# <u>What didn't you say?</u>

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The BBC 6 o'clock News shows a debate in Parliament the day after the Budget, in which it was revealed that Government borrowing is the highest it has been for more than 50 years. The Chancellor of the Exchequer, finance minister in Britain, is speaking. Either side of him sits the Prime Minister and the second finance minister. They have grim expressions and both have their arms folded in front of them. What does their posture tell you about what is going on inside their heads?

Your patient Mrs. Jenkins is about to leave the consulting room. She does not see you very often. Her symptoms of recurrent headache and anxiety do not suggest serious illness. She gets up from her chair, walks to the door and, with her hand on the door handle, pauses. Another doctor would not notice and that would have been the end of the consultation. You, the good doctor, ask her if there is a further problem. Tearfully, she tells you that about her age, in her late 40s, her mother developed a brain tumour and died within 6 months.

**It is very important that we listen to our patients. But we do not only listen.** Some of our patients cannot express themselves in language, for example, those with Learning Disability or preverbal children. They are truly human and they can feel and experience the love of God but they do not have words. All of us express ourselves non-verbally as well as in speech.

Our religious and spiritual expression is also in part non-verbal. We were at a very jolly 70$^{th}$ birthday party - we seem to have been at a number of 70$^{th}$ birthdays recently – I wonder why. Walking into the meal I was pounced on to say Grace.

Afterwards, an ebullient Jewish dentist asked me, "Why do Christians look at their feet when they pray, we Jews look up to heaven". I did not have an answer for him.

Ruth and I are both contributing to this session. We will not speak at the same time because, although two mime artists may perform together and so increase the potency of the play, two speakers using different words together just produce cacophony! First, I will speak a little about non-verbal communication and observing signs in psychiatry. Then Ruth will provide the jam in the sandwich and take as examples two non-verbal processes in childhood. We will finish by illuminating our talk in the light of the Bible.

**Non-verbal communication of our patients**

What every patient is expressing without words should be picked up by careful and methodical observation. From his posture, gesture, facial expression and behaviour he betrays his state of emotion, information about his personality and his attitude to the observer and to others, despite his silence or even contradictory verbal communication. Non-verbal aspects of communication are important in sending and receiving information about the personality. The role in society one has adopted and the group with which one identifies are intentionally conveyed, and therefore self-image is displayed. These include, according to Argyle, 'age, sex, race, social class, rank, occupation, school or college attended, nationality, regional origins, religious group and family connections'[i]. These attributes of the person are often deliberately displayed, but there are other characteristics which will be received non-verbally by observers even when the person has no intention of revealing them; for example, temperament, personality traits such as introversion, intellect, beliefs and values, past experiences.

Non-verbal communication is successful in expressing attitudes for the following reasons:

**1** For some topics there is a lack of language. For example, *shape* is more readily expressed with the hands than verbally. Describing *personality*, our own or another's or commenting on personal *relationships*, is often more easily done non-verbally. A person will attempt to communicate non-verbally his or her own physical attractiveness, role and attitude towards the other person.

**2** Non-verbal signals are more powerful; actions speak louder than words. For a schoolteacher, beckoning may be more likely to result in action than a verbal order. We were travelling by underground in London fairly late one evening in May. As we came into Earl's Court Station, there were hundreds of people, mostly men, all wearing light blue shirts on another train. None of them were smiling or talking above a moan; some looked distraught. They were Chelsea football fans and their team had just been eliminated from the Champions League by Barcelona.

**3** Non-verbal signals are less censored and therefore more likely to be genuine. If conflicting messages are given verbally and non-verbally, the non-verbal signal is accepted as truthful.

**4** Some messages, because of social censorship, cannot be made explicit in a social setting and therefore cannot be verbalized but can be conveyed non-verbally by appropriate posture, gesture and movement in space. For example, by facial expression and turning away, a person might suggest without making it explicit, 'I do not like you and am bored with speaking to you'.

5 Verbal messages are **punctuated** and **emphasized** non-verbally; for example, the pause at the end of a phrase or the cadence of voice used. These embellishments add meaning to the actual words used[ii].

*Self* talks with the body as well as with words.

## ***Signs*** **of mental distress**

Clinical diagnosis is based on symptoms and signs. The symptom is the complaint the patient makes. The sign is what the doctor observes without the patient necessarily being aware of it. In most of psychiatry both symptoms and signs are verbal – what the patient says. Rarely, there are neurological signs but more often there are behavioural indicators of distress. These are a few noted by Trethowan[iii]:

**1** *The handshake* may be limp and lifeless as in a listless adolescent, or vice-like in mania; the hand of the schizophrenic patient with negativism may be withdrawn when the interviewer offers his, or the manic or personality disordered patient may insist on shaking hands contrary to the doctor's intention.

**2** *Other forms of hand behaviour* which may be significant include bitten or picked nails, clenched hands with blanched knuckles and restless fidgeting with the fingers; all these may indicate anxiety. Heavily cigarette-stained fingers obviously reflect both the number of cigarettes smoked and the extent to which each cigarette is consumed; this may also demonstrate tension.

In what I have called 'Trethowan's ring sign' a woman during history-taking unconsciously reveals her marital difficulties by constantly sliding her wedding ring on and off her finger.

**3** *The feet* may be used for restless pacing in agitated depression.

**4** *Depressive facies* and *posture* may lead to diagnosis before the patient opens his mouth. The patient may be slumped in the chair with a fixed expression of unmitigated grief on his face and a prominent 'crow's foot' between the eyebrows.

**5** *Clothing* in mania may be distinctive and suggestive, both of the diagnosis and the hyper-eroticism that sometimes accompanies it. Hair, make-up and dress may be unequivocal demonstrations of manic mood.

**6** *Stroking the cheek* may be an indicator of emotional distress. Gillett described this: 'During the initial history-taking and assessment, there was one over-ridingly important emotive issue, as evident from observation of her body language signs. When she spoke of her son dying at the age of three, her body stiffened, the muscle tension in her face increased, as if trying to stifle expression, lacrimation increased (though only just perceptibly), and her voice rose in pitch and wavered. She then lightly stroked her right cheek with the tip of her fore-finger, as if wiping away an imaginary tear – a common sign which usually indicates a desire to cry at the same time as a wish not to show it'[iv].

All these signs, and many more, can be registered by a reasonably astute clinician. If adults convey their innermost feelings non-verbally, children do so also, and much more eloquently.

**Attachment**

Let us look for a few minutes at a Video clip of a mother with her infant. Notice how the child is actively communicating with the mother non-verbally.

**VIDEO**

What we were observing there was a form of *attachment behaviour*. The infant at rest in close proximity to his mother engages her in responsive play as he begins to explore his world. All this is nonverbal.

Attachment behaviour is goal-orientated. The main aim is to maintain proximity so that the infant can have ready access to his food supply and be protected by the mother. From his first arrival in the outside world, the infant is able to convey to his mother much about his internal state through a whimper or a cry, or through quietness. He can convey hunger, or his need for comfort and company, or discomfort, even pain. He can equally well convey contentment.

Many of you may know the work of John Bowlby, who was the first to describe these processes in detail[v]. He used the analogy of a newborn lamb. If the lamb becomes separated from his mother, calling behaviour is set up; he bleats persistently. The mother ewe instinctively begins searching, and also calling for her infant. When the two are reunited, both these behaviours subside and the infant lamb is able to feed from her and then stay quietly with her, and exploratory behaviour can begin. Something very similar happens with a human mother and her child.

Madeline McGann, a 4-year-old, went missing in Portugal two years ago. One tragic aspect of this case, for her parents, is that the searching cannot stop. The grief, and anxiety fuelling it, is continually re-activated.

Attachment behaviour is strong between married couples and is much more than the wearing of a ring. When, after some time of living together, one of the couple is lost through death, searching behaviour is part of the distress shown by the surviving partner. It is usually nonverbal but may include literal calling.

The growing infant will work hard to engage its mother in all kinds of interactions, first using smiles and facial expressions, later with preverbal communication. This is a vital part of the building blocks by which a child comes to understand what is ME and what is NOT ME. In the relationship which develops

between the child and his mother, his personality grows and develops, as does his capacity for love.

Bowlby did an important study of young children who had to be hospitalised. Prior to his work, mothers in the UK were not allowed to stay in the hospital with their children. Bowlby observed that the separation was both distressing and harmful to the children. They went through three stages of reaction. First, protest, when they were crying and calling constantly; second, despair, when the crying stopped, but silent misery, with refusal to eat or be comforted, set in; third, detachment, when the grief became hidden behind a defensive wall. In the third stage, when the mother did return, the child would refuse to look at her and acted as if he did not know her. This work eventually led to the practice of encouraging mothers to stay with their children in hospital, and share the care, being available to comfort as much as necessary.

Mary Ainsworth later followed with some studies of toddlers and their reactions when the mother went out of the room leaving them alone briefly or leaving them in the presence of a stranger[vi]. She noted what happened when the mother returned to the room, the nonverbal behaviour, and used this to classify the kind of attachments between the mother-child pairs. The securely attached child would run to the mother to welcome her back with relief and was soon ready to play again. The child with insecure attachment was in one of two groups; either ambivalent attachment, when he would remain tearful until the mother came to him, and he would show prolonged clinging and crying; or insecure -avoidant attachment, when he would ignore the mother's return and not look for comfort.

Much of the nonverbal communication between older children and their mothers (or caregivers) is driven by these early attachment processes. What we describe as 'attention-seeking behaviour ' is usually 'care-seeking behaviour'. When recognised

as such, the causes can often be understood and there is some hope that the distress can be alleviated. For instance, if a mother has been emotionally unavailable to an infant in the first year of his life, because she has been depressed, this may set up a constant need for care and attention that remains unsatisfied. She experiences the child as being too demanding and she withdraws even further. He may become constantly active in his desperate attempt to get her to satisfy his needs. This overactive demanding behaviour will only subside if she is encouraged to give him regular times on a daily basis when he has her undivided attention, when they can play together and learn to rediscover a satisfying relationship

**Attunement**

Some of you will know Daniel Stern's work on the interpersonal world of the infant[vii]. He describes an important process which he calls 'affect attunement'. This is behaviour of the mother in response to her infant which shows that she shares the infant's feeling state. Here is one example Stern gives:

*A nine-month-old girl becomes very excited about a toy and reaches for it. As she grabs it, she lets out an exuberant 'aaaah!' and looks at her mother. Her mother looks back, scrunches up her shoulders, and performs a terrific shimmy with her upper body, like a go-go dancer. The shimmy lasts only about as long as her daughter's 'aaaah!' but is equally excited, joyful and intense.*

The responsive behaviour is not just imitation. It is a matching behaviour, reflecting the infant's feeling state. It is cross-modal, i.e. the modality of the expression used by the mother will be different to that used by the infant, but it will match in intensity and in duration.

‘Affect attunement, then, is the performance of behaviours that express the quality of feeling of a shared affect state without imitating the exact behavioural expression of the inner state’ (Stern).

These behaviours are mostly instinctive but mothers are aware of them about one third of the time. It is through this process of attunement that the infant comes to understand that a feeling can be shared by another. His inner feelings are constantly conveyed in his nonverbal behaviour and need to be validated by the loving attention of his mother.

These two processes of attachment and attunement are the basis of the growth of love. They are an important part of the development of the capacity for spiritual life and for a relationship with God.

**Faith without words**

To continue the discussion on the relationship with God: our believing patients are apprehensive concerning the hostility psychiatry has traditionally shown towards religious belief. They want psychiatrists to recognise the significance of their faith and integrate it in treatment. They do not want their beliefs to be belittled or denied. Mental health service users themselves have recommended very strongly that their treating professionals acknowledge the spiritual aspects of mental illness[viii].

In Britain, and I suspect other European countries, patients with religious beliefs often feel they are misunderstood by health professionals, and their faith and its consequences for daily living devalued. The words they use about religion are sometimes considered nonsensical by secular professionals, and this leads to the patient feeling devalued as a person. Religious faith and commitment is not only expressed in words but also non-verbally, as I said earlier. We know that we belong to

God because, ‘The Spirit himself testifies with our spirit that we are God's children’[ix]. This is both verbal and non-verbal.

We ignore the non-verbal part of believing at our peril. Those who attack and detract from faith, such as Dennett[x] and Dawkins[xi], do so with words, arguments and verbal debate. They seem to have no idea of what their faith means to a believer. When they disparage the existence of God, the reality of faith in God and the credibility of Christian understanding, I for one do not recognise their description of God, faith or Christians. The dominant influence in Paul Tournier’s practice of his daily relationship with Jesus Christ holds no meaning for them. In the British group of Medicine of the Person, John Clarke recently reminded us: ‘As he talked with a patient, Dr Tournier saw the link with Christ as represented by a triangle. At the apex of the triangle is Christ. The doctor is placed at one of the base angles with the patient at the other. Doctor and patient both have one arm leading to Christ and the other arm from the one to the other[xii].

If we continue from the chapter I quoted in Romans: ‘[23] … we ourselves, who have the firstfruits of the Spirit, groan inwardly (as in childbirth) as we wait eagerly for our adoption, the redemption of our bodies.

[26] In the same way, the Spirit helps us in our weakness. We do not know what we ought to pray for, but the Spirit himself intercedes for us through wordless groans. [27] And he who searches our hearts knows the mind of the Spirit, because the Spirit intercedes for God's people in accordance with the will of God.’[xiii] Some versions render that ‘too deep for words’ or ‘groans that words cannot express’.

Much of the day-to-day communication of the individual believer with God is non-verbal – ‘groaning inwardly’; ‘the Spirit helping us in our weakness’; ‘the ‘Spirit interceding for us with groans that words cannot express’.

These psychological processes of attachment and attunement are helpful in describing some of what is going on in Tournier's triangle: God, the patient and the doctor.

**Attachment in spiritual terms**

God's world is essentially based on relationship. Keith Ward, writing from a theological perspective has explained this: "*The Christian view is that one of the chief goals of creation and evolution is the emergence of beings that to some extent possess awareness, creative agency, and powers of reactive and responsible relationship…"*[xiv]. His argument is that God, in every aspect of His creation, is concerned with relationship; this was a purpose of the creation of the world. Human beings are organisms of relationship; one of the essential features of being human involves relating to other humans. The very first story in the Jewish and Christian Bible is of Adam's need for relationship with Eve.

From the psychiatric understanding of *attachment* we see that harmony in human relationships depends upon a sense of secure emotional attachment. For the Christian, this is seen as the work of God reflected in the lives and behaviour of people. God offers attachment that transcends human failings.

We can look at attachment theory in spiritual terms, both in the ability the individual has to make strong affectional bonds with other humans and the effects of their background experience on their capacity to relate to God. At the simplest level, it is clearly easier to address personal prayer to 'Our Father' for someone who has had a strong, positive and enduring relationship with a human father. Attachment theory merits careful consideration by ministers of religion, as well as by psychiatrists, because it is helpful in explaining some of the multitude of relationship difficulties that occur in churches. A Christian child psychiatrist was asked to address a church

women's group on family relationships. In discussion, members of the audience aged in their 70s and 80s did not discuss their current experiences in families but their past hurts and failed attachments with their own mothers when they were children 60 or 70 years ago. As doctors and as Christians it is wise to take the processes of attachment into consideration in our thinking.

**<u>Attunement as an expression of non-verbal relationship</u>**

We have seen, I mean **seen,** how babies are capable of shared attention, shared intention and shared affect with another person, usually mother, even though they do not yet have verbal language. Attunement is a mutual activity in a shared relationship: during the first year of life, the infant and mother *attune* themselves to each other. On any individual occasion, *attunement* may be initiated by either infant or mother. It does not depend upon simple imitation but on a response that draws forth communication from the other, resulting in a mutual, and at the time, exclusive relationship. It is non-verbal in nature, often rhythmic and is an on-going, dynamic process.

As with attachment, it is helpful to appreciate the significance of attunement to understand the spiritual development of the child – and the adult. Attunement can form a part of the process of praying with young children in drawing their attention, intention and affection towards God; the child 'mirrors' the prayer of the adult. Later, it becomes incorporated into their communication in prayer on their own with God: it is a dialogue. God makes himself known to us and we seek Him in prayer. It is a dialogue: *"the Spirit helps us in our weakness. We do not know what we ought to pray for, but the Spirit himself intercedes for us with groans that words cannot express…the Spirit intercedes for the saints in accordance with God's will."*[xv]

The relationship with others is modelled on that with God. We are encouraged to have '*our eyes fixed on Jesus, on whom faith depends from start to finish*'[xvi]. We look at him for blessing because he has already looked to bless us: '*The Lord looks down from his sanctuary on high, from heaven he surveys the earth to listen to the groaning of the prisoners and set free men under sentence of death*'[xvii]. The communication goes in both directions, and in so doing completes Tournier's triad for the medical consultation, with our compassion for our patients: '*We love because he loved us first…And indeed this command comes to us from Christ himself: that he who loves God must also love his brother*'[xviii].

**Conclusion**

Sometimes, when we are in a clinical situation, our patients say what they mean – but not always. As we ponder on our patient's presentation, whether he or she be adult or child, we need to look at him, observe him and think to ourselves: what didn't you say? What did you, the patient, communicate to me alongside the words that you used to describe your condition?

We have tried to make the following points:

1. Non-verbal communication *occurs in all human exchange*, including the consultation between doctor and patient;
2. Non-verbal communication has different characteristics from verbal, and is *sometimes more powerful* and truthful;
3. There are useful *behavioural signs* that can be ascertained in a psychiatric interview;
4. Attachment theory describes essential features of the *development and adult functioning* of the person;

5. Attunement can be seen most clearly between *infant and mother* but has more general application;
6. *'Tournier's triad'*, Jesus Christ at the apex, the patient and the doctor, has relevance in every consultation, with Christian and non-Christian patient, with verbal and non-verbal communication, in every specialty and discipline of medicine;
7. God speaks to us in His Word. *He also speaks to us in a way that is too deep for words.*

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