, described by Jonathan as "a gateway"; conversely they gave examples where deep conversation resolved into a comfortable or thoughtful silence. Participants identified how pauses between passages of speech allow for processing and thinking and build relationship. Jill spoke of the "potential and opportunity" offered by gaps which she considers, not as empty moments, but as "absolutely full moments that allow something to happen."

Resonant with the findings of Hill et al. (2003), which described how therapeutic conversation is distinguished from everyday conversation by the way it allows silent pauses as a way of taking the conversation to a deeper level, participants observed that a change in the quality of silence can mark a gear-change in the conversation. Chris demonstrated this in his account of Marjorie, who was referred for chaplaincy support because she "seemed to have something she needed to say". In the early stages of the conversation Chris recalled noticing "pockets of silence" that he explains as gaps between the sentences and responses that helped to build rapport and trust. These silences punctuated a wide ranging story about her life, family and church. As she drew closer to what she really wanted to say the silences became

longer and more profound. When she arrived at the source of her spiritual pain, Chris described experiencing a sudden silence which came, as if, with a "thud". He explained:

> And that's when the silence came … She stopped talking … Eye contact was different … Her eyes were looking down at her hands and not at me … And I felt uncomfortable because it just seemed right to allow the silence.

There is a curious dissonance in Chris' statement, "I felt uncomfortable because it just seemed right to allow the silence". It seems to draw a distinction between discomfort with silence and discomfort with the content of the silence reminiscent of my own experience reported in Chapter Five. Chris explained that he felt uncomfortable because Marjorie was clearly uncomfortable as she encountered her own bereavement. Marjorie was not, apparently, uncomfortable with the silence; she was preoccupied with her own thoughts. Chris recognised that the silence provided a significant and safe thinking space for Marjorie which "seemed right" and, therefore, he waited in his own uncomfortableness until Marjorie was ready to continue. Out of this silence, Chris explained, Marjorie was able to articulate her greatest concern. Silence came in the middle of the encounter, introduced by her and held by Chris. He described it as "a very intense moment of concentration" and he explained that he was very conscious of "not ruining it by jumping in". The conversation which followed had an almost confessional aspect; Marjorie was able to "download" her sense of responsibility and guilt and Chris concluded, "It was gone. It had been dealt with".

Simon described two encounters with men, who had just received bad news about their wives' prognoses, and were unable to speak because they were overcome with emotion. Simon reflected, "I was just struck, on both occasions, by how little I said and how little I needed to say". He explained that, as a chaplain, he has no agenda or time constraint and this gives him permission to be silent and unrushed. This feature of the professional spiritual caregiving role is noted by several participants who speak of not keeping a diary, or wearing a watch. Resonant with the perspectives of therapists found in the research of Ladany et al. (2004), Simon suggested that this unrushed quality of silence has a role in generating empathy.

The reversal of everyday conversation, comprising words with silent pauses, to predominant silence with only occasional words, reflects the Gestalt figure-ground reversal described by Denham Vaughan and Edmond (2009) and is encountered for physiological reasons in palliative care. Accounts describe how silences become the primary mode of communication as patients become less responsive in the last days of life.

Amanda used the metaphor of a tennis game to describe the "conversation in silence" with a patient, Janice, who felt too unwell to engage:

> Amanda: I, sort of, lobbed the ball to her, and then she lobbed it back.
>
> Interviewer: With no words or some words?
>
> Amanda: With some words, but not a lot of words.

This was reminiscent of my own conversation with Pat, recounted in the previous chapter, where the spaces between his words outweighed the words themselves.

Clare's account illustrates how loss of speech can be frightening and distressing. She described a "very verbal couple" Mary and David and how, as Mary's illness progressed, she found herself in a place which "had big lumps of silence in it". Clare explained that Mary's fear was to be alone, and she could not understand that someone would stay with her when language had gone. It was in a moment of silence, sealed by the joining of hands, that the pact was made that David, and Clare, would not abandon her but stay to the end.

Several accounts demonstrate how people suffering from neurological conditions are often not only unable to speak but have diminishing movement as well. Emphasis shifts to the other senses. Touch, eye-contact and hearing become primary modes of communication and interpersonal relationships are conducted, largely, in silence. With Alison I explored the notion of caregiver choice whether to speak or to join the patient in their silence. Reflecting on her contemplative encounter with Peter, Alison admitted, "I think I can find it easy to fill the silence, do the talking. On this occasion that's what was different".

She explained that Peter used his hands as his primary mode of communication. He became deeply focused on Alison's ring which has a religious significance. Alison recalled:

> It was very profound … I felt, in the silence, he was just connecting with the Trinity for himself … He was communicating something. It felt like he was saying 'this is important'.

Clare told of another neurological patient, John, whom she visited in Day Therapy over a period of eight months. Their encounters were almost entirely silent; John's

chosen means of communication was through his eyes. In the interview Clare remembered:

> He was able to receive gaze ... So we were able to sit and look into each
> other's eyes and hold hands in a way that you often only do with lovers. But
> we did that in absolute silence and respectfulness. And it was as if John
> understood that I could manage the emotion of his illness. That's what it felt
> like to me. He understood that I could see his suffering.

The majority of participants reflected that, sometimes, words seem redundant or unnecessary. Jonathan proposed the concept of a "post-verbal phase" where a patient falls into silence, deliberately, because that's where they want to be. He identified the spiritual caregiver's role in that silence as being a witness, not intruding, coming alongside.

Describing one particular occasion, Simon explained his silence as recognition of the deeply personal moment for the dying person and her husband:

> There was just silence in the room. You couldn't even hear the patient
> breathing. It was just peaceful. And I think I'd been in the room half an hour.
> And I'd said my couple of prayers in the first five or ten minutes. The rest of
> the time was just being there … I said nothing because I literally couldn't think
> of a thing to say. And not only that, (in a whisper), I thought it was not my
> place to say anything.

Speaking of a similar situation, Chris described,

> a drama of silence … I'd said my lines [the prayers] … It was right not to have
> to say anything. There was just this total silence of taking in what had
> happened (...) I think there was a relationship [with the husband] that was

created in that silence (…) And reminded me of being a human (laughs) and not just a caregiver.

6.2.3 Silence as an enabler of change

The third overarching theme explores caregiving silence as enabling for the other person in the encounter. Reflecting the experience of Himelstein et al. (2003), participants spoke of the value of holding silence for another person at challenging times. Jill presented a patient's perspective:

> If you're used to silence and used to space and then you come into the clamour of terminal illness and the clamour of hospitals and treatment and … the intrusion of everything, then you miss the silence of eternity. You miss that deeper connection in life and you're in distress.

Here, she repeated the words of Nigel, whom she described as a capable and reserved man, whose physical condition deteriorated rapidly. She explained, "We soon realised that if we made time away that would give him a buffer to cope". Several chaplains noted that patients seem to be bombarded with conversation, albeit well-meaning. Others described terminal illness as a drama of fear and death within which caregiving silence offers a change in tempo and the possibility of gaining a new perspective.

At the first level silence opens up space and time. Charles spoke of the power of silence in the way it gives "people space to be themselves"; Julia reflected on the value of silence to create companionable space:

I'm thinking I need to use it a lot more. It's really powerful. And not something people in hospices get much of. They might get silence on their own … but they don't get silence with companionship. I think a lot of visitors find that really difficult to do.

Other chaplains noted a tension between their desire to support the silence of a dying patient and the family's need for verbal reassurance. Alison identified, "I often have that feeling of wanting to hold the space of silence with the patient. At the same time I want to talk to them [the family] if they want to talk". Jonathan suggested that one way of addressing this tension is to try to draw the family into a more contemplative style of accompaniment. He used a metaphor to explain:

If that person's sitting on a bench, metaphorically, gazing out onto her world and her life; and you're sitting on that bench looking the same way, in the same direction. My invitation, then, with the relatives very often, is 'come and sit with us on that bench', because they're still beavering away.

A desire to fill a painful situation with chatter or activity may be symptoms of what Jill described, in psychological terms, as avoidant behaviour. She explained:

the fear of death often makes people fill the time with noise … and, one thing that is both refreshing and terrifying in a hospice, is allowing people to come down from that avoidance to facing death … considerately and in a way that they feel they still have control. And that takes a lot of time, a lot of skill and a lot of concentration.

Findings suggest that the value of a silent caregiving space, in the company of a skilled spiritual care practitioner, is that it offers something more than other visitors

can give, the ability to 'be' in the presence of approaching death. The following examples illustrate caregiving silence as being with a family member at the time of death, being with a dying person and being with a patient who is in the difficult psychological place of denial of her own imminent death.

Several chaplains described how their silent presence enabled family members to stay with their loved one to the end. Alison recalled staying with a man in the last half hour of his wife's life:

> And he talked afterwards about how … he'd never been with anybody who had died before. Least of all his … He said, 'never sat, never seen it happen'. He was bewildered.

Chris reflected on his silent presence with Norman at the time of his wife's death:

> Although it was focusing on his wife, it was about him, the person left behind … and maybe the overwhelming emotions weren't on him so much, because somebody else was *there*.

Other accounts describe silent companionship with the person who is dying. Tom told of being with a patient who could not sleep because of her fear of dying alone. When he judged that she was asleep he made to leave, but the patient woke in tears. Tom concluded, "It was a time of silence which was enough I thought, and it wasn't, because silence actually goes on in sleep time too."

Amanda described a referral to visit Carol, who was in denial of her imminent death. She explained that the encounter began with close listening to Carol's story. A

question from Amanda triggered a silence. In the interview, Amanda described her

feelings:

> The silence started off for me as quite a comfortable one, but then it was so
> long that I started to feel really worried that I'd ask something that was too
> intrusive, and in a way, too much for this person to cope with.

Eventually Carol broke the silence, for the first time acknowledging the truth, "I think

I'm dying", and a significant conversation followed which enabled a helpful change,

but Amanda highlighted the complexity of this type of encounter for the caregiver.

She reflected, "It seemed, with hindsight, that she was just processing but I had no

idea what was going on for her at that time".

Amanda spoke of the risk in a wait, describing how it is the unknowing which made it

hard to assess whether to hold or break the silence. She recalled feeling very

uncomfortable recognising that this choice involves a second risk saying:

> If you feel uncomfortable, but then you try and make it better, it could end up
> making it even worse for the patient because you haven't given them the
> space and you've helped them to go to a deeper place, but then you've taken
> it away from them.

It is here that the notion of being with the other person and the potential for change

coincide to create a silence which seems to be truly caregiving. If silence offers the

other person time to assimilate thoughts and these thoughts are deeply held, and

difficult to engage with, then it is not surprising that it takes time to frame them

coherently and express them in words. James explained the need for the caregiver to

become "more present" in these most challenging moments, somehow amplifying the presence of God in the room and enabling the other person to become more themselves.

Several chaplains told of referrals to visit patients who seemed to have something they needed to say. In the case of Marjorie, the patient described above, Chris reflected on the close care of her family. He said, "It seemed like they were attaching themselves to her, like a hug around the bed, but one which actually stopped her from saying what she wanted to say". This highlights a difference between the companionship of visitors and that of a professional caregiver who is free from familial emotional ties, and also has the ability to be silent in a difficult space. Steve explained:

> It's the willingness on the part of the person silent, necessarily to allow the other person to speak. If you're silent, sometimes there's an openness for another person to be able to begin to open themselves up verbally and connectively.

Illustrative of this, James described how a time of silence with a young patient enabled her to verbalise the truth, "I don't want to die". He recalled how these words "came forth from her", his language demonstrating their impact, and he concluded that, in the articulation of truth a person, and their family, is enabled to identify where they are and then take the next step.

When language is inaccessible, findings show that caregiving silence can enable expression without words. Julia made a conscious decision to give Maria, for whom English is a foreign language, extra time to express her needs. She recalled:

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I was very aware that she was trying hard to keep it all together and I wanted her to feel comfortable not to do that if she didn't want to. It felt really important to keep that silence. I think she needed that silence for her own working out of what she wanted to let free and what she didn't.

Julia described how silent companionship enabled Maria to express her anger and grief describing "a tight jaw and really strong eye contact". She had felt that Maria wanted a non-verbal appreciation of her pain. It seems that Maria preferred Julia's non-verbal response to caregiving words. The discernment about when to speak and when to hold silence is a recurring theme but there may be a particular case for silence when, for the other person, silence is the only means of self-expression.

Many accounts describe tears and Jonathan explained, "It is the quality of pausing. What you're offering is space, silence offers space in time. You're pushing the pause button and that releases emotions".

Chaplain Jill recognised that for Nigel, who could not speak or move as his illness progressed, her accompanying silent space enabled him to express himself, and his anger, non-verbally. She described one occasion when "his body was almost rippling … but the way he communicated it to me was with his eyes … and with his body language … almost reaching out".

As a dimension of spiritual care, silence is recognised, by participants, as sacred space. Amanda described opening up the deepest part of ourselves for God's presence and Simon presented a Christian theological position that chaplains bring the presence of God to the encounter. Reflecting Phase One findings, a number of accounts refer to silence that follows spoken prayers. Steve recounted being called in

to a patient who asked for affirmation and prayer at the end of her life. He reflected that, by a simple ritual with a holding cross, her uncertainty was resolved. His own experience was that "silence released a presence of love in the room … a real sense of common union and a tangible presence of the immanence of mystery and love" and concluded that "there was nothing more to say".

6.2.4 Observed change

Chaplains' accounts describe beneficial changes in the people with whom they have shared silent encounters. Amanda's willingness to "just sit" with June who didn't want to speak was rewarded with thanks. Jonathan reported, "My silence helped them to be calm, I've heard that from families". Simon ventured, "I think the silence I employ might give them a feeling of peace, a feeling of being cared for, of being held at a very vulnerable moment".

Simon's account highlights how silence as listening enables a story to be told and James cited occasions when silent, attentive listening offers a better solution than medication, reflected in the value of being heard, even when nothing is said, noted by Jill and James earlier.

An example of silence as a medium for communication came from John's wife who greeted chaplain Clare with the words, "John tells me you understand", despite the fact that John and Clare had not spoken during eight months of silent encounters. Similarly, it was in silence and through touch that Alison understood that something important was happening for Peter.

After the silence which enabled Marjorie to speak of her pain, Chris reflected that she "seemed relieved … she was more at peace … she shrugged her shoulders as if a

weight was off". Amanda described how Carol was able to move from denial to choosing to "talk to her family. She sorted out lots of things … and she died really peacefully" and how, patient, Janice's disengaged expression of a "really bad day" was transformed into an active statement, "Right, you can go and tell my visitors that I'm going to have a little wash and brush up and then I'll be ready to receive them". For the young woman described by James there was sense of closure, once the truth had been articulated, James noted:

> It was a moment of release … It just freed up something in the patient and in her parents. It is kind of saying 'this is where we are. Now we can take the next step'.

Three chaplains told of a kiss from the other person in their encounter understanding it as a goodbye and 'thank you' for their silent presence; Tom recalled, "It was just packed with real emotion. It was really powerful". Julia remembered a big smile from Maria; she reflected, "Giving her the opportunity to just sit back and be silent, she seemed to really appreciate that".

Charles thought that, for Bill, "the silence was filled with validation for who he was as a person", and Steve explained that, following his ministry, he left the room quietly:

> I didn't want to interrupt the silence … I didn't want to draw attention to me because her attention was in the right place. To my thinking she was where she wanted to be and I'd served whatever purpose I was able to.

In the interview, he concluded, "To find a stillness allows for a restoration, or even a new comprehension, within the person, of their worth and value simply as a human being".

6.3 Conclusion

In this chapter silence has been described as a way of being with another person that offers companionship and connection. As a therapeutic, caregiving intervention, silence enables a caregiver to be present with the other person, to listen and attend, to hear, honour, and empathise, to acknowledge that there may be no answers but to stay with that other person in what may be a difficult place. Shared silence embraces the notion of common humanity resulting in a relationship, which is sometimes likened to the intimacy of lovers, from which both parties may emerge changed.

As a medium for communication silence operates in close relationship with speech; this involves a constant evaluation on the part of the caregiver to achieve the most helpful balance between silence and words. Allowing gaps and pauses builds trust and rapport and a sense of deepening silence often indicates 'something going on' for the other person. When words are not possible or necessary, silence becomes the primary mode of communication working with non-verbal signs, such as touch and eye-contact, to communicate presence and reassurance.

Finally, silence has the potential to enable change, opening up a caregiving space where people can take time to be, and be with themselves, reconnect with others and with God. The companionship of a skilled caregiver enables the other person to stay in a difficult place, whether that be with a loved one in their last hours as

described by participants Simon, Alison and Clare or with their own situation illustrated in the accounts of Chris, James and Jill. Silent time and space offers the opportunity to think and process, and then to articulate or express truth; this may be accompanied by emotional release. Observed outcomes are the possibility of acceptance, restoration of a sense of self-worth and an ability to take a next step illustrated in participant Amanda's description of patient Carol who was enabled to talk to her relatives and put things in order before her death. At the end of encounters in silence, participants generally found people to have a greater sense of peace.

The purpose of this phenomenological inquiry was to uncover essential qualities of spiritual caregiving silence and these are explored in Chapter Seven. The contribution of this chapter leads to three areas of discussion related to the nature of silence as a way of being, the meaning of silence expressed in the notion of being together and the value of silence as a caregiving space which offers the potential for change.

CHAPTER SEVEN

Discussion: The nature, meaning and value of silence in spiritual caregiving

This research sought to gain deeper understanding of the nature, meaning and value of silence in spiritual caregiving at the end of life. The two-phase phenomenological methodology, set within a subjective-objective epistemological framework, enabled me to explore and explicate my own understanding of silence both in my personal experience and professional practice as a chaplain and then, to seek the experience of other palliative care chaplains to deepen and broaden my horizon of understanding. In this I drew on the theory of Gadamer (1976) that it is in the fusion of multiple horizons that an interpretation emerges which strives for truth.

Chaplains were recruited for reasons of homogeneity and because they are recognised as specialists in spiritual care. In this discussion, I use the terms 'participants' and 'chaplains' as collectives to describe participants from both phases of the research and I distinguish those who took part in Phase One by the term 'co-researchers'.

In the findings, reported in Chapters Five and Six, I have interpreted the nature of a type of silence described as spiritual caregiving silence as a way of being with another person; the meaning of this way of being is that it evokes a sense of companionship and connection and its value is that it creates caregiving space which has the potential to enable change.

Three key themes have emerged. Silence, as a way of being, has several modes which involve the caregiver as actor and participant. Being with another person in silence enables them to be with themselves in a way that they could not be alone, and this is, in itself, has value. Furthermore, from the relationship of being in silence together, comes the potential for change.

In this chapter, these themes will be discussed more fully and in relation to the wider literature including material introduced in Chapters Two and Three. In addition, I will develop a conceptual model that encapsulates the relationship of the key themes outlined above and has helped me to crystallise my understanding of spiritual caregiving silence. This follows a personal reflection on the research process and a summary of setting and context.

7.1 Development of understanding

The research process has confirmed my initial perception that silence, as a way of being with another person, feels important and valuable to the caregiving relationship; it has illuminated the multifaceted nature of silence, identified in existing literature, and shown that the type of silence defined as spiritual caregiving silence is multifaceted in itself. In addition, findings from Chapter Five highlighted a notion of quality and depth, which describes the level of engagement in, and content of, the silence.

As I reflected upon these findings, it seemed both surprising and obvious to discover that spiritual caregiving silence is imbued with the qualities of spiritual care itself. One purpose of hermeneutic phenomenology is to seek invariant qualities, "those

which make a phenomenon what it is and without which the phenomenon could not be what it is" (van Manen, 1990:107); spiritual caregiving silence is what it is because it occurs in a spiritual caregiving context, and, as findings from this research indicate, spiritual caregiving silence has the potential to enhance the quality of spiritual care.

Finally, I am still surprised by the rich variety of examples shared in the interviews. Participants acknowledged that chaplains occupy a privileged position in being present in the intensely personal moments of a person's dying and in sharing the feeling of loss and grief which arise for them and their families. The encounters remain with them and several chaplains were visibly moved as they recalled them.

I could not have anticipated the content of their accounts and the theme of change transcends my own initial sense of silence as a medium of spiritual connection. Chaplains tended not to use the term 'transformed', found in the literature, but transformations were apparent in stories of people who, through accompanied silent space, found ways to accept themselves and their situation and move on with the life that they had remaining. In my interpretation, there are situations where silence itself effects a change during an encounter by creating caregiving space; on other occasions silent caregiving space is a necessary stage in a process with leads to expression or articulation of truth; this, in turn, effects a change for the other person and sometimes for the caregiver too.

The role of accompanying another person in silence is skilled and complex. This thesis concludes that spiritual caregiving silence is cross-disciplinary, like chaplaincy itself, incorporating understandings of silence from spirituality, psychology and communication theory, into the holistic practice of interdisciplinary palliative care.

The setting and context of palliative spiritual care was described in Chapter Two as holistic and patient-centred, with an emphasis on human relationship and 'being with' over 'doing for'. A notion of liminality is present both in the end-of-life setting and in spiritual care, which supports right-relationship with self, others and the transcendent through a contemplative disposition of presence, listening and attending. Silence offers a non-intrusive way of being with another in this transitional space where words may be unnecessary or inadequate.

Spiritual care encounters generally take the form of a conversation between a caregiver and patient and family members. Following Nolan (2012:18) who suggests that the term 'patients' opens a gap between health carers and "'those for whom we care'", I have adopted the term 'other' to denote the person, or persons, being cared for, whether patient or family member, to emphasis the status of common humanity in the relationship.

Spiritual care conversations include a combination of speech, non-verbal communication and silence. As in everyday and therapeutic conversations, silence and speech are closely intertwined but at the end of life, for a variety of reasons, silence often takes a more prominent role, supported by non-verbal signs.

Figure 11, introduces the foundation for a conceptual model illustrating, diagrammatically, the conversational and relational nature of spiritual care encounters. It shows how silence and speech, though soft-boundaried, are ultimately alternative to one another whilst non-verbal communication is continuous throughout the encounter. The caregiver and the other person are shown in relationship; in this diagram, though not always in the end-of-life

caregiving encounter, both have the potential for speech and silence.
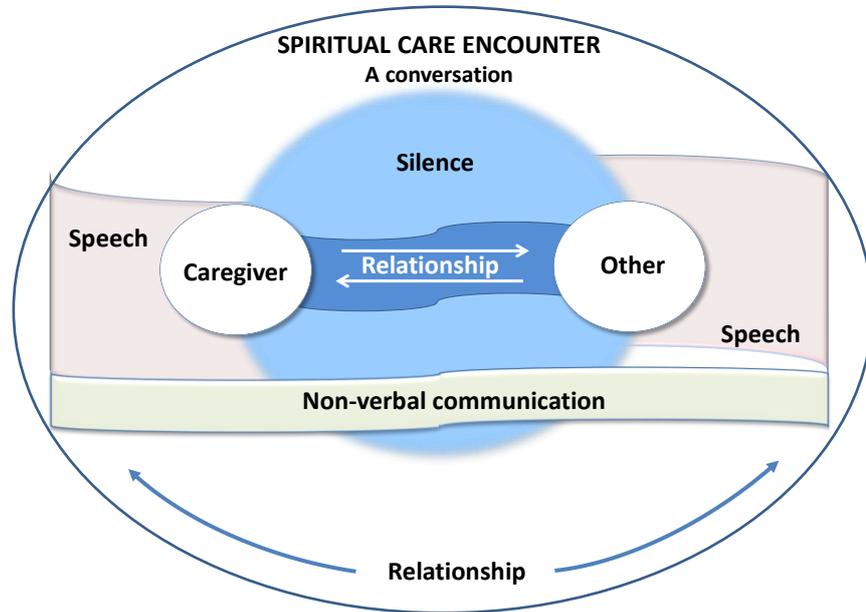
Figure 11. A diagrammatic representation of the relationships in a spiritual care encounter

7.2 The phenomenon of silence

Findings reported in Chapter Five (illustrated in Figure 9) highlight the divergent themes of silence in chaplains' lived experience; this reflects understanding of the phenomenon in psychoanalytic literature (Serani, 2000). It will be helpful to consider this quality of divergence before continuing.

Firstly, the capacity of silence to be both an interior disposition and an external caregiving space; at the end of Phase One I pondered this at length. In contrast with the philosophical assumption that silence is always connected to discourse (Dauenhauer, 1980), co-researchers had given examples of finding silence in a church or in the quiet of the countryside and this seemed not unusual in human experience.

The distinction is found in religious traditions where external silence is recognised as an environment and discipline within which interior silence may be cultivated (Keating, 2012). From the perspective of negative theology, Davies (2008) highlights the limitations of the English language to express these different dimensions of silence turning to the Russian word *tishina*, translated as "the silence of the forest" (2008:201), to denote absence of sound, or stillness, and *molechanie* as the silence of one who ceases speaking. Davies suggests that, "the two silences are in constant tension and their relation can be a richly ambiguous one" (2008:201).

Drawing on this insight, I have explored my understanding of the relationship between interior and external silence and sound, as shown in Figure 12. In this diagrammatic representation, the position and dimension of each element is not fixed, however, following Heidegger (2010), the self who experiences interior silence, is shown as being-in-the-[external]-world of silence and sound.

External silence, acknowledging the assertion of Cage (1968), generally contains some level of sound or noise illustrated by the solid circle. Interior silence is perceived as more than simply the cessation of speech. Kabat-Zinn (2005:84) suggests that, in interior silence, one suspends all activity in "a shift from doing to simply being". The darker circle represents interior noise, such as thinking and distraction, which surfaces during interior silence (Keating, 2012).

Consistent with these insights from contemplative spirituality, co-researchers noted that whilst external silence facilitates interior silence, it is also possible to maintain interior silence in the noise of the world; conversely, one can sit in external silence and experience interior noise.

Silence of the self - interior

Silence - external

Sounds (noise) of the self - interior

Sounds and noise - external
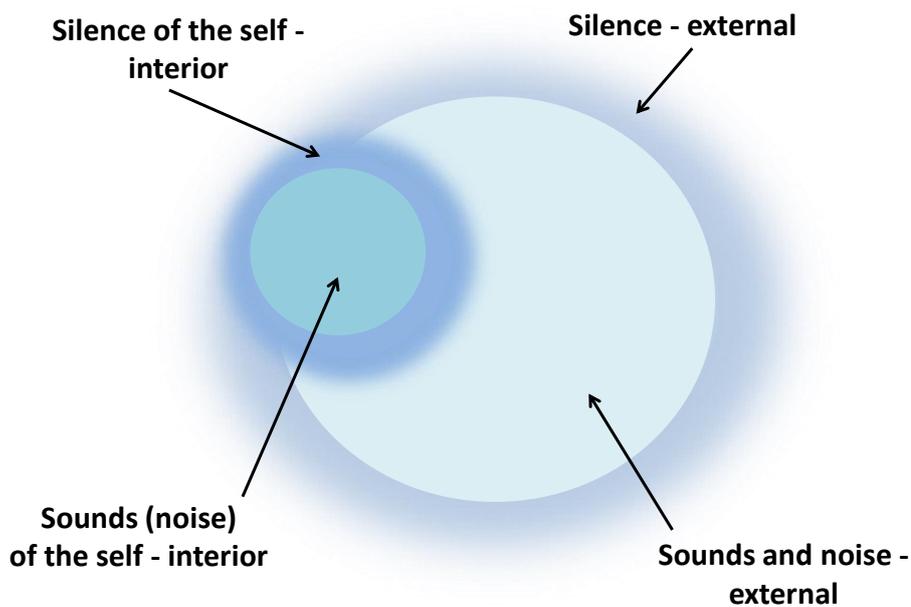
Figure 12. The relationships of interior and external silence and sound

The terms silence, quiet and stillness seemed to be used interchangeably by co-researchers. Hyde et al. (2010:97) note the relationship and value of all three words to describe communication without sound; they claim, "no one single word captures all that reflects the essence of silence".

Secondly, I was interested in the perception of silence as both comfortable and uncomfortable, a point also highlighted in previous research discussed in Chapter Three (Hill et al., 2003; Ladany et al., 2004; Barber, 2009). In both phases of this research participants described themselves as comfortable with silence, and this was not surprising given the self-selecting recruitment process and the personal spiritual discipline expected of chaplains. Participants across both phases described the ability to be in silence with a patient as part of their role, whilst several noted the temptation to fill silences with unnecessary speech. However, they recognised that

other people may be less familiar with silence and the importance of checking that the silence was not uncomfortable for them. They also emphasised their readiness to make verbal conversation when needed. Resonant with Dauenhauer (1980), several participants identified that silence involves a risk and this supports assertions in the literature that to be therapeutic, silence should be intentional (King, 1995; Savett, 2011) and requires skill and practice (Hill et al., 2003; Barber, 2009).

When I reflected on my own experience, reported in Chapter Five, I was surprised at the frequency and intensity of my own uncomfortable feelings in silent encounters. Paul and John, who participated in Phase One, also identified feelings of extreme discomfort when silence conveyed rejection and, in Phase Two, Amanda and Chris reported discomfort when they were uncertain of what was going on for the other person in the silence. Here the distinction between silence as a structure and as a medium for communication, identified by Saville-Troike (1995), is helpful; structure suggests form and medium implies content. These are qualities implicit in the metaphor of silence as "a container of words" (Sabbadini, 2004:229). A container has shape, dimension and the capacity for content; my own conclusion, in Chapter Five, was that it is necessary to distinguish discomfort with silence from discomfort with the content of the silence. Either way, participants confirm that staying with personal discomfort in silence can be beneficial to patient care.

The conclusion of Phase One was that these themes were underpinned by a notion of quality and depth. Returning to Sabbadini's (2004) metaphor, the shape of a container defines its capacity for depth; this resonates with my own early self-reflection (see Figure 6 in Chapter Five). In Phase Two, participant Chris identified the

movement into deeper silence as a mark of more complex content; this is consistent with Dauenhauer's (1980) description of deep silence as the silence that is present throughout dialogue. However, for Dauenhauer (1980:8), deep silence is bound up with utterance, "ordering pattern to sound phrases and intervening silences"; in this research, chaplains' experience seems to suggest that, in spiritual caregiving, the deepest silences contain no utterances at all, even external sounds may be temporarily subsumed.

Likewise, in Chapter Six, participants' experiences suggest that the greater the complexity of the content for the other person, the deeper the caregiver must move into the containing silence. This may be compared with Zeligs (1960) emphasis on importance of the benevolent attitude of the analyst but seems to demand deeper engagement than simple benevolence. For example, participant Charles associated depth of silence with depth of commitment and Tom spoke of a willingness to be part of a process of change. Similarly, James described an attitude of "becoming more present" highlighting a relationship between silence and the spiritual caregiving focus on presence found in both nursing and chaplaincy literature (Edwards et al., 2010; Kelly, 2012).

Building on the model introduced in Figure 11, in Figure 13 I visualise that, in spiritual care conversations, both caregiver and other have the potential to move backward and forward on a continuum from a predominance of speech to deep silence.
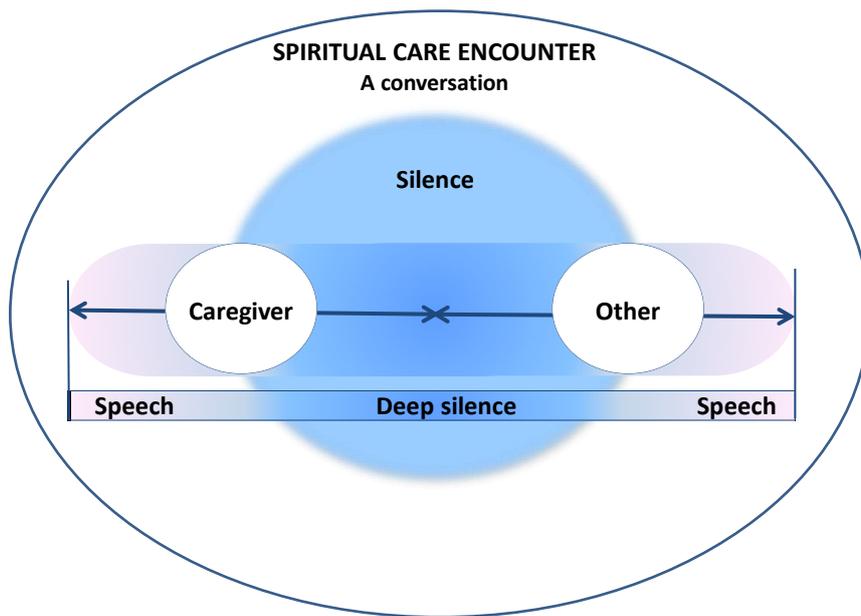
Figure 13. Spiritual care conversation: a continuum from speech to deep silence

In the conversational norm of listening, one party is silent while the other speaks and then in turn-taking, the roles are reversed (Bruneau, 1973); at other times both parties may fall silent together. It has been found in this thesis that a level of trust and relationship is necessary for shared silence to be comfortable within spiritual care encounters; this concurs with the research of Hill et al (2003), Ladany et al (2004) and Barber (2009) in psychotherapy. Furthermore, chaplains in this research alluded to moments when both caregiver and other move into a state of deep silence; it is here, I argue, that silence, of itself, becomes caregiving and, as inferred by Savett (2011) and Tornøe et al. (2014), the caregiver him or herself, by entering into silence, becomes the tool which makes the silence effective.

7.3 Spiritual caregiving silence

Consistent with the aims of spiritual care, I have defined spiritual caregiving silence

as a silence which is intended to support the spiritual wellbeing of the other person.

A spiritual care encounter may not include silence and not all silences are caregiving;

Figure 14 demonstrates my perception that spiritual caregiving silence is located at

the intersection of the two, and shows examples of both phenomena that fall outside

my definition.
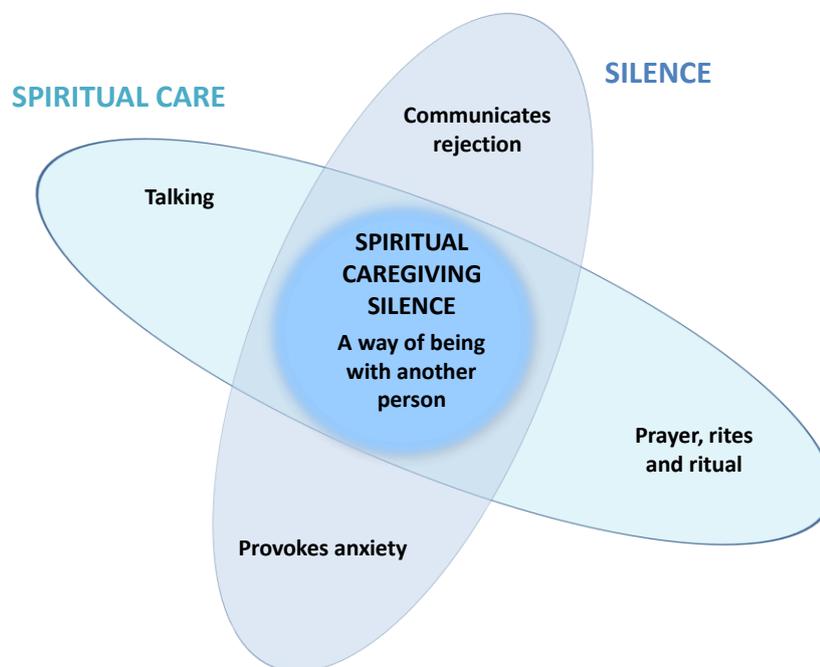
Figure 14. A diagram to show spiritual caregiving silence at the intersection of silence and spiritual care

I have noted that it is not surprising that the qualities of spiritual caregiving silence,

found in this research, are embedded within spiritual care itself. As explained by

Knutson and Kristiansen (2015), silence can only be understood within the context in

which it arises. Similarly, in this thesis, silence emerges as a means of and a medium

for communication, consistent with the theory of Saville-Troike (1995). Resonant

with the experience of Zeligs (1960) in psychoanalysis, findings suggest that, in

spiritual caregiving, communication is two way. Participants explained their own

silences as intended to convey openness, availability, no agenda and no time

pressure epitomised by Charles as "giving people space to be themselves".

7.3.1 The nature of spiritual caregiving silence: a way of being with another person

Spiritual caregiving has been described as privileging being over doing; spiritual

caregiving silence has been found to be a way of being with another person. This

resonates with a line-of-argument in the literature review, reported in Chapter

Three, that caregiving silence is not so much a tool to be used as a practice to be

learned, and seems to ally itself to the monastic approach to silence outlined in

Chapter Two.

Monastic silence has been described as waiting on the other (Goulding, 2003). In an

exploration of contemplation, Merton (1973:112) writes of

> an expectancy ... a higher kind of listening, which is not an attentiveness to
> some special wave length, a receptivity to a certain kind of message, but a
> general emptiness that waits to realise the fullness of the message of God
> within its own apparent void.

This alternative disposition, to the communication mode, is noted by Dauenhauer

(1980) in his term 'liturgical silence', which he describes as a waiting without

expectation of response. He describes it as: "the silence of the to-be-said . . . which is

silence beyond all saying" (Dauenhauer, 1980:16-19). 'Saying', in this context, is not

an act of speech but a Heideggerian understanding of the "call of Being"

(Dauenhauer, 1980:131) to which man must first listen in silence, and then respond.

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In this research four modes of being, for the caregiver, have been identified; they are outlined in Table 11 and will be developed in more detail below. These take into account the interior and external nature of silence, discussed above. My own learning, reported in Chapter Five, was that silence is not an end-in-itself but has purpose. This research has shown that the primary purpose of spiritual caregiving silence is being with another person, but within this, there are more nuanced purposes for the way of being described. These too, are shown in Table 11 and guide the progress of the following paragraphs.

Table 11. Four modes of caregiver silence

Caregiver mode of silence	Purpose
Being silent (or being silence)	Stillness Listening Nothing to say; when words seem redundant; when there are no answers Therapeutic: to create caregiving space
Being in silence	Attending Witnessing Not interrupting
Being in silence with another person	Shared silence
Being with the silence of another person	Therapeutic: holding Inadequacy of words Non-abandonment No words are necessary

Being silent has been explored in psychoanalytic and communications literature. To be silent is understood as to refrain from speech either by personal choice or external pressure. There is a distinction between being silent and being silenced (Fivush, 2010; Hyde et al., 2010). Hyde et al. (2010:97) distinguish the verb 'to silence', suggesting an external influence, from the noun 'silence' which "tends to

suggest an inward sense of tranquillity". Participant Jonathan's use of the noun, in "it's being silence", seems to draw upon the latter understanding of the word. Several chaplains noted that they are recognised as a calm person and a calming presence. To 'be silence' suggests an embodiment of the phenomenon that goes beyond the state of mind proposed by Back et al. (2009) and is manifested in a disposition of stillness resonant with the silence of the forest definition proposed by Davies (2008).

Findings from this research suggest two caregiving motivations for being silent. Firstly, to offer the other person the opportunity to speak; silence is a quality of listening and the value of listening in caregiving settings has been demonstrated in previous research (Mowat et al., 2012; Manzano, 2015). The importance of listening to speech and silence was reported in both phases of this research.

Similar to Wilmer (1995), who proposes the value of 'listening in' to the silences of others, there is evidence in participants' accounts of the importance of 'listening in' to silences. For example, Charles' comment, "The silences were being able to live with the silences that happen in life when there isn't an answer" suggests that resonant with Dauenhauer's (1980:19) description, spiritual caregiving silence acknowledges a "silence beyond all saying".

The second reported reason to be silent is because there is nothing to say; this is nuanced differently from being silenced, rather it describes an intentional participation in a silence which exists externally to the caregiver. Several chaplains cited occasions, especially around the time of death, when words seem to become, not only redundant, but an intrusion into a sacred moment. Here, like the figure-

ground reversal proposed by Denham-Vaughan and Edmond (2010), silence becomes the prevailing way of being.

In the term "being silence," Jonathan introduced a more active way of being a silent presence in the encounter. To 'be silence' implies more than refraining from speech; Jonathan described how he uses his silence as a deliberate therapeutic offering to break the cycle of suffering and create a space where a new perspective may emerge. Similarly, I found "myself stilling" in an attempt to calm the atmosphere in a patient's room and Susan spoke of using touch to "engineer a moment of quiet". To 'be silence' suggests an embodiment of the phenomenon where the caregiver becomes not only the one who stops speaking but the source of the absence of sound.

It may be that the ability of a chaplain to introduce silence, or influence the direction of conversation, is in part due to the perception of their role by others in the encounter. This perception is explored by Nolan (2012) and in research by Todd (2013) into Bible-study groups, where he notes difference, in turns of conversation and lengths of silence, between priest-led comments and questions and interactions between lay members. Similarly, in this research, Jonathan, a rabbi, described how chaplains are expected, by others, to take the lead. His intentional aim of encouraging people to take pause in silence is echoed by other participants and is, perhaps, particular to spiritual care; in other therapeutic situations the aim of caregiver silence seems to be, more often, to encourage the other person to talk or to facilitate the therapeutic process (Ladany et al., 2004).

My interpretation of chaplains' experience is that being in silence is both active and participative. Active silence involves being silent oneself and, on occasion, being silent with the intention of changing or creating an environment for the other. Participative silence demands active silence, in the first sense of being silent oneself, but, as explored in my reflections on ownership of silence in Chapter Five, it does not initiate the silence but participates in the silence of the other person or people present. My experience is that active silence is necessary because to speak or move would break the silence. It resembles the state of active passivity noted by Lunn (2009), in spiritual direction, described as not to be mistaken for doing nothing but an intentional choice to be still, to wait and to attend.

Being in silence includes qualities of witnessing and not interrupting; 13 participants spoke of "just sitting" with a patient. Being in silence with another person enables shared silence and shared experience. Both parties are silent, but the silence does not seem to belong, particularly, to one or other rather it is experienced as ambient, illustrated by chaplain Alison's description of her contemplative experience with patient Peter as being "in your own little world".

Being with the silence of another person, as described by Jonathan, resonates with the therapeutic quality of caregiving silence recorded in psychotherapeutic literature (Hill et al., 2003; Ladany et al., 2004; Barber, 2009) and also in palliative care (Himelstein, 2003; Back, 2009; Moriichi, 2009; Capretto, 2014). Examples from this research are Jonathan's deliberate silence at the beginning of an encounter with a young woman which led to a significant and healing conversation and Amanda's

discerned decision to continue to hold silence with a patient trying to come to terms with the imminence of her own death.

Chaplains identified that to be with the silence of another acknowledges the inadequacy of words to express the experienced suffering, illuminated by co-researcher Paul's comment that "amid awful circumstances and grief … there are just no words to say". My own experience of being with the silence of a suffering-other was reported as "agonising" and interpreted as compassion, literally suffering with another person. Several participants highlighted that, in the moment where the human instinct is to withdraw or as Paul said, "run away", the spiritual caregiving role is to determine to stay in solidarity with the suffering person, echoing the stance of non-abandonment described by chaplain Capretto (2014) in Chapter Three.

Being with a silence of rejection was my experience with Josie, reported in Chapter Five. Resonant with Roger's (1967:1) therapeutic experience with a silent young man, and Todd's (2013) findings, in Bible study groups, that insight is more a product of fellowship than knowledge, it seemed to be the experience of relational care which contributed to change; Josie slowly warmed to my persistent silent presence and we were both changed.

Chaplains described other occasions of being with silence when there are no words necessary because there is already a sense of completion and peace. Once again, this may be a manifestation of caregiving silence that is particular to spiritual care; where other interventions are undertaken in order to treat a 'problem', whether that be pain, depression or social isolation, spiritual care is offered to all patients (NHS Scotland, 2009). As reported by Tornøe et al. (2014), this research found that when

patients have reached what Jonathan described as the "post verbal phase" and there is nothing more to say or do, silence and non-verbal modes of communication are the options that remain.

This research has not explored the experience of the other person in the relationship, and this offers potential for future research, as I will note in Chapter Eight, but participants' accounts note that patients and family members exercise the choice to be silent and to be in silence. As recipients of care their silences are not presumed to be caregiving, however their participation is necessary for shared caregiving silence to occur.

Whilst there is general agreement in the literature, echoed in the findings of this research, that caregivers hold the responsibility for the conduct of the caregiving encounter, Cassidy (1988) suggests that, in holistic palliative care, health professionals, patients and family members meet in an acceptance of common humanity. I argue that the experience of common humanity is heightened in an encounter in silence, illustrated by Chris's comment that a relationship was forged between him and Norman in their shared silence which reminded him of his own humanity.

7.3.2 The meaning of being with another person in silence: connection, communication and companionship

Several participants noted people's fear of being alone in the presence of death or dying. This experience resonates with Hughes (1985:97), quoted in Chapter One, who alludes to the difficulty of spending time alone because it affords the opportunity to "look at ourselves in the mirror". In this thesis, I argue that being with another

person means that they are not alone and that being with another person in silence introduces a notion of 'being alone together'. This is illustrated by participant Amanda, who described the experience of being with herself in the company of patient Janice, who was also being with herself. From this, and other accounts, I infer that being with another person in silence may allow them to be with themselves in a way that they could not be on their own. Several participants' described how their silent accompaniment supported relatives to stay with their dying loved one to the end. My thesis builds upon the findings of Capretto (2014), in bereavement care, that silence in the presence of another person facilitates grief work that cannot be effected in isolation; and demonstrates the value of silent accompaniment in a wider range of palliative spiritual care situations.

The conclusion of Chapter Six is that mutual participation in silence, as with spoken conversation, can evoke a sense of companionship and connection and provide a medium for communication between caregiver and the dying person or their family member. In addition, there is a quality of attentiveness on the part of the caregiver, which is instrumental in evoking the other qualities within the relationship.

Companionship is a quality of being with another person which is central to this thesis. Defined as the feeling of fellowship or friendship (Oxford Dictionaries, 2016) that arises from being with another person with whom one feels closeness or relationship, it conveys something deeper than a casual or professional encounter. A companion is defined as someone who one travels with or spends extended time with, literally "one who breaks bread with another", and "a person who shares the experiences of another, especially when these are unpleasant or unwelcome"

(Oxford Dictionaries, 2016). This latter definition resonates with caregiving experiences in end-of-life situations described by the chaplains interviewed for this research, and reported by other authors such as Himelstein, (2003); Tornøe, (2014); and Capretto, (2014).

Several participants identified that, where talking demands a level of engagement, a disposition of silence is a way of being with another person which is non-intrusive and makes no demands of them; from their own experience of illness, some identified the burden of having to make conversation with visitors. Of particular relevance to this thesis, is Julia's point that even in hospices, there may be a lack of silence with companionship.

In my early self-reflection, reported in Chapter Five, I recognised a quality of attending to the other person in my spiritual care practice which felt the same as my attending to God in prayer. From the perspective of spiritual direction, Lunn (2009:225) describes attending as *kenosis* (self-emptying) which she describes as a "deeply theological act (...) It involves putting aside one's own thoughts, feelings and desires in order to attend to the other". This disposition resonates with the accounts of participants and is also described in the findings of Capretto (2014). Thus, attending implies a deep level of silence and patient-focus on the part of the caregiver.

Deeper levels of silence in both caregiver and other seem to evoke a sense of connection, which goes beyond the capacity of words. Chaplains in this research liken the experience to the intimacy of lovers, or a well-attuned married couple. I perceive these as practical examples of Denham-Vaughan and Edmond's (2010)

understanding that being present to another in silence diffuses the self-other boundary. At this deeper level, silence becomes a medium for communication; transcending Sabbadini's (2004) definition of a container of words, silence has been described as enabling expression of meaning without the use of words. This is illustrated in chaplain Clare's reflection on her silent interactions with patient John, "It was as if John understood (…) that I could see his suffering."

Several participants observed a connection between the other person and God during their encounters, similar to the experience of Rajski (2003), who uses contemplative prayer as part of therapy. Chaplains in this research noted that, at these times, the purpose of their silence as caregiver is not to get in the way but to be still and allow that connection to happen.

In her contemplative encounter with Peter, participant Alison identified both kinds of connection: between Peter and herself, and between Peter and God. Buber (1937) notes that such moments of intense connection are transient; this is supported in contemplative prayer traditions (Egan, 1984) and demonstrated, in this research, by the way Alison describes returning to the normality of the Day Service lounge. Alison's confirmation that her contemplative encounter with Peter did not reoccur in future visits supports a second insight from contemplative prayer, that moments such as these are gifted; they cannot be achieved by an act of will (Goulding, 2003).

Thus, the findings highlight that the meaning of spiritual caregiving silence is in its relational qualities, found in the attending of the caregiver to the other person, and in the mutual sense of companionship, connection and communication which is evoked.

7.3.3 The value of spiritual caregiving silence: space that offers the potential for change

This research has revealed that spiritual caregiving silence enables change. The opportunity of being with self in a relationship of silent companionship with a skilled caregiver, supported by a sense of connection and attending to verbal and non-verbal communication has been shown to have intrinsic value. This value is recognised by Rajski (2003) as an element within psychotherapy. In this research participants said that no more may be needed. However, they also identified additional value in the caregiving space that is created by silence, demonstrating that it has the potential to enable change. Change is identified in the articulation or expression of truth; it facilitates emotional release, an opportunity for dialogue and a sense of relaxation leading to acceptance, restoration and peace. These outcomes are identified in the conceptual model (Figure 15) presented at the end this chapter.

Caregiving space, which provides the opportunity to be with self, was found to trigger emotions, explained by Jonathan as "pushing the pause button", which enables emotional release, leads to helpful conversation and the possibility of seeing a way forward. Several participants gave examples of a period of caregiving silence leading to a moment of change. This is consistent with experience of the outcomes of long silences in psychological therapies (Rajski, 2003; Harris, 2004), and with Zeligs (1960) insight that the benevolent attitude of an analyst will help a patient to develop self-assurance and self-realisation.

In Phase Two of this research, five accounts describe an articulation of truth. In other examples, where patients were physically unable to speak or the message was

unsayable, expressions of truth have been described as non-verbal and, in the shared

silence, somehow heard and understood by the chaplain. It seems that, it is not only

the articulation or expression but also, being heard and accepted that offers

opportunity for healing and peace consistent with the value attribute to therapeutic

silence (Zeligs, 1960; Fivush, 2010; Knutson and Kristiansen, 2015).

Participants also described how silent encounters which reveal truth seem to be

complete in themselves, stating that there was no need for further discussion.

Indeed, some chaplains were reticent about recording or reporting the content of

silent encounters. This reflects chaplains' particular reputation for confidentiality and

trust, noted by Coates (2010), and is perhaps one of the more ambiguous features of

spiritual care in the evidence based environment of UK healthcare.

In summary, findings support the argument that, as an enabler of change, spiritual

caregiving silence has the potential to help another person towards acceptance and

finding a way forward; this is consistent with reported experience in counselling and

psychotherapy. Similarly and consistent with the aims of holistic palliative care,

occasions of spiritual caregiving silence have been shown to lead to the possibility of

restoration and peace; described by participant Steve as "a new comprehension of

worth and value as a human being".

7.3.4 Essential qualities of spiritual caregiving silence

The intention of a phenomenological project is to come to a deeper understanding of

the essential qualities of the phenomenon which has been explored (van Manen,

1990). The primary quality of spiritual caregiving silence that emerges is that it is a

way of being with another person; it has been found to be both an interior quality of

self, which contributes to listening and witnessing, and an external space in which the caregiver and the other person participate in a relationship of shared humanity.

In common with other types of silence, spiritual caregiving silence has been found to have both form and content acting as a means of communication and a medium for communication of messages or content. A notion of depth of silence describes levels of complexity of content and also levels of absorption in the encounter.

Spiritual caregiving silence has been found to work in close collaboration with speech and non-verbal modes of communication; the choice to use or keep silence is a fine discernment for the caregiver. Because of its contemplative quality, which is primarily concerned with attending to the other, silence makes a particular contribution to person-centred spiritual care.

Spiritual caregiving silence combines understanding and experience of silence from cross-disciplinary fields of religion and spirituality, psychology and human communication echoing the position of spiritual care itself.

7.3.5 Conceptual model

From the discussion above, a conceptual model of spiritual caregiving silence has been developed (Figure 15). Drawing on Figure 11, this illustrates the relation of silence, speech and non-verbal communication in a spiritual care encounter and demonstrates the continuum from speaking to deep silence, for the caregiver and the other person in the encounter, visualised in Figure 12. It incorporates the different modes of 'being', 'being in' and 'being with' silence identified in Table 11, noting that silence can be both active and participative.

The model highlights themes that contribute to the meaning of spiritual care giving silence identified in section 7.2.2: the caregiving disposition of attending and the sense of companionship, connection and communication that is evoked. As argued above this, of itself, offers value. Additional value is shown in the capacity of silence to enable change; noted in section 7.2.3 as expression of truth, verbally or non-verbally and emotional release. Value is identified in observed outcomes of acceptance, restoration and peace.
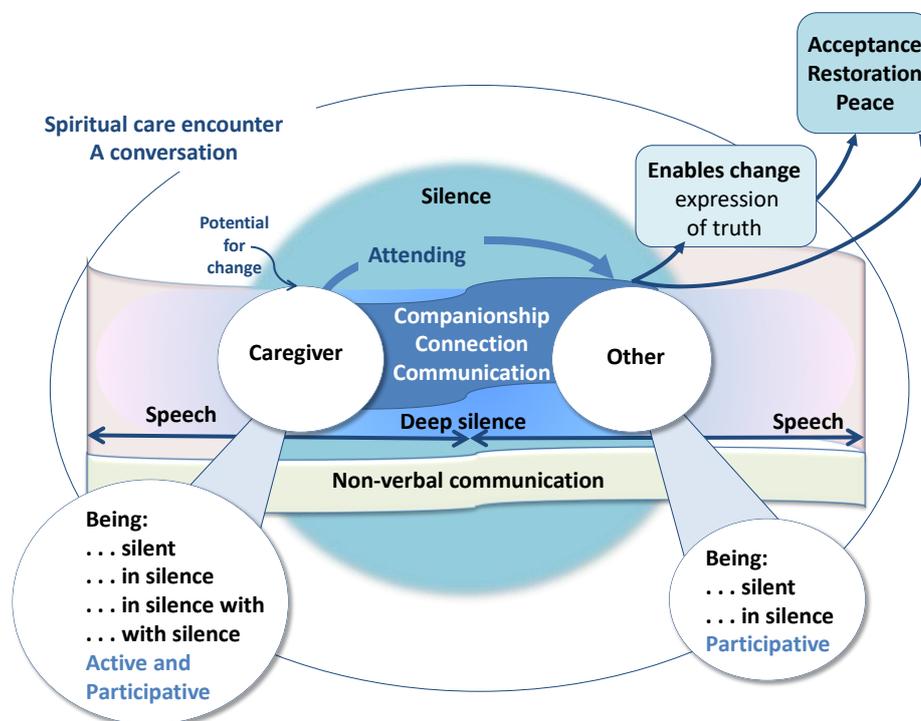
Figure 15. A conceptual model of spiritual caregiving silence as a way of being with another person

7.4 Conclusion

In this chapter I have discussed a type of silence described as spiritual caregiving silence. It shares common themes with silences used or practiced in religion and spirituality, the psychological disciplines and wider human communication. The spirit

of holism, foundational to palliative care, emphasises that boundaries between disciplines are not distinct, but findings suggest that spiritual caregiving silence, like spiritual care itself, has a particular role and purpose in interdisciplinary palliative care.

Spiritual care giving silence is interpreted as a way of being with another person and, I suggest that, this is its intention and its end. A way of being exemplifies the priority of a practice of silence, over use of silence, highlighted in the literature and understands silence as embodied in the caregiver. Further, spiritual caregiving silence has emerged as more than simply a quality of the caregiver; the capacity of silence to be both interior and external means that caregiver meets the other in a space of common humanity, in the silence, and may experience both active and participative roles. Thus spiritual caregiving silence is complementary to the spoken word, and also differentiated from speech by the particular contribution it offers to end-of-life care.

CHAPTER EIGHT

Conclusion: Spiritual caregiving silence as a way of being in end-of-life care

In this thesis I have explored and interpreted a type of silence, described as spiritual caregiving silence, in the context of palliative spiritual care where I have suggested that silence of the other person, whether they are a patient or family member, may become more prevalent for a variety of reasons.

The aim of the research was to deepen understanding of the nature, meaning and value of silence. This has emerged as a way of being with another person, which evokes a sense of connection and companionship and has the potential to enable change. The two phase phenomenological methodology enabled, in Phase One, explication of tacit knowledge to reveal a personal horizon of understanding, expanded through the shared experience of other chaplains and, in Phase Two, a description and interpretation of twelve other chaplains' lived experience of silence in end-of-life spiritual caregiving encounters.

I have found that spiritual caregiving silence incorporates qualities of spiritual care itself, with the intention of supporting the spiritual wellbeing of the other person in the relationship. As a way of being for the caregiver, this silence operates in close cooperation with both speech and non-verbal modes of communication. I have interpreted a continuum, from a disposition of speech to deep silence, and a number of modes of being silent and in silence for both parties in the caregiving relationship.

In my interpretation, caregiver silence is active, when caregivers use or practice silences intentionally for the spiritual wellbeing of others, and participative when caregivers choose to be silent themselves in order to not interrupt a silence which is external to themselves. Therefore, to be silent is a discerned caregiving decision and involves the risk of promoting or prolonging a period of silence, which may be uncomfortable for the other person. It involves assessment of whether it is the silence or the content of the silence that is uncomfortable for the other person because silence, in itself, that is uncomfortable for the other person falls outside the definition of spiritual caregiving silence proposed in this thesis. However the lived experience of chaplains, in this research, demonstrates that both silences and the content of those silences can be both comfortable and uncomfortable for the caregiver.

The purpose of spiritual care, understood as to be with another person, informs the caregiving decision to stay in silence with the other person in their situation, which may be extremely difficult, and in a silence which may feel uncomfortable. Moreover, I argue that, at these times, it is helpful for the caregiver to move deeper into the shared silence in order to support the other person in their suffering. Thus spiritual caregiving silence is shown to be a complex element of interpersonal human relationship, which offers value to patient care in terms of therapeutic companionship without the interruption or intrusion of words.

To be silent, in silence, suggests a fusion of silences which are both interior and external to the self of the caregiver. I have argued that to 'be silence' in an encounter, as described by Jonathan, is to somehow embody both interior and

external silence for the other person. This contemplative characteristic seems to denote a shift from spiritual caregiving silence as an act of the caregiver, to a silence which is caregiving of itself. In shared silence, there is the opportunity for a person to be with themselves in a way that they could not be when alone.

8.1 Contribution to practice

This research has focused on the experience of palliative care chaplains, described as spiritual care specialists, but spiritual care is part of the remit of all caregiving staff and volunteers. Noting the guidance in *Spiritual and Religious Care Competencies for Specialist Palliative Care* (Marie Curie Cancer Care, 2003), that caregivers must be cognisant of their own levels of spiritual caregiving ability, some of the deeper and more complex experiences of spiritual caregiving silence recounted in this thesis, especially those which are explicitly religious in nature, may not be for all caregivers. Chaplains undergo specialist formation and training and are supported by their own faith tradition and spiritual practice. However, all health caregivers will encounter times of silence with patients and family members in the course of their professional practice, especially, I argue, at the end of life. Where examples of lived experience, as reported in this thesis, resonate with the experiences of other practitioners, there is the opportunity for reflection and a deeper understanding which may, in turn, inform their approach to caregiving.

At the beginning of this research I was aware of a persistent curiosity relating to my own practice: would a deeper and more authentic practice of silence in my own spiritual life help to enhance the experience of the people I encountered in my

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professional role as chaplain and spiritual caregiver? This has not been specifically addressed in this thesis, which focuses on spiritual caregiving silence as a phenomenon. However, other chaplain's experience, reported in Chapters Five and Six, suggests that a personal practice of silence does support the professional practice of spiritual caregiving. This is supported in the wider caregiving literature discussed in Chapters Two and Three. To be the calm person that other people encounter, to stay in silence in the most difficult places with other people, demands an ability to be comfortable with silence oneself and to be comfortable with self. Spiritual traditions suggest that this ability to be with self is fostered in times of personal silence.

8.2 Contribution to knowledge

This thesis presents original empirical research into the phenomenon of silence in the context of spiritual caregiving at the end of life. It offers a unique insight into the lived experience of palliative care chaplains in end-of-life encounters. In acknowledging the cross-disciplinary nature of spiritual care, the thesis draws together knowledge in an original way, from psychology, communication theory, religion and spirituality to illuminate the nature of spiritual caregiving silence. A close connection between the phenomenon of silence, research question and methodology has contributed to congruence.

In the subjective process of immersion in the phenomenon and in the description and interpretation of themes, my personal understanding has been deepened and shared. The research began with a perception that silence is ignored and avoided in contemporary Western society, due to a lack of familiarity and understanding, and

that knowledge of the value of silence in palliative caregiving resides predominantly in the tacit domain. Thus, it is known but has been less often explored in scholarship. The possibility that this may lead to misinterpretation and uninformed practice has been suggested. This thesis contributes new knowledge in the form of a deeper understanding through reflection on examples of lived experience to inform understanding and practice and stimulate new interpretations.

Principles of evidenced-based care place value on that which is empirically demonstrated to be of value. The lived experience described and interpreted in this thesis is that silence, as an element of spiritual caregiving, does offer value in terms of spiritual wellbeing for patients, and their family members, at the end of life. However, as this thesis has shown, spiritual caregiving silence is a way of being with another and is thus process, and not outcome, focused. Consistent with the conclusions of previous studies, there is no suggestion that an active silence can be prescribed or used to achieve a preconceived objective.

8.3 Limitations

There are a few limitations to the thesis which I acknowledge. For instance, I have argued that spiritual caregiving silence is imbued with the qualities of spiritual care giving itself. Hence it is a type of silence that can only be understood in the context of a spiritual care encounter, and findings may not be transferrable to other inter-personal situations.

The thesis describes and interprets the lived experience of palliative care chaplains, who have a particular and specialist role in spiritual caregiving including support for religious needs. Perception of their role, within the institution and as representatives

of their faith community, may influence the content and character of the caregiving encounter. Thus some silences experienced by participants, of this research, are specific to their chaplain role.

The subject has been explored from a largely Judeo-Christian perspective; although this is the predominant influence in Western spiritual care, it may not be representative of experience in other faith traditions or cultures. The research does not include the experience of other health caregivers who also have a responsibility to offer spiritual care and, because of their primarily clinical and caregiving role, have a different relationship with patients and their families.

This research has not sought, and I do not presume to describe, the experiences of the other person, whether a patient or family member, in the caregiving relationship. Their perception of the silence(s) will have been different from that observed by participants and their perspective is a point of interest for future research. Whilst the spiritual wellbeing of the other person has been described as central to care, and some observations have been made about the effects of silence, the primary purpose of this research has not been to measure or assess outcomes of silence for patients or family members. Rather this research sought a deeper understanding of the lived experience for chaplains as health caregivers in the context of palliative care, in order to facilitate deeper understanding of silence, as a spiritual caregiving phenomenon, for other chaplains and caregivers.

The research focused on end-of-life settings and experience may not be directly transferable to acute healthcare, other spiritual care or wider caregiving settings where silence may occur for different reasons. Finally, the contextual and

interpretative nature of a phenomenological inquiry into the experience of a small homogeneous sample of participants makes no claim to generalisability.

8.3 Opportunities for future research

Following the theory of Gadamer (1976) that knowledge approximates more closely to truth in the fusion of multiple horizons, it would be useful to continue to deepen understanding of spiritual caregiving silence by exploring the experience of other caregivers for whom spiritual care is part, but not the totality, of their role. Similarly, it would be useful to explore the perspective of specialist spiritual caregivers from other faith traditions.

As highlighted above, empirical research into the experience of silence in caregiving from the perspective of the other person in the encounter would provide useful comparative data especially in the light of the findings of Barber's (2009) research which noted different experiences of silence from the perspectives of therapist and client. This may be difficult, or not possible, with people very close to the end of life but for palliative patients earlier in their illness journey, and for family members, the opportunity to contribute their experience may be perceived as helpful and would expand the field of knowledge. In addition, a philosophical inquiry into the relationship of silence and other allied concepts such as space, presence and stillness, which have been explored in other disciplines and contexts, may offer further useful enlightenment.

8.4 Last words

For the reader, I hope that something of the interpretation of spiritual caregiving silence in this thesis has resonated, or will in the future, with aspects of your own

experience of silence; as qualitative research this is a primary measure of trustworthiness and quality.

For myself, I look forward to the opportunity to deepen my own interior silence and whatever the fruits of that may be; as I learned in March 2013, it is not possible think about silence and be silent at the same time.

The philosopher Wittgenstein is quoted as saying, "whereof one cannot speak, thereof one must be silent" (Stanford, 2014). I have engaged in a critical realist, spiralling dialogue between self and the phenomenon of silence at some length, but to dialogue with silence on its own terms, is to dialogue without words. I have come to understand that knowledge of silence is not so much to be learned as discovered in silence itself, through being silent, being in silence and being with silence.

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Appendices

Appendix 1. Search strategy: PsycINFO

Search undertaken 17/03/2015

Search ID#	Search terms	Search Options	Last run by	Results
S14	S12 AND S13	Search modes – Find all my search terms	Interface – EBSCOhost Research Databases Search Screen – Advanced Search Database - PsycINFO	714
S13	(ZL "English")	Search modes – Find all my search terms	Interface – EBSCOhost Research Databases Search Screen – Advanced Search Database - PsycINFO	3,558,922
S12	S8 AND S11	Search modes – Find all my search terms	Interface – EBSCOhost Research Databases Search Screen – Advanced Search Database - PsycINFO	827
S11	S9 OR S10	Search modes – Find all my search terms	Interface – EBSCOhost Research Databases Search Screen – Advanced Search Database - PsycINFO	753,020
S10	AB patient* OR client* OR therap*	Search modes – Find all my search terms	Interface – EBSCOhost Research Databases Search Screen – Advanced Search Database - PsycINFO	735,084
S9	(DE "Patients") OR (DE "Geriatric Patients") OR (DE "Hospitalised Patients") OR (DE "Medical patients") OR (DE "Outpatients") OR DE ("Psychiatric Patients") OR DE ("Surgical Patients") OR DE ("Terminally Ill Patients") OR (DE "Clients")	Search modes – Find all my search terms	Interface – EBSCOhost Research Databases Search Screen – Advanced Search Database - PsycINFO	90,271
S8	S1 AND S7	Search modes – Find all my search terms	Interface – EBSCOhost Research Databases Search Screen –	1,041

			Advanced Search Database - PsycINFO	
S7	S2 OR S3 OR S4 OR S5 OR S6	Search modes – Find all my search terms	Interface – EBSCOhost Research Databases Search Screen – Advanced Search Database - PsycINFO	390,816
S6	AB therap* OR counsel*	Search modes – Find all my search terms	Interface – EBSCOhost Research Databases Search Screen – Advanced Search Database - PsycINFO	347,037
S5	(DE "meditation" OR DE "Spirituality") OR (DE "Pastoral Counselling")	Search modes – Find all my search terms	Interface – EBSCOhost Research Databases Search Screen – Advanced Search Database - PsycINFO	18,151
S4	DE "Palliative Care"	Search modes – Find all my search terms	Interface – EBSCOhost Research Databases Search Screen – Advanced Search Database - PsycINFO	7,927
S3	(DE "Psychotherapeutic Processes") OR (DE "Psychotherapeutic Counselling")	Search modes – Find all my search terms	Interface – EBSCOhost Research Databases Search Screen – Advanced Search Database - PsycINFO	34,801
S2	DE "Therapeutic Processes" OR DE "Therapeutic Environment"	Search modes – Find all my search terms	Interface – EBSCOhost Research Databases Search Screen – Advanced Search Database - PsycINFO	20,507
S1	Silence OR DE "silence"	Search modes – Find all my search terms	Interface – EBSCOhost Research Databases Search Screen – Advanced Search Database - PsycINFO	5,406

Appendix 2. Record of searches

Electronic database search

Date	Database	Date range	No. results	No. retained	No. excluded
06/03/2015	MEDLINE	1962 - present	600	66	534
07/03/2015	Academic Search Complete	No limit	476	74	402
09/03/2015	CINAHL	No limit	428	28	400
14/03/2015	Proquest*	No limit	135	7	128
15/03/2015	AMED	1996 - 2015 (no limit)	12	7	5
15/03/2015	PsycINFO	No limit	714	132	582
			2365	**314**	**2051**
* Proquest databases searched: International Bibliography for the Social Sciences, Proquest Dissertations and Theses A&I and UK and Ireland					

Journal index hand search

Date	Database	Date range	No. results	No. retained	No. excluded
27/03/15	Journal of Health Care Chaplaincy	1987-2015	0	0	0
23/02/15	Scottish Journal of Healthcare Chaplaincy *	1998 - 2013	6	1	5
27/3/15	Journal of Health Care Chaplaincy (UK)*	2006 - 2011	0	0	0
25/02/15	Health and Social Care Chaplaincy	2013-1015	8	2	6
23/02/15	Journal of Religion and Health	1961 - 2015	5	5	0
21/02/15	Journal for the Study of Spirituality	2011 - 2015	8	2	6
21/02/15	Practical Theology	2008 - 2013	10	5	5
			37	**15**	**22**

*In 2013 Scottish Journal of Healthcare Chaplaincy and Journal of Health Care Chaplaincy combined to become Health and Social Care Chaplaincy

Google Scholar Alert: Search terms 'silence, "spiritual care", end of life from September 2013 until October 2016 2 articles retained. **Total number of hand search results: 39**

Appendix 3. Sample completed data extraction sheet

Paper for Data Extraction	
Search ref	Psych 123
Author	Ladany, N., Hill, C., Thompson, B., O'Brien, K.
Title	Therapists perspectives of using silence in therapy: a qualitative study
Source	Counselling & Psychotherapy Research, 4, 1, pp. 80-89
Country	USA
Year	2004
Discipline	Psychotherapy

	Description	Comments
Document type	Report of qualitative research	
Methodology/ Theory/ Model/tool	Consensual qualitative approach	
Design/ Sample	12 experience therapists 2 case examples (neither silence as care)	
Context	Psychotherapy	
Focus of paper	Therapists' use of silence; why therapists use silence	
Findings/ proposition	"The sole general client-focussed reason [for using silence] was that therapists believed they use silence to convey empathy, respect, support (e.g. to give the client space; to honour something the client said, to hold, to nurture or give the client permission to be themselves)"; "to demonstrate understanding and provide therapist conditions that would facilitate the therapeutic work"[1]; "to facilitate client reflection; to challenge the client to take responsibility and control (by creating a little distance)".	[1] Does this make for patient centred care or 'therapeutic work' centred care?
Conclusions	"Therapists typically perceive themselves as using silence to convey empathy, facilitate reflection, challenge the client to take responsibility, facilitate expression of feelings or take time for themselves to think what to say." "A sound therapeutic alliance is needed; therapists often educate the client about their use of silence; silence would not be used with patients who are psychotic, highly anxious or angry. "No specific recommendation can be made in terms of when to use silence".	
Conceptualisation of silence	Silence as "a pause in the dialogue"; "silence is a multifunctional intervention. Similar-looking silences could be motivated by a variety of different reasons" by the therapist; "silence	

	cannot be conceptualised as a single entity in therapy with a single therapist intention and a single client perception";	
Specific words/ phrases that describe silence	"from cruel inhumanity to tender concern" (Gill 1984)	
Perceived +ve aspects to patient care (caregiving)	<u>Facilitative</u>: "can <u>allow clients to reflect</u> on their own thoughts and feelings"; "<u>convey respect</u> and <u>empathy</u>"	
Perceived –ve aspects to patient care (not caregiving)	"raise <u>anxiety</u>, exert <u>pressure</u> to communicate"; Could lead to <u>negative consequences</u> in therapeutic work; "some clients may experience silence as <u>insulting, withholding or critical</u>"; "<u>reflecting therapist anger, stressful or heightening their fear of abandonment</u>"	
Potential cause of misunderstanding	Silence used in early sessions; where client experienced it a withholding; where client came from a family that used silence destructively. "Even though therapists may have benevolent intentions for using silence, clients may perceive silences to be anything from benevolent to intimidating."	
Demands upon/ qualities of caregiver	"Therapists typically believed they learned how to use silence from their own experience as a client and from supervision"[2]; "when <u>anxious</u> some therapists used silence less whereas others used it more"; silence was used when they "<u>did not know what to do</u>" and when "<u>distracted</u>". "All therapists observed (without staring) what was happening with clients in relation to therapy; "looked at the client's body language indirectly and made occasional eye contact"; "looked slightly away from clients but always attending to clients non-verbals". What therapists do in the silence: "thought about what was going on in the therapy; "very busy"; "daydreaming"; "metaphorically held clients"; "actively engaged". Silence was rarely formally taught as an intervention. Experience of silence comes largely from their own clinical experience and supervision.	[2] suggests that it is not so much a taught skill as an experiential skill
General Comments		
What is novel	The perspective of "why use of silence?" This is the only qualitative study of therapists' experience of silence.	
Specific Experience(s) of silence:	Case 1: therapist uses silence to challenge the client which made the client "very uncomfortable". However, "the therapist's use of silence seemed to help the client confront his problem." Case 2. The case started with two contra-indications for the use of silence (weak	

	alliance, fragile client + early in treatment). "Although the therapist reported initially feeling fine about the silence, the therapist ended up breaking the silence when she observed the client sitting rigidly and glaring at her". The client "felt attacked and unsupported by the silence". Described as "misapplied silence" which led to "negative therapeutic consequences".

Review Question: How do people in professional care-giving roles describe their experiences of silence in inter-personal relationships with those in their care?

Brief description of paper	Ladany seeks to understand why therapists use silence in therapy. He suggests that it is an infrequent intervention (Hill 1986) and stresses the multifunctional quality of silence as an intervention with potentially beneficial and negative impact on the therapy. 12 experienced therapists are interviewed, their general conclusion is that they use silence for the benefit of the therapy i.e. "to convey empathy, facilitate reflection, challenge the client to take responsibility, facilitate expression of feelings or take time for themselves to think what to say." Ladany cites one example of where silence is used [albeit in a risky way] successfully and one where the intervention failed and resulted in the end of the therapy. A strong therapeutic alliance is a prerequisite. Therapists suggest that comfort with the use of silence comes with experience.
Relevance to my study	The fact that this study focuses so strongly on the use of silence and specifically why therapists use silence reduces its relevance to my research. Neither of the case examples is relevant, because neither case demonstrates silence as care (the most caring action is the breaking of the uncomfortable silence in case 2.) However the research gives a picture of how therapists perceive their use of silence, and how 'at odds' this can be with the client experience and I think this offers a salient warning to spiritual caregivers who may believe that in 'using' silence they are providing benevolent care.
Concerns	The paper seems to prioritise success of the therapy over care of the patient. This may be an accurate portrayal of the objective of psychotherapeutic treatment but highlights the gap between therapy and care (specifically spiritual care).
Quality of paper: Rigour, value, credibility	**Evidence Assessment Tool** (Hawker et al 2002:1295) Title and Abs: Fair, Intro and Aims: Good, Method and data: Fair, Sampling: Fair, Data analysis: Good, Ethics and Bias: Very poor, Findings, conclusion: Good, Transferability: Fair, Implications and Usefulness: Good. Total score: 300.
Other material in this paper not relevant to review question	"As therapists none of us wanted to use silence in a withholding manner or as a way to increase the client's overall level of anxiety"
Further reading/ Other relevance	Frankyl, Levitt, Murray – Dyads – silence as pause Kenny, C. (2011) The power of silence in everyday life – ordered Urlic, E, The phenomenon of silence EXC - groups
Author's contact details	Nil3@lehigh.edu

Inclusion and Exclusion criteria

Inclusion	Exclusion	
English language texts		✓
Empirical research and articles published.in peer reviewed journals	Book reviews	✓
Reports primary experience of silence from the perspective of the caregiver	Does not include primary experience of silence.	✓
Focus on silence		✓
Silence in a professional caregiving contexts with patient, client or family member	Group therapy Non-caregiving disciplines Inter-professional communication Non-professional care-giving e.g. Family or informal carers	✓
Focus on silence as an element of care including clinical consultation or therapy	Silence that is not an expression of caregiving: • Patient/ client silence • Taboo/ stigma, that which is "not discussed" • "conspiracy of silence", use of silence as power or control Self-care Silence as a part of individual spiritual practice	✓

Does the paper still meet inclusion/exclusion criteria?

		Comment
Yes	✓	
No	☐	

Appendix 4. Phase One recruitment pack

An invitation to take part in a research project:
Silence in Spiritual Care at the end of life

Dear Colleague,

My name is Lynn Bassett and I am a palliative care chaplain and a student in the PhD Palliative Care programme at Lancaster University. My research aims to explore the nature, meaning and value of silence in spiritual care at the end of life and I am asking other palliative care chaplains to share their experience.

Participants will be asked to attend a one-to-one conversation style interview at their own place of work or at a mutually convenient venue. The study is designed in two phases. Interviews are expected to take place during June to August 2013 (phase 1) and April to June 2014 (phase 2). It is possible to participate in either phase 1 or phase 2.

How do I find out more?

1) An information sheet is included with this letter.

2) Complete the Expression of Interest form and either email to l.bassett@lancaster.ac.uk or print out and post to Lynn Bassett, Spiritual Care Co-ordinator, The Peace Hospice, Peace Drive, Watford. WD17 3PH.

Your personal information will be kept confidential.

What happens next?

At this stage you are not committing yourself to the project. The first step is that you will be contacted to make an appointment for a telephone conversation to answer any questions you may have and discuss your possible participation. The decision about which phase you may be involved in will be made based on your availability and best fit for the needs of the study.

Thank you for your interest.

With best wishes

Lynn Bassett

Silence in Spiritual Care at the end of life

Expression of Interest

I am interested in participating in the above research project. Please contact me to arrange a convenient time to discuss this further.

I am currently employed as a palliative care chaplain.

Name: …………………………………………………………………………

Job Title: ……………………………………………………………………

Name of Workplace: ……………………………………………………….

Address: …………………………………………………………………………

………………………………………………………………….………………….

………………………………………………………………….…………………

Tel: ………………..……………….. Mobile: ………………..………………

Email: ……………………………………………………………………………….

Preferred method of initial contact: …………………………….........

Return this form to Lynn Bassett, The Peace Hospice, Peace Drive, Watford, Hertfordshire WD17 3PH or email to l.bassett@lancaster.ac.uk

Thank you for your interest.

Participant Information Sheet

Silence as Spiritual Care at the end of life

My name is Lynn Bassett and I am conducting this research as a student in the PhD Palliative Care programme at Lancaster University, Lancaster, United Kingdom.

What is the study about?

The purpose of this study is to explore silence as an element in spiritual care at the end of life by asking palliative care chaplains to share their experience of silence in encounters with patients and their family members.

Why have I been approached?

As someone currently in post as a palliative care chaplain you may be able to offer experiences of silence in the context of end of life spiritual care giving.

Do I have to take part?

No. It's completely up to you to decide whether or not you take part.

What will I be asked to do if I take part?

The study is designed in two phases. Both phases involve a one to one unstructured interview, lasting between one and two hours, with the researcher either at your own place of work or at a mutually convenient venue. You will be invited to participate in either phase 1 or phase 2.

- Phase 1. Interview during June to August 2013. Following transcription and analysis a draft depiction of your data will be sent to you for your comments between August and November 2013.
- Phase 2. Interview during April to June 2014.

You may withdraw your data from the study up to 2 weeks after your interview.

Will my data be confidential?

The information you provide is confidential. The data collected for this study will be stored securely and only the researcher conducting this study will have access to this data:

- o   Audio recordings will be deleted once the thesis is submitted and assessed.

- o Hard copies of transcripts will be kept in a securely locked filing cabinet.
- o Transcripts and data files on the computer will be encrypted (that is no-one other than the researcher will be able to access them) and the computer itself password protected. Data will be archived after the completion of the study and destroyed within 10 years.

- o Your personal details will be stored separately from the transcript in a secure filing cabinet and will be destroyed once the thesis is submitted and assessed.

- o The typed version of your interview will be made anonymous by removing any identifying information including your name. Anonymised direct quotations from your interview may be used in the reports or publications from the study, so your name will not be attached to them.

There are some limits to confidentiality: if what is said in the interview makes me think that you, or someone else, is at significant risk of harm, I will have to break confidentiality and speak to my academic supervisors about this. If possible, I will tell you if I have to do this.

What will happen to the results?

The results will be summarised and reported in my PhD thesis and may be submitted for publication in an academic or professional journal. A summary of the results will be sent to you for your information.

Are there any risks?

There are no risks anticipated with participating in this study. However, if you experience any distress following participation you are encouraged to inform the researcher and contact the resources provided at the end of this sheet.

Are there any benefits to taking part?

Although you may find participating interesting, there are no direct benefits in taking part. There are however potential benefits to palliative care chaplaincy and to a wider audience in deepening understanding of the value of silence in spiritual care.

Who has reviewed the project?

This study has been reviewed by the Faculty of Health and Medicine Research Ethics Committee, and approved by the University Research Ethics Committee at Lancaster University.

Where can I obtain further information about the study if I need it?

If you have any questions about the study, please contact the main researcher:

Lynn Bassett email: L.bassett@lancaster.ac.uk

or my supervisors: Dr Sarah Brearley email: Sarah.brearley@lancaster.ac.uk;

Dr Amanda Bingley email: A.bingley@lancaster.ac.uk

Complaints

If you wish to make a complaint or raise concerns about any aspect of this study and do not want to speak to the researcher, you can contact:

Professor Paul Bates Tel: (01524) 593718
Associate Dean for Research Email: p.bates@lancaster.ac.uk
Faculty of Health and Medicine
(Division of Biomedical and Life Sciences)
Lancaster University
Lancaster
LA1 4YD

Resources in the event of distress

Should you feel distressed either as a result of taking part, or in the future, the following resources may be of assistance: www.counselling-directory.org.uk

Thank you for taking the time to read this information sheet.

Appendix 5. Topic guide for Phase One unstructured interviews

Interview stage	Questions
Introduction Consent to interview Consent to recording	
Background/ contextual information	1. Tell me about your work here . . . . • Your role • How long have you worked here? • Your experience in palliative care and/or chaplaincy in this role or similar? Would you mind me asking . . . 1. Your age 2. Your religion/ faith background/ influences
Definitional questions	Is silence a part of your own spirituality (or has it ever been)? Can you tell me more . . . I'd like to ask you a bit more about your experience of silence as a phenomenon . . . What does the word silence (or the concept of silence) mean to you? Are there associations with particular places or people? Does it bring to mind images . . . or other words? Are there experiences of silence which are particularly vivid for you? What sort of feelings or thoughts does it generate in you? Are you aware of physical changes in your body when you are in the presence of silence? What time and space factor affect you awareness of silence and meaning you attribute to it? Are there any other important aspects of the experience or meaning of silence to you

	that you'd like to share? I'd like to move on to your experience of silence in your work . . . 2) In patient encounters
Core discussion In-depth – attitudinal/evaluative/explanatory questions Use follow up questions/ prompts/ probes Move from general to specific	 Can you think of a time when you experienced silence with patients or family members? Perhaps you could give me an outline of the situation. How did it feel to you? Did you notice changes in yourself? What about the other person? What do you think the meaning of this silence was for them? Is this a typical example of silence with another person or are there different experiences. Perhaps you can think of another situation where silence had a different effect . . . Are there times when you have experienced silence as uncomfortable (for you, for the other?)
Drawing the interview to a close Signal closure Summarise	 Finally, can I just check back that I have correctly understood the key points of your experience . . . Is there anything else you'd like to add? Any burning issues that you have not had the opportunity to mention . . . Thanks for participation
After the interview If the participant wants to say more . . . listen . . . check out if it is ok to include any new ideas in the data Ensure participant is left in a good place.	

Appendix 6. Ethics committee consent for research

LANCASTER UNIVERSITY

Applicant: Lynn Bassett
Supervisor: Dr Sarah Brearley
Department: DHR

22 March 2013

Dear Lynn and Sarah,

Re: Silence in spiritual care at the end of life

Thank you for submitting your research ethics application for the above project for review by the Faculty of Health and Medicine Research Ethics Committee (FHMREC). The application was recommended for approval by FHMREC, and on behalf of the Chair of the University Research Ethics Committee (UREC), I can confirm that approval has been granted for this research project.

As principal investigator your responsibilities include:

- ensuring that (where applicable) all the necessary legal and regulatory requirements in order to conduct the research are met, and the necessary licenses and approvals have been obtained;

- reporting any ethics-related issues that occur during the course of the research or arising from the research to the Research Ethics Officer (e.g. unforeseen ethical issues, complaints about the conduct of the research, adverse reactions such as extreme distress);

- submitting details of proposed substantive amendments to the protocol to the Research Ethics Officer for approval.

Please contact the Research Ethics Officer, Debbie Knight (01542 592605 ethics@lancaster.ac.uk) if you have any queries or require further information.

Yours sincerely,

S C Taylor

Sarah Taylor
Secretary, University Research Ethics Committee

Cc Professor T McMillan (Chair, UREC); Professor Paul Bates (Chair, FHMREC)

Research Support Office
Research and Enterprise Services

Lancaster University
Bowland Main
Lancaster LA1 4YT
United Kingdom

Tel: +44 (0) 1524 592003
Fax: +44 (0) 1524 593225
Web: http://www.lancs.ac.uk

Lancaster University

Applicant: Lynn Bassett
Supervisor: Dr Sarah Brearley
Department: DHR

07 January 2015

Dear Lynn and Sarah,

Re: Silence in spiritual care at the end of life

Thank you for submitting your amendment for the above project for review by the Faculty of Health and Medicine Research Ethics Committee (FHMREC). The amendment was recommended for approval by FHMREC, and on behalf of the Chair of the University Research Ethics Committee (UREC), I can confirm that approval has been granted for this amendment.

As principal investigator your responsibilities include:

- ensuring that (where applicable) all the necessary legal and regulatory requirements in order to conduct the research are met, and the necessary licenses and approvals have been obtained;

- reporting any ethics-related issues that occur during the course of the research or arising from the research to the Research Ethics Officer (e.g. unforeseen ethical issues, complaints about the conduct of the research, adverse reactions such as extreme distress);

- submitting details of proposed substantive amendments to the protocol to the Research Ethics Officer for approval.

Please contact the Research Ethics Officer, Debbie Knight (01542 592605 ethics@lancaster.ac.uk) if you have any queries or require further information.

Yours sincerely,

S.C. Taylor

Sarah Taylor
Secretary, University Research Ethics Committee

Cc Fiona Aiken, University Secretary, (Chair, UREC); Professor Roger Pickup (Chair, FHMREC)

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Appendix 7. Worked example of data analysis in 'wholistic' approach (see van Manen, 1990) showing progress from summary of one account to emerging theme

Extract from 'Summary of accounts' (Appendix 15) showing progress from summary and identified thematic aspect (underlined) to formulation of meaning in account 9a

Ref	Summary of account	Formulation of meaning
9a	Julia describes her support for Maria, the wife of a terminally ill patient. Because English was not the wife's native language, <u>Julia gave her plenty of time to express herself</u>, but <u>Julia's silence also gave the wife space for herself to express her own emotion</u>.	Accompanied silence is a medium for self-expression and release without the use of words

Extract from working document showing contribution of formulated meaning of account 9a to thematic cluster and emerging theme. Thematic clusters and emerging themes are shown in full in Table 10, p. 113)

Formulated meaning statements clustered	Thematic cluster	Emerging theme
1c. In a "silence of intimacy" a truth can be "expressed" without the use of words enabling a "greater sense of peace". 8c. Feelings and emotions that cannot be expressed in words can be communicated non-verbally in silence. <u>9a. Accompanied silence is a medium for self-expression and release without the use of words.</u> 11a. Shared silence offers space for processing and emotional release.	Silence enables self-expression without the use of words	Silence enables expression and communication of truth (with or without words)

Appendix 8. Personal experience of silence in patient encounters

Key phrases which illuminated qualities of silence are underlined.

Sarah (Journal 19/04/2013)

Today Sarah was in a low place. I have never seen her so low. She was tired, twitching slightly and seemed afraid that a fit might be brewing. <u>Sarah can't speak more than a few words so it is hard for her to express herself</u> normally and even more so today with the <u>oppression of fatigue.</u> <u>There is little point in disturbing her with questions that she is unable to answer so, after checking out some basic needs, we agreed that she would like me to sit quietly with her and hold her hand.</u>

<u>It was agonising</u>, from time to time she would utter an anguished moan, "oh,wo,wo,wo,wo,wo . ." and <u>there was nothing I could do</u>. <u>She alternated this with a cry [I thought] for her mother, "mum, mumumm", to which I was able to respond "yes, she's on her way".</u> <u>Aside from that we sat</u>, her eyes sometimes closed but frequently opening to look at me intently and perhaps pleadingly. As I do, <u>I tried to meet her gaze with a confident and comforting smile (I did not feel too confident inside).</u> There is this balance to be struck between offering total attention while not seeming to stare. <u>I meet her gaze when she turns it upon me but I don't feel comfortable if every time she opens her eyes she finds me 'watching' her,</u> so I keep a shifting glance at approximately 45 degrees <u>trying to be a comfortable, attentive, but not intrusive, presence.</u> I wonder if it seems that way to Sarah.

A nurse looks in with that familiar mix of <u>attention, stillness, kindness and compassion</u> that I have seen so many times before. <u>She is totally attentive to Sarah, saying not much, touching her arm lightly, watching and waiting. It feels so reassuring.</u>

It reminds me of the stillness I saw in nurse Jane some months ago. The patient that day had become overwhelmed by a panic attack because she did not know when her relatives were coming. 10 minutes before, I had been with her and she had been fine. We'd had a general and pleasant conversation. Now she was out of her room, crimson in the face and inconsolable. I guided her to a chair and we sat together, gently trying to unpack her distress. Soon Jane joined us. She had contacted the husband and he would be with us shortly. Meanwhile Jane and I sat with the sobbing patient. <u>Jane didn't say a word, she didn't move, the quality of her stillness was captivating and calming.</u> <u>Perhaps I might have said more as an attempt at consolation but Jane's stillness was enough, there was no more needed. Somehow she absorbed the anguish and pain.</u>

Josie (Journal 07/03/2013)

Josie was angry, <u>so angry that she declined to speak to people</u>. When she did speak it tended to be terse, abrupt, aggressive even abusive. She was angry at her illness, angry that her life had been cut short, angry at her husband, angry at the hospice and its staff and volunteers. Perhaps she was even angry at her own anger.

On my first visit I was rejected immediately: "The chaplain! What sort of chaplain are you? You're not a priest!" (I'm very familiar with this charge). And then, "My own priest has been. I don't need anything more from you." I exited with my usual offer to be contacted if anything came up. I felt very sorry for her husband, a quiet, patient man who seemed not to be able to do anything right but, equally, was expected to stay by her side.

When I visited the next week, I approached with some trepidation. The staff had reported how difficult their encounters with Josie had been. She greeted me with brusque civility. "Yes, please" she would like Holy Communion. I obliged and she made the appropriate responses. Would she like me to call again? "Yes, tomorrow." I recognised the refuge in control that is not unusual in patients who have lost control of almost every other area of their life. I agreed to visit tomorrow, despite it not being a normal working day for me and sensed that Josie warmed a little. Someone was willing to go the extra mile for her – perhaps she was not as worthless as she felt . . .

And so it continued: I visited regularly, as often as I could. She always greeted me civilly but then sat in her angry silence; face directed about 145 degrees away from me, arms folded tight. Attempts at conversation were either ignored or answered with monosyllables. It seemed that she really didn't want to talk. She certainly didn't want to be psycho-analysed. "Would you like me to leave you in peace?" I sometimes ventured. "No, I'd like you to stay" she said. For how long? The nurses sometimes smiled at my persistence and constant rejection. I learnt that I had to make my own excuses when it was time to leave; there was no natural end to the encounter.

As I sat with Josie in the silence, I had to wrestle with my own feelings. Rejection was ok; I did not feel hurt by this, but futility? Should I be doing something more useful, visiting someone who actually wanted to talk to me? What should I be doing? Should I be praying quietly? I did sometimes, but more often I found a way of attending to Josie quietly, not forcing my whole focus upon her but being totally "there for her" sometimes glancing lightly towards her, more often sitting with my gaze slightly averted gently mirroring her own, sometimes making the odd comment about the TV or passing events in the ward, inviting conversation but generally ignored.

As I sat with Josie I began to see the world with her eyes: there were many things that seemed quite surreal – the sounds of people laughing and joking, out of sight, somewhere down the corridor, the fact that the volunteer who brought the dinner put the tray down the wrong way round with the cutlery pointing towards some invisible other at the end of the bed. In the silence I noticed these things, they were somehow amplified. It was as if we shared an ironic joke about the way the rest of the world operated. It was not us who were out of sorts, but them. In these wordless encounters I felt a growing connection with Josie, I came to love her.

Craig (Journal 15/06/2013)

A junior doctor called me from my desk to visit Craig. After a short briefing I followed her down the unit and into his room. It was a two-bedded room and the curtains were drawn around his bed. Inside were at least six people surrounding the bed. Ward round was in progress. Craig looked very small and overwhelmed. Discussion with the doctors had highlighted the imminence of his death and Craig was not prepared. He had a wife and young children to think about, no will, and much to do. The consultant introduced me and, within seconds, everyone else had melted away leaving a scatter of empty chairs around the bed.

I sat down, unsure of what he hoped for from me. Instinct told me that, after the hiatus of activity that had preceded, the best I could offer was a little space. Using a slow and deliberate pattern of speech I introduced myself, emphasizing that he did not need to talk if he didn't want to, that it was ok just to take breath but that, if he did want to talk about anything, I was there to listen. There was a pause. He looked at me in bewilderment. I wished I could have offered more.

When he spoke, it was clearly and directly, like the businessman he was, addressing his PA. "Actually, I would like to talk," he said, and his story and his needs began to unfold.

By the end of the day his case was heralded as a multi-disciplinary team success: family brought 'up to speed', solicitor contacted and will written. Craig died peacefully the next day while his children unpacked the toy box in the lounge area.

Where was the silence? It was in the transfer of power from the healthcare professionals to himself in that fragile moment when we were left alone together amidst a pile of empty chairs. I could have spoilt it, broken it by taking control, by offering a menu of services. Instead, I met him where he was, in uncertainty and vulnerability. The silence was my acknowledgment that I had nothing to offer. Alternatively, he could have chosen to exert his control in a different way, to send me away, to retire within himself . . .

In this encounter is a glimpse of the *via negativa* of caregiving, a shadow side identified by what care giving is not. The silent caregiver is not someone who brings something to the situation, aside from the bringing of self. The silent caregiver comes open-handed and willing to receive.

Appendix 9. Phase One: Self-inquiry. Qualities of silence

Qualities of silence	Thematic cluster
An absence of speech; when conversation is exhausted; counter-point to sound; small sounds are amplified; hosts non-verbal actions: sitting quietly, holding her hand; mirroring body-language; sitting down; quiet attending; being there; Patient focus; attention; kindness; compassion	Communication in silence
Stillness (8 references); quiet; constancy; holding or grounding; important to hold; patient focus; attention; kindness; compassion; watching; waiting	Stillness – embodied silence
Listening; allowed anguish to be expressed; filled with anticipation; gaps in the conversation; discerned pastoral decision; waiting; being calm; offered space; transfer of power; nothing to offer but self; pause; space between words; long gaps between short phrases; gave emphasis to words; allowed story to be told	Silence as a quality of listening
Helplessness; felt futile; discomfort; awkward; a prison; imprisonment; witness; compassion; shared perception; thinking time; the silence reached in to me	Silence as witness
Shared silence; shared humanity; being together; sharing something in common without words; connection; sitting together; intense; thick; heavy; tangible; amplified the sense of sacred; filled with love; God's presence becomes noticeable	Connection in silence
Comfortable; companionable; companionship; *cf.* long married couple or the intimacy of a car journey; occasional words; comfortable with own silence; open and willing to receive	Silent companionship

Appendix 10. Profiles of co-researchers

Personal profile

Co-researcher	Spirituality	Age	Sex	Personality	Experience/ Understanding of silence	Finds personal silence
Paul	Christian	41	Male	Only child. Contemplative reflective;	Tuning in; before prayer; connection	Outside; In church
Susan	Christian	57	Female	A calm person	Reflective time; quiet; switching off; focusing; Integral to worship; there could be more	Countryside; holiday; beginning of the day
John	Christian background. Favours an Eastern meditative, mindfulness approach	55	Male	Only child; Quite an internal person; used to his own company; enjoys silence.	Connectedness; shared (not administered)	Countryside;

Professional profile

Co-researcher	Job title/ Other role	Previous occupation.	General comments
Paul	Chaplain/ Adult and children's hospice	Parochial ministry	Personal opportunities for silence and stillness have reduced since he has been at the hospice. Paul is aware of the power of his silence and stillness and balances his need to be silent and still with the comfort of the person he is with.
Susan	Chaplain/ Bereavement Officer	Healthcare administration	Susan's calm persona is recognised and valued by nursing staff. The importance of personal silence has grown alongside her work. She uses touch as a way of enabling a period of silence with patients and family members.
John	Chaplain/ leadership role/ Psychotherapeutic counsellor	Parochial ministry	John describes the hospice as "a place where I have grown as a human being" "I am the sort of counsellor who says very little anyway"

Appendix 11. Phase One: Co-researchers experience. Core qualities of silence

Qualities of silence in personal experience and patient encounters

Personal experience of silence	Silence in patient encounters
Of the environment - External silence In church; quiet; lovely and peaceful; in worship. A silent retreat; "quite liberating". Silent places; countryside; no noise; natural sounds; Absence of silence in the world; silence isn't about being noise free.	Important Invaluable; important.
Of the person - An interior disposition Enjoyable; important; valuable; difficult to find; a state of mind; being able to be still; contemplation; reflective; just sit; affords connection in prayer; "a refreshing sense of coolness"; awareness of being alive; exhilarating and frightening; immediacy; intense; allows us to be with ourselves in a way that we're not when we're busy-busy; mindfulness, being in the moment; life-giving; quietness; not enough; switching off from everything that's going on around and focussing.	Therapeutic space Time is a luxury that chaplains have; just being there; just sit; be still; quiet; hold their hand; space and silence before and after prayer; calm presence; silent time for the patient; nothing to say; quality silence.
Temporal Moments of quiet; at the beginning of the day; personal prayer time.	Tool / intervention Being present; aware of being in the space; a moment of internal silence; to encourage "people to find that stillness for themselves"; reflective time for patients; space to calm down; freeing a time of silence, to bring peace and reduce anxiety; time to "take stock"; just sitting; not thinking we have got to fix or ask questions; therapeutic use of silence; space for the person to think, process, say something; use of stillness; engineer a moment of quiet; help other to stay in the silence by holding their hands; hold a quiet moment; hold the silence; I try not to presume the content of the silence.
Spatial Space; a place where that particular kind of connection with God can happen.	Comfortable or uncomfortable Comfortable with silence; thinking through options; prayerful; expectational; waiting; being comfortable in silence is founded on relationship and trust. Awkward; alleviate their discomfort; it can feel uncomfortable if the silence is being done to you; uncomfortable when I'm met with silence; the patient may be "sussing

	you out"; you feel you ought to be doing rather than sitting; colleagues might question 'what's the point of that?'
Transcendent Holy ground; presence; tuning in; powerful; communication/ connection with God.	Connection Allowing something to happen; an intimate sharing; pregnant; something going on; intense; processing; holding; just being in that silent space together; a shared moment of mindfulness; tangible; profound; helpful and therapeutic; a presence of a feeling in the room – love; profound, overwhelming but not frightening . . .the Holy Spirit; after communion; calmness . . . and sometimes tears. You can almost feel the closeness of God.
A medium Silence allows the other things to happen [in prayer]; there's a strength to be gained from waiting in the silence; reflective time.	Rejection [1] Silence as rejection is hard; you have to not run away from it.
	Of the other [2] Stillness of the body [of a dead person]; when the patient is unresponsive; after death; the silence of bereaved families is "produced by shock"; they just couldn't take it in
	Silence in formal services [3] Time of stillness and quiet; important to include a period of silence or a time to reflect

Shaded areas represent qualities that are not central to this research, and reasons:

[1.] Rejection is not a quality of caregiving silence.
[2.] Silence of the other is not a quality of caregiving silence.
[3.] This is outside the terms of this research which focused on inter-personal caregiving encounter and is therefore not discussed in Chapter Five findings

Appendix 12. Sample depiction

HE.CH1 – (Pseudonym: Paul)

"I've always had a leaning to be more contemplative, reflective kind of person." As an only child I'm "quite happy in my own space"; "I like people but I like being on my own too". "Quiet has always been quite important"; it is "different from silence but, I think it's connected."

I grew up in the countryside where the little village church was always open. I liked to go in and just sit; it was "lovely and peaceful".

"Spiritually, as I've evolved, I have really found the value of moments of quiet, stillness" and especially in church. As a student I became aware of the special quality of the time of silence after the prayer of consecration. And, when I celebrate myself, "I instinctively just want to hold that silence". It reminds me of the Old Testament verse: *'The Lord is in his holy temple, let the earth be silent before him'.*

The presence of the reserved sacrament "helps me enter into silence" and "connection with the Lord". "One of the most profound experiences of silence I have ever had was during exposition of the Sacrament while on retreat; it was "just … electric is not the right word … I've never forgotten it."

The paradox is that, whilst chaplaincy offers me "the luxury" of having time with people, compared with the "juggling" of parochial ministry; it does not offer the same opportunity for time in silence before God. I really miss that stillness at the beginning of the day; "Home is busy. I don't have a church that I can go and sit in" and I "don't have the opportunity, now, to go on a retreat".

It's harder to find silence in the hospice chapel; you can hear bells going, and people come and find you and "you feel you ought to be doing rather than sitting". In this "season of my life" I don't have so much time just being still and silent." In fact "my main time of prayers is when I walk my dog in the morning". There is "stillness, in terms of walking and praying and just being, but I'm not still inside because I'm walking, and I walk fast."

"Silence is … initially, a state of mind", it is about "being able to be still and then put yourself in the place where that particular kind of connection with God can happen". Of course, you can be connected with God in activity as well as in silence, but there's a particular quality of

connection in silence.

"My preferred way of praying is to precede [words] with silence", whether those words be intercession or confession or scripture reading, "you precede that with stillness and silence in order to then be able to connect through prayer". Silence "allows the other things to happen". It makes you aware that you are doing something different; entering onto holy ground.

When I think about silence I think about "space" and "presence". It's a presence that's "always there, but just allowing you to really be present to that presence … "tuning in to it", "it's powerful!"

Silence comes into my work in a number of ways. It is "an invaluable part of what we offer". Firstly, "during a conversation, [there is] that therapeutic use of … giving space for the person, whether that's the patient or the family member, to think, to process, to say something that they want to say."

Secondly, silence in those situations where there is nothing to say. "In the midst of just awful circumstances and in the midst of grief before [or after] someone's died, just being there and maybe holding someone's hand or maybe giving someone a hug."

Often "there's a definite request from the family to go and say a prayer when someone has died. Here, there's a quality of stillness and silence that's certainly different"; "there is that stillness from the body" which may have been quite restless before. Again I wouldn't feel the need to "rush in with verbal prayer" but "just to sit next to the person that's died, hold their hand and be still and quiet and … then … to say something. Sometimes it's my need, just to say goodbye, to go to the room and "sit for five minutes … just to be there, [still] with them".

Thirdly in formal services: "I try and make sure that there's time of stillness and quiet" in the "daily quiet time in our chapel", in our weekly chapel service and in the "monthly service of laying on of hands and anointing"; the "use of stillness with each person [is] brief but very precious". I think it's important to encourage "people to find that stillness for themselves" so they have the opportunity for "peace as well as whatever [activity] is happening in the Day Room."

Finally, when I'm "with a patient or a family and praying", I can hold that quiet moment, that moment of silence by just holding a hand and being still. "Space and silence," both before and after a prayer, can be very important. But the silence must feel right for them too. It can "feel uncomfortable if the silence is being done to you."

I think it's something that chaplains "have in our toolbox maybe, that we are ok with just

sitting with someone, not thinking that we have got to fix, or ask lots of questions to get the bottom of why they are distressed" but just to sit [alongside].

People often say that I am a calm presence. "I don't particularly feel that myself". My focus is always on what is right, for the patients, for the family member, I'm with in that moment. Who do they need me to be? Sometimes people spend a "lot of time talking" and then "the talking needs to stop and silence needs to come" and "I can move quite quickly from chit chat to stillness and silence" when that moment arrives.

Being comfortable in silence with someone else is founded on relationship and trust. Silence, with someone you don't know so well, can be awkward; awkward for them or awkward for me. Rejection in the form of silence is "hard" but "you have to let it go" and "actually … not run away from it either". The patient may be "sussing you out"; are you "ok to be with him, or her" in this situation? So, even if it has been awkward and uncomfortable, it is still worth going back, maybe not tomorrow but the next day … "because it could all have changed".

During the working day "I'm aware of … consciously moving from one situation to another, [and taking time] perhaps through breathing, through letting go in some other way" but "not consciously through silence particularly." I do not take time out between each patient visit, usually seeing "little groups of two or three" before taking "a proper break" but "I'm aware of sometimes needing to do a deep breath" … perhaps "I've been with a grieving family, planning the funeral and then … I make myself a cup of tea and I can imagine myself going "wow!" or just a "phwooo," just sort of letting it go."

Appendix 13. Creative synthesis

Silence dwells

    at the core of my being

        often unnoticed

        and undisturbed,

            but indisputably there.

I find my silence

    when I pause

    in a moment of mindfulness

        or prayer.

In a silent place

    my silence stirs within me

        resonating with the heartbeat

            of the universe . . .

              captivating and compelling.

I notice my silence

    in meeting the silence of another.

Sometimes it feels comfortable

    and deeply connected.

At other times it is awkward

    and unsure,

        like the first ice of autumn. . .

            the relationship is still too thin.

        Silence needs a scaffolding

          of relationship and trust

            in order to feel secure.

Silence is an offering of space

          and time.

        In silence, I am completely present

        and nothing more.

Appendix 14. Phase Two data collection: Profile of participants

Pseudonym	Gender	Age	Faith tradition (as defined by participant)	Time in post (years)	Interview duration (minutes)
Jonathan	M	41	Jewish	5	63
James	M	53	Roman Catholic	3	61
Steve	M	51	Congregational	1	46
Chris	M	50	Roman Catholic	1	80
Alison	F	56	Church of England / Buddhist (15 years)	4	47
Clare	F	49	Quaker (originally Roman Catholic)	2	46
Simon	M	54	Roman Catholic	1	61
Tom	M	69	Church of England	2	59
Julia	F	45	Christian (wider spiritual/ Buddhist interests)	1.5	41
Charles	M	52	Spiritual not religious. (Background in Church of Scotland)	13	57
Jill	F	52	Church of England	7	89
Amanda	F	59	Anglican	7	57

Comparison with first national profile of UK hospice chaplains (Thomas, 2014)

	National profile (Thomas, 2014)	This research
Age: 40 – 49	18%	25% (n=3)
Age: 50 – 59	44%	67% (n=8)
Age: 60 +	38%	8% (n=1)
Sex: M	55%	58% (n=7)
Sex: F	45%	42% (n=5)
Faith Group:		
- Church of England/ Anglican	57%	33% (n=4)
- Catholic	5%	25% (n=3)
- Methodist/ Baptist/ Congregationalist	21%	8% (n=1)
- Other	17%	33% (n=4)

Appendix 15. Phase Two data analysis. Wholistic method: Summary of accounts

"What meaningful phrase may capture the fundamental meaning or main significance of the text as a whole?" (van Manen 1990:93)

Ref	Summary of account *(identified thematic aspect is underlined)*	Formulation of meaning
1a	James describes a young woman's despair as she tries to come to terms with the many implications of her terminal illness. At a point in her story she stops. <u>There is a silence, described as "pause", broken by an empathetic expletive, from the caregiver. This "word", or statement of truth, marks a moment of change or "release"</u> from which the patient is able to move on identify and address her main concern.	Out of silence an empathetic truth is articulated which marks a moment of change.
1b	James meets the same patient later in her illness journey. She seems to need to say something. <u>After a long and painful silence, she is able to express her deepest concern "I don't want to die" after which there is a "relief" or "relaxation".</u>	Out of silence a personal truth is articulated which seems to bring some relief.
1c	James describes a gentleman close to death, who seemed to have something he wanted to say. <u>The truth he expressed was not spoken in words but heard and understood, in an articulation of love and a kiss. Afterwards, there was "a greater sense of peace".</u>	In a "silence of intimacy" a truth can be "expressed", "heard" and "understood" without the use of words enabling a "greater sense of peace".
1d	James describes a non-specific scenario where a terminally ill young patient returns to the in-patient unit, visibly distressed, after a Day Therapy session. <u>The clinical choice is whether to administer sedatives or provide a listening presence.</u>	Caregiver silence, which involves "just" sitting and listening, allows the other to tell their story and alleviates distress.
2a	Jonathan described a non-specific scenario where a family are gathered around the bed of a loved one who is dying. Their talking demonstrates "a cultural uncomfortableness" with silence and there may be an expectation of helpful words from the caregiver. <u>He uses silence as a deliberate therapeutic offering, to "de-clutter" the situation and provide a space for attunement and assessment. His silence attempts to "break the cycle" of suffering to allow a space where a new perspective may be possible.</u>	Caregiver silence is an acknowledgement of "speechlessness" in a situation where words are inadequate. Silence creates a space for attunement, assessment and the possibility of a new perspective.
2b	Jonathan describes a young female cancer patient who made a request for "someone to talk to". He began the encounter by allowing a silent interpersonal space, despite being in a noisy external environment. This <u>silence allowed an emotional release and provided "the gateway" to a long and significant conversation.</u>	Caregiver silence allows the other to stop and take space opening "a gateway" to significant conversation.
2c	Jonathan describes the experience of sitting with a	Caregiver silence

	dying patient who is no longer able to speak. <u>Caregiver silence, in this "post verbal phase" is described as "not interrupting" the peace that exists in the room. In silence there is connection in the form of "soul-to-soul dialogue" that doesn't use words.</u>	acknowledges the silence in the room and may lead to wordless soul-to-soul connection.
3a	Steve describes an out of hours visit to a lady who is dying and her daughter. The request was for affirmation and prayer. Later Steve returned when the patient was alone, bringing a holding cross which had been blessed by the local church community. <u>In the silence Steve experienced "a real sense of common union" and a "tangible presence" of "divine mystery and love". No words were necessary.</u>	In shared silence, common union and a tangible sense of the divine are experienced that transcend the need for words.
4a	Chris describes a referral to a female patient, Marjorie, who the staff had suggested might be frightened of dying. Their <u>conversation began with "pockets" of silence as relationship and trust was built,</u> but when the patient came to the matter that was troubling her most, <u>Chris experiences the silence as a "thud", an intensity which marked the importance of the moment.</u> Later, when the conversation resumed <u>there was more silence, enabling the patient to share all her concerns and find a place of acceptance and peace</u> before she died. Chris suggests <u>an additional aspect of caregiving silence which is the holding of the content of their conversation in confidence.</u> After he leaves the bedside, <u>nothing is said to staff or relatives.</u>	"Pockets of [shared] silence" contribute to trust building and relationship. Holding silence with another enables deepest concerns to be articulated and shared leading to a greater acceptance and peace. Respect for confidentiality means that the caregiver continues to hold silence after the encounter is over.
4b	Chris describes a <u>"drama of silence"</u> in a coincidental meeting with Norman, the husband of a dying patient. He visits and says the prayers as requested and the patient dies. <u>The silence occurs after her death as her husband and Chris share the moment in common humanity.</u> The husband's gratitude is marked with a kiss. The healthcare assistant who attended came to a new understanding of the role of the chaplain.	A drama of shared silence holds an experience of profound connection and common humanity, beyond the capacity of words.
5a	Alison describes Peter, a Day Services patient with a neurological condition which means that <u>he cannot speak.</u> He communicates with his hands. On one particular occasion <u>their silent communication went to a deeper, contemplative level</u> when he became focused on a ring on her finger which was a symbol of the Trinity.	Silence provides a medium for communication and connection when words are not possible. "An encounter in silence" is experienced as deeper, "contemplative" and "profound".
5b	Alison describes sitting with Michael at the bedside of his wife as she dies. Michael did not find it easy to stay in his wife's room and gladly accepted her offer of companionship. To begin with he talked, but as his anxiety subsided, <u>Alison's silence enabled him to settle in the silence himself.</u> They remained, without speaking, until his wife died. There was another silence, after Alison had said the commendation.	Silent caregiving presence enables another to stay in a difficult place where there are few words.

	Michael did not move. He was silenced by shock and bewilderment, but <u>with her non-verbal encouragement and silent presence he was able to express his grief.</u>	
5c	Alison describes a non-specific scenario of a family gathered around the bed of a dying patient. The family are keen to talk but <u>Alison feels the need to hold the silent space for the patient</u>. She recognises <u>the balance to be struck between the need to acknowledge the silent patient and to respond to the need of the family to talk.</u>	Holding the silent space of a dying person has to be balanced with the needs of a family to talk.
5d	Alison describes a non-specific scenario of sitting in a comfortable silence in an in-patient room where <u>the patient may either be too unwell to maintain a conversation or after a conversation has been concluded</u>. This is described as a <u>"companionable silence"</u>.	Companionable silence occurs when people are comfortable in each other's company and do not feel the need to talk.
5e	Alison describes a home visit to a patient with Motor Neurone Disease (MND). <u>She cannot speak</u> and communication is via a whiteboard.	Silence or speech are caregiver choices when the other does not have that choice.
6a	Clare describes multiple encounters with John, a patient with MND over an eight month period. John communicated with his eyes and <u>they shared comfortable and intimate silence through holding hands and eye contact.</u> As his illness progressed, Clare met with John's wife and <u>they were able to hold silence together at John's bedside</u> in his last days.	Silence is an effective means of communication which says more than words.
6b	Clare describes, long term in-patient, Mary and her husband David. Mary loved to talk and <u>the silence that came as she lost her language skill was hard for her.</u> Knowing that someone was there became increasingly important. <u>The 'pact' between David and Clare and Mary, to stay with her to the end, was sealed in a moment of silent holding hands at her bedside.</u>	When verbal language loses relevance, silence marks a commitment of non-abandonment.
6c	Clare describes Mike, a Day Therapy patient, who became taken with the labyrinth. When he spoke about becoming stuck, <u>Clare was silenced as she recognised, intuitively and with a shock, that he was close to death</u>. The <u>care-giving silence occurred after she and Mike and his wife Sally prayed together and Clare experienced a strong desire not to leave the moment</u>. Mike's heart failed shortly after and he was admitted to Intensive Care in the local hospital. Clare continued to visit and spend time in silence with Mike and his family before treatment was withdrawn and he died.	The silence of a caregiver may communicate their emotions to the other. (but this silence is not caregiving)

Shared silence after a time of prayer can create a feeling of wanting to stay in the moment. |
| 7a | Simon describes, in parallel, two similar encounters with husbands who have received bad news about their wives. <u>He is surprised at how little he needs to say</u> in the early part of their meeting as they come to | Use of silence is a powerful supportive tool offering time, space and permission to the other. |

	terms with their shock and grief. Later, as they begin to make sense of their situation, <u>caregiver silence continues to be an important dimension to the conversation by allowing reflective space between topics.</u>	
7b	Simon describes accompanying one of the husbands in account (7a) at the time of the death of his wife. <u>After saying the prayers there are no more words to say and the two, later joined by a nurse, wait in silence.</u>	In shared silence the caregiver is a reassuring presence where words would be an intrusion.
7c	Simon describes supporting the same gentleman (7a & 7b) in his bereavement journey. <u>Silence features in their meetings as an invitation to move the conversation to a deeper level.</u> The <u>hospice as a place of "sanctuary" where it is possible to be silent with self</u> is also discussed.	Caregiver silence offers a cue for conversation to move to a deeper level Hospices offer a place of silence and sanctuary. (Outside spiritual caregiving relationship)
8a	Tom describes a female patient disfigured by facial cancer who made a point of covering her face when visitors entered the room. After a series of trust building visits, she began to be less vigilant. On one occasion, as she reached for her mask, Tom said "you don't need to do that". <u>Silence is characterised as the acceptance she read into these words</u> and the relief which followed. Later in her illness Tom sat with her as she, apparently, slept but when he went to leave the room she was upset because she was afraid to die alone. Tom reflected that <u>"silence actually goes on in sleep time too"</u>.	Meaning can be "read into" that which is said and that which is unsaid. To sit in silence while another sleeps is still companionship.
8b	Tom describes visiting a male patient who would not want a 'religious' visit. <u>Tom's silence is the silence of not talking about religion but simply bringing himself to the encounter.</u> He describes this as <u>"unspokenness"</u>. Finally, the patient surprises him by asking for prayers before his death.	Being with another is more important than what is spoken about
8c	Tom describes a young male patient who had <u>lost his ability to speak as his illness progressed</u>. Over two days, Tom had visited and <u>just stood quietly</u>, or held hands, by the bedside. On this occasion <u>he pulled Tom close and kissed him. The gesture was "packed with emotion".</u> And then he died.	Feelings and emotions that cannot be expressed in words can be communicated non-verbally in silence.
9a	Julia describes her support for Maria, the wife of a terminally ill patient. <u>Because English was not the wife's native language, Julia gave her plenty of time to express herself</u>, but <u>Julia's silence also gave her space for herself and to share her own emotion.</u>	Accompanied silence is a powerful medium for self-expression and release without the use of words.
9b	Julia describes her <u>own experience of illness</u> and her appreciation of <u>a companion who can mix silence with both light and serious conversation</u> in "a little dance".	Silence with companionship is important in hospice care.
10	Charles describes a series of meetings with Bill, a Day	"Silence is about space and

	Services patient, who had been told that that there was no more active treatment. Charles reflects upon <u>the silences that the patient brings in the context of the lived silences in their meetings.</u> He is very conscious of not imposing his own interpretation or meaning.	relationship, giving people space to be themselves".
11a	Jill describes meetings with a Day Services patient, Nigel, who she accompanied for two years. As a person for whom personal space was important, <u>time out in the company of a silent caregiver enabled him to cope</u> with the "intrusion" of his illness and treatment. <u>As he lost the power of speech, he was able to express emotion without words, and in the sharing there was release.</u>	Shared silence offers space for processing and emotional release.
11b	Jill describes meeting with the adult son of a patient who could not tell him that he loved him. Jill is asked to articulate these words. In the emotional outpouring which followed, <u>Jill remained a silent presence until a place of healing and peace was reached.</u>	Silent caregiver presence provides a safe space where emotion can be expressed and released, leading to healing and peace.
12a	Amanda describes Carol, an inpatient she was asked to visit because the patient was in denial about her illness. After inviting her to tell her story and careful listening, Amanda asked a leading question. <u>The silence which ensued seemed comfortable at first, but went on so long that Amanda began to worry about the effect of her question on the patient. She took the "risk" to remain with the silence and the patient was able to articulate the truth that she was going to die.</u> After this she was able to talk with her family, make plans and died peacefully a few days later.	Silence provides a processing space, for engagement with truth which is healing.
12b	Amanda describes Janice, an inpatient who accepted her visit but felt too unwell to talk. There was <u>communication in silence and occasional words</u> but it <u>was when Amanda made to leave</u> that a chance remark caused the patient to rouse and express her main concern.	Sharing the silent place of the patient offers them opportunities for engagement if and when they choose
12c	Amanda describes a series of visits to an inpatient, June, who <u>didn't want to talk.</u> Amanda would introduce herself and <u>then just sit with her</u>. When she was discharged, the patient thanked Amanda profusely for all that she'd done.	Shared comfortable silence communicates acceptance.

Appendix 16. Phase Two data analysis. Selective approach: Example of progress from transcript to emerging theme

Participant HPCH5 (Alison)

1. Excerpt from original transcript showing significant statement underlined

It was like he was communicating something about that through the ring or through the whole, through the exploration of this ring with me, in a way that, of course, he can't speak. He can't . . . say anything. You know, in some way, it felt to me like he was saying, 'this is important'. #00:07:01-8#

I: Do you think he was communicating his faith? #00:07:03-6#

P: Yeah, because it was much more than, 'Oh yeah, it's the three-in-one ring' and then he moved on, you know. He was really with it, he was really holding it and feeling the three. Ya, I felt he was really, um, in the silence he was just . . . connecting, perhaps, with the Trinity, for himself. Whatever that meant or means for him. #00:07:26-9#

It was really profound. It felt very, um . . . yeah it felt very profound. And then we just, then we just. 'Cos I was like really . . . . 'wow'. You know, I was really, kind of, taken up with the experience and realised, sort of had a sense anyway, of what was happening. So then I, kind of, just left him to do whatever he was doing, I suppose. #00:07:52-9#

So there was a lot of communicating in the silence. And then he'd carry on holding my hands in his lovely hands. He has the most amazing hands (laughs). #00:08:05-0#

2. Extraction sheet showing my emphasis (underlined) and formulation of meaning

Time code	Ref	Text	Formulated meaning
#00:06:08-6#	5.3 (5a)	It was like he was communicating something about that [his faith] through the ring or through the whole, through the exploration of this ring with me, in a way that, of course, he can't speak. He can't . . . say anything. You know, in some way, it felt to me like he was saying, 'this is important'.	5.3.1 Communication can take place without words 5.3.2 Wordless communication can be heard and interpreted
#00:07:03-6#	5.4 (5a)	I felt he was really, um, in the silence he was just . . . connecting, perhaps, with the Trinity, for himself. Whatever that meant or means for him. It was really profound. It felt very, um . . . yeah it felt very profound. So there was a lot of communicating in the silence.	5.4.1 In silence it is possible to connect with something beyond space/time reality 5.4.2 Connection in silence may evoke feelings in the caregiver 5.4.3 Silence is a space where communication takes place

3. Attribution of formulated meaning statements to thematic meaning clusters

Sample from spreadsheet with formulated meaning statements from above <u>underlined</u>

Thematic meaning clusters	Formulated meaning statements (HPCH5)
3. Silence as space	<u>5.4.3 Silence is a space where communication takes place</u> 5.14.2 Holding silence for another enables them to "settle" in silence themselves 5.17.2 Holding a silent space with a patient must be balanced with the needs of the family to talk
6. Silence as waiting	5.19 Waiting in silence is a giving of self and time and control. It contributes to trust building and relationship. 5.20 Caregiver waiting can be "pregnant", a time for internal dialogue
9. The relationship of silence and dialogue/ conversation	5.2 Silence in the caregiving relationship may be punctuated by occasional words 5.9 When anxious chatter subsides it is possible to 'just be' in the company of another
10. The role of silence in companionship	5.14.1 The companionship of another may enable someone to stay in a difficult, silent place 5.18 Companionable silence involves being comfortable in the presence of another. It may take the place of or follow verbal conversation
13. Silence as communication	<u>5.3.1 Silence can take place without words</u> <u>5.4.3 Silence is a space where communication takes place</u>
14. Types of silence	5.11 The silence of "watching the breath" of a dying person is a contemplative silence similar to that practiced in mindfulness meditation 5.12 Qualities of contemplative silence are being attentive, attuning and noticing 5.15 There are different types of silence characterised by no words or verbal communication but there may still be "lots happening"
20. Silence in caregiver's professional practice	<u>5.4.2 Connection in silence may evoke feelings in the caregiver</u> 5.5.1 It is easy to fill silence. In spiritual care giving it is important to discern when not to fill silence. 5.5.3 Caregivers participate in silent space and may be affected.
21. Silence in the other's personal spirituality/ experience/ condition	5.6 When patients cannot speak, silence is an inevitable part of the encounter 5.17.1 Caregiver silence is an attentive response to a silent patient.
22. Connection/ relationship/ empathy	<u>5.4.1 In silence it is possible to connect with</u>

	something beyond space/time reality
	5.4.2 Connection in silence may evoke feelings in the caregiver
27. Silence as listening/ learning/ hearing/ attention	5.3.2 Wordless communication can be heard and interpreted

Appendix 17. Example of verbatim quotes from the data which support emerging themes

1. Silence is a way of being with another person

Charles: "Silence is about space and relationship, giving people space to be themselves. And if there's a power of silence, it's how the silence allows relationships to be built between healthcare professionals and patients or clients and their family members."

Steve: "I think part of the privilege of spiritual care is that we don't require anything of the other person. And, if they require nothing of us, then silence is the shared experience. You're still alongside that person and it's a matter of care through presence."

Jonathan: "It's not doing silence, it's being silence, being with silence."

Clare: "He was able to receive gaze … So we were able to sit and look into each other's eyes and hold hands in a way that you often only do with lovers. Be we did that in absolute silence and respectfulness. And it was as if John … understood that I could manage the emotion of his illness. That's what if felt like to me. He understood that I could see his suffering."

Amanda: "We did engage in conversation, but it wasn't in words. There was a lot of communication going on in her body language. In the silence that we had, actually the amount of words were very few but there was an enormous amount of communication going on from her to me. From me to her as well."

Jill: "We are only people by the way we are persons alongside each other."

Charles: "I see my task as a chaplain to show that validation, that worth, that love for people … That's what I would do in that silence, it's like from Biblical terms, "you are beloved". Because sometimes people don't feel beloved, people feel abandoned … And the central thing for me is being a guest and a host in the relationship."

Simon: "And I think if you are a Christian … there would be a theological argument that, in silence perhaps, you bring the presence of God or Christ as well."

Amanda: "I think, as chaplains, what we have to offer is to open up that space, that silence, for the deepest part of ourselves for God's presence."

2. Silence as the primary mode of encounter

Clare: "I think, for me, it [silence] says a lot more than words. I find it an effective means of communication. And I'm very comfortable with it. And it feels as if I can get, learn, understand … absorb, experience, feel a lot more through silence than, often, I can through words."

James: "The silence was built on trust and in moments. He never said that word. And I never asked him, "what exactly are you trying to tell me?" [described as "an interpretive kind of silence"]

Clare: [Of Mary and her husband whom Clare described as "such a verbal couple … a couple who couldn't do silence".] "Language and words had gone. And this was a slightly different place for Mary, which now had big lumps of silence in it."

Alison: "I do sit and hold hands with a lot of patients but there was something that happened with him … which felt a lot more contemplative … and encounter in silence is probably how I'd put it."

Chris: "So in the silence, there was silence and there was noise, because, you know, there were other things going on that I was aware of. There were people in other bays and it was on the corridor." [*contrast with his first scenario where he says:* "I wasn't aware of conversations in the corridor or something going on outside. It was an intense moment of concentration.]"

Chris: "It was a communication that happened without something being described or defined. I think only silence could carry that."

Alison: "It's almost as if you don't have to say very much."

Jonathan: "I will say, "I don't know how you feel, I have no permission to give words right now, all I can give you is silence."

Jonathan: "Yes, and the feedback so far has been, "thanks for that, thanks for not saying anything". You deliberately say, "there's no words for this. We don't need words right now."

Jonathan: "Even when I am sitting with a person's body … Even then I want to give silence to the moment … because I don't know any religious words or other words that I would use [that] are capturing the momentous quality of what has just happened. That's where I think words are just too small. And the universe is silence, that's my way of thinking. There are no sounds in space."

3. Silence enables another to stay in a difficult space

Alison: "I think Michael did want to do it [stay with his dying wife] and he was glad that he had, but he would have found it incredibly difficult just to sit there on his own."

Clare: "And it was a sort of pact or agreement [sealed in a moment of silence] that we'd stay with her through to the end. Which we did. It was hard for David. Very hard. But we did."

Simon: "I think to share someone's last moments in silence, in peace … and it was the death she wanted with her husband by her side. He said it gave him comfort. It wasn't duty, but that sense of carrying out his wife's wishes right to the end, and being attentive, that was the word; he'd done the right thing. He'd fulfilled his promise to her."