Medicine of the Person.
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Dr. Madeleine Ruedi-Bettex.
Non-Verbal Communication in the Caring Relationship.

Non-Verbal Communication In Difficult Situations.

I am concerned with the place of non-verbal communication in situations in which bad news such as a diagnosis of serious illness makes its presence felt in the life of a person or perhaps in the unlocking of a secret. In doing so, I shall draw attention, in the first instance, to an experience I had with groups of doctors in training about how to disclose to the patients the results of tests for the AIDS virus and also a case of sexual abuse in an institution for handicapped children. As a second stage, I intend to recall the writings of Dr. Paul Tournier to illustrate the awareness in his experience of non verbal communication.

I would like to begin this lecture by speaking of a case that I got to know of from George Kohlrieser. He is an American psychologist whose primary concern is mourning, self-esteem and violence. The case is about a little grandmother, as he calls her, who wakes up one night to find a man standing beside her bed. He is holding a baton. “Oh, you must be cold” she says to him, “it is very cold.” He hesitates. “Listen, I am going to prepare some soup for you”, she says. She gets out of bed, puts her arm around him and leads him into the kitchen as though he were her son. She eats with him. “I am going to make a bed for you”, she says. “It is snowing outside.” The next morning the police arrive. The man is a psychopath. Before arriving at her house, he has brutally killed a family of four people with his baton. He was unable to kill her because she had made a link with him.

Very few words were spoken in this story; what mattered was played out on a different level. The idea of music with its different ranges of sound, for example, or the scope of organ music seem to me relevant to illustrate the resources of communication that do not involve words. We have a saying in French: Music makes the song! A glance, a jest, a silence, that conveys meaning other than by words, form the basis of a relationship. A wonderful richness is available if we are able to take account of it. Harmony between music and words makes possible a closer relationship between one person and another. Coherence between the non verbal and the verbal reinforces the impact of what is said, whereas if there is discordance between the two kinds of message, it is always the non verbal that carries weight.

Our whole behaviour is a potential means of communication and acts as a signal or a message that may, or may not, be perceived by the person whom we are facing. The working out of these messages, and their reception, are often unconscious. Their significance fits into a quite different context. I recall a meeting, during a working group, where two men were in competition to head the group. In the interval, both went out into the corridor and simultaneously lit a cigarette. The

relaxed atmosphere was a forecast that one was about to be present at a confrontation of leaders.

As a convenient summary, I would like to suggest a scheme of behaviour following the method of Albert E. Scheflen, drawn up by J.-M. Noyer.

I. Style of voice.
   a. Linguistic "yes . . .
   b. Paralinguistic hm. . . ." silence.

II. Physiological behaviour.
   a. Bodily movements including facial expression.
   b. Items that spring from the neurovegetative system (colouration of the skin, dilation of the pupil, visceral activity etc.).
   c. Posture.
   d. Bodily noises.

III. Tactile behaviour.

IV. Mapping out one's territory.

V. Other types of behaviour that convey information, for example the emission of smells.

VI. Styles of dress, the use of cosmetics or the wearing of ornaments, etc.

VII. Behaviour following consultation with a medium.

VIII. Non rational behaviour belonging to the Middle East.

Styles of behaviour, apparent from an external point of view, appear through our five senses as belonging to a different origin or as indications of handicap according to the individual situation. One colleague of mine had a sense of smell that told him if a woman were pregnant as soon as she crossed the threshold of his surgery. Deaf or blind people develop sensorial compensations from their handicap.

We might add to our five senses other channels of perception such as intuition, revelation or modified states of consciousness that put us in touch with realities that escape rational analysis.

Personal perceptions are modified by socio-cultural and psychological filters validated or invalidated through personal history. "That MAY BE or that May NOT BE!" The way I see the world is personal, unique. Communication requires me to enter into the world of another person and to invite him to enter into mine. A

relationship between two people implies reciprocity and will invariably change the way I look at the world and change me.

My professional career, over several years in Switzerland, has brought me into contact with adult neurological hospital patients followed by paediatric neurological cases in the U.S.A. At this time, I used to love to see my chief make contact with small children in their beds by putting his smiling face on their stomachs to enable them to take hold of his hair with a huge smile. What a marvellous way of introducing himself and making a relationship with these young patients.

I interrupted my medical career for 13 years in order to give priority to my family. I gave up clinical medicine at the end of this period and decided to make use of my previous experience to devote myself principally to areas in which, it seemed to me, communication is difficult, namely sexuality, death and mourning and the place where the two meet in infection with HIV and Aids. Contact with the Medicine of the Person and with Paul Tournier greatly confirmed me in this choice. Thanks to additional training, I was able to play a pedagogical part in the promotion of health and sexual education of young people, their parents and their teachers. In the middle of the 1980s, at the time of the emergence of AIDS in Switzerland, I was asked with a colleague, who trained adults, to structure and to put into practice a training programme for the prevention of the AIDS virus and of the people responsible for this. In this body, required by the Swiss health authorities, we worked until the year, 2,000, with multidisciplinary groups in which the members came from 11 different professions and brought a mutual enrichment to their complementary skills.

The Swiss Medical Federation wanted, for its part, a training confined only to doctors. The purpose of these residential seminaries, lasting 48 hours, was to define the relationship between doctors and their patients, notably in the prevention of infection from AIDS and following the announcement of a positive result of a test for antibodies for AIDS. This work was done in the form of conversations between two people sitting on chairs opposite one another, one taking the part of the patient and the other the part of the doctor. The idea is to clarify the situation that takes place when the patient has a conversation before the taking of a sample of blood which he has agreed will be tested for antibodies against the Aids virus. He comes back a week later to hear the result of the test that the doctor has. The conversation was limited to a maximum of 20 minutes. After the people, who took part in the conversation, and the group observing them, have expressed their feelings, photographic film made possible a more precise analysis of the stages of the discussion.

Certain people exclaimed, “The situation is artificial!” It was, however, a gripping experience for those who took part in the scene to the extent that awareness of time and the presence of observers were completely effaced, the doctor playing an official role, his natural part, with the other pole of the conversation taken by a

colleague-patient. Both lived through authentic emotions that they described after abandoning the role play.

The following observations are necessary. They have a clear bearing on the verbal aspects. I intend to cite as little as possible of these in favour of the non verbal communication.

To welcome the patient is fundamental. One should walk in front in order to open the door for him. This is far better than waiting before him behind a desk, eyes lowered or arms crossed. There should be no false joviality, the expression should be neutral, the glance encouraging. Once the patient is seated, the preamble should be as brief as possible and the giving of the result direct. Any attempt to dress up, or to defer, the result causes tension to increase. It represents, for the patient, an unacceptable power, on the part of the doctor, to withhold something that matters to him and in which he does not share. At this stage of the interview, the bearing of the patient reveals anxiety, his feeling of powerlessness. Clothes may be brusquely removed or thrown down, a bag, placed on the knees, diminishes access to the body, and the body held like a spring indicates a sense of panic. Anger sometimes follows if the result is withheld. For example, a man, unable to contain his irritation seized the doctor by his tie, saying, “You give to me this result?”

The most acceptable way for the patient to receive information is by adopting a neutral stance with no ill will. Straight after the first exchange, the doctor can ask about the emotions that have been aroused. “What does it mean to you to receive this information?” This question can open an exchange that will allow the expression of words reflecting the shock that has just been received as a blow, the ground that has been removed, and the end of the world.

Immobilization, sideration, a face of marble, are often the only visible reaction. Other signs may be noticed if the doctor is sufficiently calm to allow time for the unfolding of the scenario taking place before him.

- the absent glance turned aside
- a change in the colour of the skin
- a sensation of heat or of cold
- a cold sweat
- the odour of sweat that signals fear
- a shake of the head as a sign of denial
- refusal of access to the body, shrivelling
- muscle tone, maintained or flabby
- tears, visible or repressed
- clearing the throat or other bodily sounds
- loss of a word, hesitation, silence

These signs indicate intense emotions, sometimes so intense that the person witnessing them is not fully aware of their significance. For example, a “patient” ,totally impassable, said after a knock out blow, that he would not have been able to wring out his shirt drenched in sweat.

One may think at a moment like this that the emotions are indicators of the needs of the person. The doctor has, in such a situation, the opportunity to use his insight to bring the patient back to reality, to accompany him down the road along which he must walk where everything is not lost. To accompany is not to go ahead, not to rush him, but to remain, step by step, at his side.

Support is provided in a helpful manner by an open bodily composure, kind, the glance forward, an indication that silence is acceptable. The idea is to be totally present and accepting, fostering a relationship of equality with an easy passage between the non verbal and the spoken word.

Careful observation of the patient makes it possible to reflect a sign, to verbalize it. “I notice that you are feeling angry, knocked down, or seized by intense cold . . .” and, finally, “Am I mistaken about this?” Another method is a mime in a mirror without offering an interpretation. “What do you make of this gesture?” An opportunity is available for the other person to put what he sees into words. This puts the doctor in a position to grasp the needs of his patient, to provide reference points in the disarray of the moment, to make sure that he has been understood, or understands correctly, to supply objective information, to offer another appointment in the near future to talk further. It is important to inquire who may share this news, who can provide support and what the patient will do after leaving the consultation.

For these doctors to play the part of a patient was an enlightening and outstanding experience

To the extent to which they felt themselves understood and supported, they acquired a more nuanced vision of the reciprocity of the relationship. The comments of their patient-colleagues, following the analysis of the conversation, revealed the reactions set in motion by the attitude of the doctor. The time of waiting for the result from taking the blood sample, then the period in the waiting room and finally in the consulting room, causes anxiety to rise to a crescendo. The offer of a glass of water before announcing the result is an omen for catastrophe. The disquiet of the doctor in the face of his delicate task further destabilises the patient who gains the impression that it he who must reassure the doctor. Coldness can be felt as indifference, excess of compassion coveys the impression of being treated as a child. If the doctor allows himself to be bound by a statistical appreciation about the patient’s future; the future appears as a sombre and ineluctable prediction. Worse than all for the patient is the feeling of having become an object, rather than a subject, in the doctor’s view as he tries put a face on the problem.

I have received completely credible testimonies from patients suffering from cancer. They have been able to share, in encounter groups, the shock experienced when the result of the biopsy was made known. Sometimes the attitude of the doctor is such an announcement by telephone seemed to them preferable in cases where the ability to convey a non verbal message is inadequate. Anger arises when won is treated like an object. The patient feels highly devalued. A highly competent doctor who parades his superiority and who conveys the impression that the patient is unable to understand what is happening to him, and so does not explain the proposed treatment loses his credibility by the attempt to be understood. The same happens if the attempt to make contact almost amounts to incivility.

From the experience of training, undergone by the doctors, one comes away with the conviction that non verbal communication is a source rich in information for the doctor and a tool to aid his understanding of a case. How may he handle what he has observed from the patient? Should he consign it to his file without a word? Should he be tempted to decode what his encounter reveals without knowing how to and, therefore, acquire power over the patient?

If one is serious that the non verbal part is the more important in what transpires and that a word is necessary to clarify the situation, it follows that there is a moral responsibility to try hard to make the link between a non verbal and a verbal message. The patient should be encouraged to put into words an emotional experience, to bring the meaning of the event into the present moment. He needs to understand the way in which it resonates with his personal story.

A person receiving news or confirmation of a life threatening diagnosis faces a situation comparable to mourning, the shock unbalances him, one might say pulls him apart and carries the same emotions that are seen following the loss of a loved one. The time of mourning for his previous health passes through the emotions of incredulity, fear, revolt, anger, guilt, sadness and despair. The doctor, present at the beginning of this process, can play the privileged part of a witness. A true relationship can be established if he is capable of welcoming all these messages with neither judgement nor excessive compassion. The relationship can encourage their explicit formulation.

The role of witness seems to me to be a vital point of a therapeutic relationship that links the non verbal and the verbal. The witness has the opportunity to offer his presence and humanity to the other person who is passing through a unique experience as sharp as a sword. He can assure him that he is alive and has strength in reserve. The therapist can, by his empathetic attitude, re-establish a relationship of equality with his patient suffering from diminished identity. He can restore his status as a person able to take up his responsibilities.

In a quite different context, I had the opportunity to take part in a situation where access before a word was spoken was a condition that allowed the expression of emotions. It concerns the revelation of a secret.

This happened in an institute for handicapped children. With a male colleague, we went every year to meet the children in the sexual education group. A group of children, whom we knew, were driven every day by the same driver. This man used to take detours to take advantage of the situation. For several months the children submitted to sexual abuse on these journeys. A rule of silence was imposed upon them. One of these children let drop a few words that aroused the suspicion of his mother and she informed the people in charge. A difficult enquiry, at the centre of the institution, followed. The children had great trouble in speaking about the facts when they were revealed. They said, “You must ask Madeleine and Daniel to come”. We met them in the usual group, seated in a circle. We asked them what they would like to say to us. Little by little their tongues were released. We then invited them to tell us how they were feeling. We had placed, in the centre of the circle, cards representing the four basic emotions, joy, fear, anger and sadness. They were free to choose the card that seemed appropriate at the moment and to say whatever they wished about it. What a heap of anger, sadness and fear emerged. We wondered how to manage these emotions and so we called for a break. What a comfort! They did exactly what we could have wished. They were moved to the recreation corner of the room and began to express their anger by punching the cushions with their fists. Then they came back into the circle and said that they were feeling better. They, and their families, were surrounded with care by the members of the staff of the institution whom we also had upheld. None of these children, in late adolescence, showed any consequences of this traumatic episode.

The reason for our interest in non verbal communication is surely the resources it brings to life in us to provide support beyond the use of purely medical knowledge. What did Doctor Paul Tournier, the founder of the Medicine of the Person, say about it when he was confronted with difficult experiences faced by his patients? He did not use the term, non verbal communication, explicitly. The term came to be more widely in use following research into communication that began in the United States during the years 1950-60. From the examples that he cited from his practice and in his writings, it is clear that this area of communication attracted his attention in particular in the difficult situations through which he accompanied his patients. John Clark indicated for me the references that belong to this area and I thank him for this. I am going to recall here some of Paul Tournier’s reflections that link with our theme and also cite some passages from his books.

Paul Tournier was attentive to every dimension of the person of his patients and enquirers. He listened, not only to the words expressed but also to attitudes, emotions and questioning about the spiritual dimension. His was a listening of 360 degrees.

Here are some examples that he offers to us.

“In order really to understand, we need to listen, not to reply. We need to listen long and attentively. In order to help anybody to open his heart, we have to give him time, asking only a few questions, as carefully as possible, in order to help him better explain his experience. Above all we must not give the impression that we know better than he does what he must do. Otherwise we force him to withdraw. Too much criticism will also achieve the same result, so fragile are his inner sensitivities.” (*Marriage Difficulties*, p.25).

“One has to be alert to the many little signs that betray the inner struggle in a person who would like to open his heart, and cannot bring himself to do so.” (*The Person Reborn*, p.220).

And again, concerning understanding and a reciprocal attitude:-
“When I question the person who has just told me something he has never dared to admit to anyone else, he replies: ‘I was afraid of being misunderstood.’ That is it: he has felt he was understood. The feeling that he is understood is what helps him to live, to face any problem, however difficult, without being false to himself. It is a moment of truth, of confidence, of deep emotion, for him – but also for me! I have not understood only with my head, but with my heart. I too will never be the same again. The mysterious resonance we have experienced is personal contact, which commits each of us to the other.” (*A Listening Ear*, p.10).

Understanding the person whom one is helping:-
“The ideal support, then, is a presence, a vigilant, unshakable, indefectible presence, but one that is discreet, gentle, silent, and respectful. We want help in our struggle, but do not want our personal responsibility to be taken from us. A look, a smile, an intense emotion – these are the things that can help us to win our victories over ourselves.” (*A Place for You*, p.192).

At one of the last sessions of the Medicine of the Person, at which he was present, Dr. Tournier referred enthusiastically to the FLASH described by Michael Balint
“Suddenly there is a flash, that is to say, a genuine encounter between doctor and patient. Now what can the flash be but something not rational, not scientific? An impression, a feeling which for my part I should call communion. There is indeed from time to time, sometimes without a word being said, a feeling of meeting – the flash!” (*A Listening Ear*, p.34)

For Paul Tournier scientific competence and a warm heart go together.
“Do not misunderstand me! I am not advocating the rejection of science. The greatest scientists are the ones who understand that science has its limitations. They know that two things go to the making of a doctor – great scientific competence and a great heart. And scientific training cannot produce the great heart! The ability to relate, to enter into contact with one’s patient, to be open with

him, to become his friend – all this has nothing to do with science, and must come from a different source." (*A Listening Ear*, p.80).

"My ambition was to be a humane doctor. I wanted to be liked. My manner towards people was pleasant, even paternalistic. That did not take me very far. If we are to go further than that we need to be freed from ourselves. I did not realise that I was myself the resistance blocking the current." (*A Listening Ear*, p.35).

"We are touching here on the problem of the meaning of disease. The medical diagnosis is an objective, scientific matter. But when we come to the realm of meaning, that is for the patient himself to discover. The more our patients are concerned with the meaning of their sickness, the more important it is that they are able to express themselves. And to be ready not to get an answer. It is not I who can tell a patient what is the meaning of his illness. All I can talk about is my own search for a meaning for myself.

"In order to tackle a question as difficult as that of meaning, it is important to realize that often the answer comes only afterwards. . . Since it is true that the meaning of an illness is often apparent only later, it follows that an act of faith must be made at the start: we have to keep faith that there is a meaning." (*A Listening Ear*, pp 36-37).

The thought of confidence takes us to the heart of Paul Tournier's spiritual experience. Silent meditation was, for him, a matter of primary importance. It meant spending time listening to God every day.

He invoked his personal faith when he spoke about the sensitivity of his patients to any absence of harmony between his words and the conviction behind them.

"They know quite well whether our exhortations to confidence are only words or proceed from personal conviction, whether we are inviting them to have confidence in themselves without *our* having any real confidence that they will succeed

The real problem is not between my patient and me, but between me and myself, deep in my own heart. The faith that is needed is not that which I might exhort my patient to have, but my own. It is my own personal experience of God's power that gives me the certainty that he can transform my patient's life" (*The Adventure of Living,* p.215).

"So there are two kinds of confidence: natural confidence – the sort we place in a person because of the good qualities we know he possesses; and supernatural confidence – the sort we place in a person because of what God can do in him" (*The Adventure of Living*, p.215).

Paul Tournier allows us to know himself , not only as a witness in this vital moment of his patient's life when he is able to reveal himself at a more profound level, but also as a witness of what is taking place in his own life through his relationship with God. His attitude to the person whom he is meeting is full of respect. He does not intend to make a conquest of him.

"The more I am persuaded of the importance of seeking God's will for oneself, the more sceptical I become about the possibility of saying what is his will for others. That is the source of all kinds of intolerance and abuse. People who claim to know what is God's will try to impose it upon others with the arrogance which comes from the conviction that they are the repositories of divine truth. I avoid that at all

costs. I can never know what is God's will for someone else" (*A Listening Ear*, pp.15-16),

One might wish to enquire whether the availability necessary to practise the kind of medicine that takes account of all the signs, that come from the patient, is compatible with the constraints known to doctors. For Paul Tournier, "It is useful to ask ourselves if we are making good use of the little time we have, or if we are allowing ourselves to be tossed about like a cork in the torrent of modern life" (*A Listening Ear*, p.96).

Here I am at the end of this journey in the work of Paul Tournier. The scarlet thread that underlies the different experiences that I have cited, the story of the small grandmother, the training of doctors, the revelation of a secret, the path of Paul Tournier, the thread passes through the experience of love, whatever the spiritual source that sustains it. The heart alone enables one to see clearly.

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Page references to quotations are included in the text.