

“Going down” and “getting deeper”:
physical and metaphorical location and movement in relation to death and spiritual care
in a Scottish hospice

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Biographical note

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ABSTRACT

This paper illustrates how attending to the metaphors people use for particular concepts, and to the context in which they use them, can increase our understanding of the meanings they attach to those concepts. It considers two linked emergent findings from an ethnographic exploration of spiritual care in a Scottish hospice: 1) the relationship between the perceived likelihood of palliative care patients’ deaths and their physical location in and movement between various parts of the hospice, and 2) the use of physical metaphors to describe both the increased probability of particular patients’ deaths (“going down” or “going downhill”), and spiritual care (“getting deeper”). The paper explores these findings and the relationships between them. It discusses how workers in this hospice located death somewhere other than “here,” both physically: in private spaces, and metaphorically: DOWN, which has strong negative associations. Workers also metaphorically located spirituality elsewhere: DEEP, so that “getting deeper” with patients meant that workers metaphorically accompanied them somewhere else. Although DEEP does not have the negative connotations of DOWN, “getting deeper” might mean encountering distressing, or DOWN, emotions. Many workers sought to counter these negatively perceived emotions by “cheering up” patients, rather than “getting deeper” with them.

Keywords: metaphor, hospice, death, dying, spiritual care, Scotland

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INTRODUCTION

The “linguistic turn” in the social sciences has brought with it a growing attention to discourse, both in research-created contexts, such as interviews, and also in real-life situations. Applied discourse analysis focuses on language in real-life situations (Gunnarsson, 1997) and, while much work in this area is within applied linguistics (Cameron & Low, 1999), there is also an increasing interest in discourse in health care (Gotti & Salager-Meyer, 2006). In this context, the focus is often on communication between professionals and lay people, and on difficulties which may arise with such communication (Wodak, 1996), but consideration of normal, unproblematic discourse between people also provides insight into their understandings (Cameron, 2001).

One topic of increasing interest for discourse analysis is the use of metaphors (Cameron & Low, 1999). Metaphors are key in how people understand the world, since metaphors both reflect and create reality, and (therefore) capture the values, assumptions and hidden meanings that people assign to concepts (Lakoff & Johnson, 1980; Lakoff, 1993). Thus, paying attention to the metaphors people use for particular concepts may increase our understanding of how they construct those concepts.

Of most relevance for this paper is Lakoff and Johnson’s discussion of how people use physical metaphors for abstract concepts, particularly “orientational metaphors,” relating to UP or DOWN (Lakoff & Johnson, 1980: 112-5). In many cultures metaphors for negative concepts are oriented DOWN, and metaphors for concepts which are perceived as valuable or positive are

oriented UP (“things are looking up”). Positive metaphors are never oriented DOWN nor negative metaphors UP, although some cultures do not have the metaphoric pairing MORE IS UP and LESS IS DOWN (Lakoff, 1993: 240).

Lakoff and Johnson argue that “external systematicity” provides coherence between metaphors, such that, for example, all metaphors with an upward orientation share the positive connotations of UP (1980: 23-4). These positive associations link to posture, since upright bodies are associated with health and lying down with ill health (people lie down to die). So people’s bodies both carry and construct meanings. These are not isolated but relational and postural, and “involve the relations between the body, the surrounding space, other objects and bodies, and the coordinates or axes of vertical and horizontal” (Grosz, 1994: 85). We think of ourselves in relation to space and develop metaphors accordingly; our shared experience of bodies in space is a basis for communicating mood and feelings (Hockey & James, 1993: 76). Physical metaphors for concepts are therefore freighted with other associations. So, for example, many religions, including Christianity, conceptualise heaven or the afterlife as being UP (Yamada et al., 2002). CONTROL is also metaphorically UP (“being on top of things”), and DOWN therefore implies loss of control, being subject to control or an external force (Lakoff & Johnson, 1980: 24). In turn, weakness, vulnerability and distressing emotions are associated with DOWN, and their negative connotations interweave and reinforce each other (Froggatt, 1998).

Examination of the metaphors people use for particular concepts is therefore helpful for increasing our understanding of how people construct those concepts and of the values which they assign to them. However, little research to date has examined how metaphors are used in health and health care, either in general, or, more specifically, in relation to death and dying. Of the few investigations which have explored this (Sontag, 1979; Sontag, 1989; Savage, 1995; Froggatt, 1998; Anderson, 2001; Seale, 2001; Stanworth, 2003; Utriainen, 2004), two studies

have specifically investigated the use of metaphors by people in hospices. Stanworth (2003) explores how hospice patients use metaphors when discussing the meanings of their experiences, while Utriainen (2004) examines the metaphors used by Finnish hospice workers when speaking about their interactions with patients.

The Finnish hospice workers in Utriainen’s study stated that dying people need “the presence (closeness, being there) of another person” more than anything else (Utriainen, 2004: 132). “Closeness” is itself a metaphor, but Utriainen does not focus on this particular metaphor. Instead, she considers the metaphors of “nakedness” which these workers used, both when elaborating their understandings of “closeness,” which they said meant that they were “undressed of their professional skills and roles,” and also when stating that dying people became “denuded,” “layer by layer,” of their personal qualities and characteristics (op. cit.: 134). The Finnish workers said that they sought to prevent this potential “denuding” of dying people by trying to “wrap” them, by which they meant trying to preserve their “personal qualities” through talk and touch (op. cit.: 141).

Illustrating Lakoff and Johnson’s argument that metaphors are fundamental to expressing abstract concepts, metaphors are also evident in discussions of death and dying which do not explicitly consider the use of metaphor (for example, Reimer, Davies & Martens, 1991). So, too, in her discussion of UK nurses’ understandings of spiritual care, Ross (1998) states that nurses can give spiritual care on different levels – from “deep” to “superficial” (p. 131) – but does not reflect on the fact that these are metaphors. Instead, she takes their intelligibility as read, although she elaborates that “deep” spiritual care means being “intimately involved in helping patients meet their spiritual needs,” or “being prepared to ‘be with’ the patient” (op. cit.: 127-8). Similarly, while Stanworth (1997) points to the different “depths” of reality and communication

encountered in talking with hospice patients, and considers the metaphors patients may use in “deeper” conversations, she does not examine “depth” itself as a metaphor.

This paper considers two interlinked findings which emerged from an ethnographic study exploring the spiritual aspects of care in a Scottish hospice. General findings from the study are discussed elsewhere (Vivat, 2004; Vivat, forthcoming). The current paper focuses specifically on how workers in the hospice used space and spatial metaphors. It discusses the physical metaphors of location and movement which workers used to talk about death (“going down/hill”) and spiritual care (“getting deeper”), and how these metaphors interwove with the significance they attached to where particular “kinds” of patients were physically located in the hospice. The paper considers how close attention to these interlinked findings increases understanding of the attitudes of workers in this hospice towards death and spiritual care, and reflects particularly on the relationship between these findings and the metaphors of “nakedness” used by Finnish hospice workers (Utriainen, 2004).

METHOD AND ANALYSIS

The study investigated spiritual care in one particular hospice (pseudonymised as “St Z’s”), and used ethnographic methodology (that is, both participant observation and interviews) so as to explore both practices and talk about practices (Savage, 1995). The management committee of St Z’s granted access and ethical approval for the study, and I conducted fieldwork for 14 months. For the first 8 months I went to St Z’s on 3 or 4 days per week, for an average of 4 hours per day. During this time I attended every weekly case conference, every Friday session of day care (a day-time service for palliative care patients who were living at home), and the Friday after school

drop-in group for bereaved children. I went to St Z’s on other occasions depending on factors such as if someone I was shadowing or planned to interview was working on that day, or if an event I thought would be particularly interesting was taking place. I also spent several night shifts there. During the final 6 months of my fieldwork I gradually decreased the frequency of my visits to St Z’s.

My participant-observation varied in its proportions of observer and participant depending on where I was in the hospice. St Z’s had 2 wards: “St E’s,” the elderly care ward, and “St P’s,” the palliative care ward. On the wards and during case conferences I was close to being a “complete observer” (Bernard, 2006: 347). In these situations I took verbatim notes. I was more of a participant in day care and at the children’s drop-in, where volunteers were common and I was often considered as such. Here I took fieldnotes in a small notebook which I had with me at all times. I “expanded” (that is, wrote up in more detail, and reflected upon) all my fieldnotes as soon as possible after I had taken them.

Over the 14-month period I also conducted loosely structured one-to-one interviews with 24 workers. My selection of interviewees was purposive (Bernard, 2006: 189-91). Initially, I sought to obtain a cross-section of all workers’ perceptions, so I selected people to interview on the basis of their professional roles and/or where they worked in the hospice. However, ethnographic analysis proceeds iteratively (Wolcott, 1999), and over the course of my fieldwork (as I consider in more detail elsewhere (Vivat, 2004; Vivat, forthcoming)) I began to question whether spiritual care was generally provided in St Z’s. I therefore began to select particular interviewees (and to shadow particular nurses) who I thought, or other interviewees suggested, might provide this kind of care.

One interviewee, “Dr Marshall” (the medical director¹), did not want his interview tape-recorded. I therefore took verbatim notes during this interview. The other 23 interviews were

tape-recorded and transcribed following Jefferson's transcription convention (Jefferson, 1984; van Dijk, 1997) and analysed using techniques from discourse analysis (Cameron, 2001). This analysis revealed the prevalence of metaphors in talk about spiritual care, and my increased awareness of this in turn led me to notice the frequent occurrence in my fieldnotes of metaphors relating to death.

FINDINGS

St Z's was partly NHS-funded and partly charitably funded, and run by an order of nuns, four of whom worked in the hospice: the matron, the deputy matron, a day care worker (a retired nurse) and a receptionist. Most other workers in St Z's were also female. Male workers were: Dr Marshall and the second medical consultant, two nurses, the two maintenance workers, and a few volunteer drivers. Most workers were White, Scottish and from the local community, as were nearly all patients. Otherwise, one GP was Black, and he and a few other workers were English (like myself), while the nuns were all Irish.

Ethnographic methods highlight the taken-for-granted (Wolcott, 1999; Bernard, 2006), such as one emergent finding in this study: the expectation that particular "kinds" of patients would be located in particular places in St Z's. Patients' specific locations, and any changes in these, were highly significant for people in the hospice, especially if patients were moved between public and more private spaces. A second emergent finding, linked to the first, was the widespread use of physical metaphors. Workers in St Z's conveyed their perceptions that particular patients were more likely to die via one of two related orientational metaphors: "going down" or "going downhill." They also used metaphors of location and movement to talk about the spiritual aspects of care, particularly the phrase "getting deeper." The paper will now

consider each of these findings in turn.

Patients’ physical location and movement in St Z’s

St Z’s was situated on the side of a hill. The building extended above the downward slope of the hill, and so the hospice was partly single storey and partly on two storeys. The main entrance into the hospice was at the top of the hill, and led into the reception area. Beyond this were the two wards. St E’s (the elderly care ward) was the larger, with 22 patients; St P’s (the palliative care ward) had 10, very occasionally 11, patients. Day care was on the lower ground floor, and had a separate entrance, further down the hill.

Palliative care patients were primarily located in St P’s, St E’s or day care. Each ward contained further distinct spaces: 4-bedded rooms and single or “side” rooms. St P’s had two 4-bedded rooms (one for men, one for women) and two single rooms, and a third single room for occasional emergency admissions. St E’s had four 4-bedded rooms (two for women, two for men) and six single rooms. Close attention to patients’ specific locations in St Z’s revealed the implicit, taken-for-granted expectation that particular “kinds” of patients would be situated in particular spaces.

The distinction between the “kinds” of patients in each space related to the perceived probability of their deaths. 4-bedded rooms on St E’s were generally occupied by “elderly care” patients, who were unable to live at home, but did not have any specifically life-limiting illnesses. Palliative care patients who were admitted to St Z’s for “respite care” or “symptom control” were usually given a bed on one of the 4-bedded rooms on St P’s. However, they seldom stayed there for any length of time. Instead, after a few days or weeks, they either went home or were moved

to a single room on one of the two wards. Those patients whose symptoms were perceived as problematic and/or who were perceived as likely to die relatively soon were moved to single rooms on St P's. Other patients, who did not fit either of these (implicit) categories, but who were unable to return home (for a range of reasons such as lack of support at home, or their increasing frailty), were moved to single rooms on St E's.

In general, therefore, patients stayed in St E's for much longer than in St P's, and on each ward people in 4-bedded rooms were expected to live longer than people in the single rooms on that particular ward, who were usually there for relatively shorter periods. People in 4-bedded rooms on St P's were usually there for a few days or weeks, while, since patients on St E's generally lived considerably longer than patients on St P's, some patients on St E's stayed in the 4-bedded rooms for years. On both wards it was rare for people to die in a 4-bedded room, and those patients who were perceived as more likely to die than other patients on that ward were usually located in single rooms. Palliative care patients in single rooms on St P's were perceived as likely to die in days or weeks, while palliative care patients in single rooms on St E's usually lived for several months or longer (figure 1).

These expectations of where particular "kinds" of patients would be located were tacit and never explicitly identified. However, workers' tacit understandings became more evident when they had difficulty with situating some patients, especially when they perceived that particular patients were in the "wrong" places. For example, "Jimmy M" was a palliative care patient who spent an exceptional length of time in the 4-bedded room on St P's. He stayed in St Z's for almost six months, but was never transferred to St E's as workers would normally expect. Workers frequently discussed Jimmy's specific location in the hospice, and this highlighted their usual expectations.

Jimmy M was in his mid-50s, and was first admitted to St Z’s in April. He had primary lung cancer and brain secondaries, and was unable to use his legs or arms. After a while he regained some movement, but it became clear that his wife could not look after him at home, so he remained in St Z’s, and stayed on St P’s until he died in late September. Jimmy was admitted to the 4-bedded room on St P’s, and he enjoyed the company of other patients. However, few other patients remained there for any length of time, and many died while he was there. Workers were aware that Jimmy found this difficult; Dr Marshall began the discussion of Jimmy at a case conference in May by saying:

He’s well physically and mentally, but all the deaths on the ward are bringing him down a bit.

However, at this time workers did not feel that they could permanently move Jimmy M from the 4-bedded room to a single room on St P’s. They did so occasionally, but he did not have difficult symptoms, and was not perceived as likely to die within days or weeks (so did not fit either implicit category for allocating single rooms on St P’s). He was therefore moved back to the 4-bedded room if another patient fit either implicit category and so was considered to be a higher priority. Other patients in Jimmy’s situation were moved to a single room on St E’s, but workers did not consider this appropriate for him.

So, following a case conference in mid-June, “Pat” (the physiotherapist) said: “Jimmy’s very unhappy.” “Helen” (the home care coordinator, who had previously been a sister on St P’s) responded:

It’s a problem, longstanding patients with other people dying [...] I remember a lady; we thought we’d done everything we could for her; when she was going home she said to me: “I’ve seen 17 people die here.” [...] [Jimmy]’s not going home, but it’s not good keeping on moving him between the ward and a single room. And it wouldn’t be good to put him in St E’s either; he’s a young man still.

Helen's remarks illustrate workers' sense that patients should not die in the presence of other patients, and that people who were perceived as likely to die relatively soon should therefore be in single rooms. Although Jimmy M was "not going home" (that is, was expected to die in St Z's), he was perceived as a "longstanding patient," that is, as unlikely to die in the near future. However, in contrast to most patients, workers' predictions of the likely length of Jimmy's life were not the primary factor in where he was located in St Z's; this was overridden by his age. Even though palliative care patients in St E's were mostly in single rooms, workers felt that, as a relatively young man, Jimmy would find being on the elderly ward difficult. He was therefore not moved to St E's, but remained in the 4-bedded room on St P's. However, workers were uncomfortable with him being there, and repeatedly discussed his location until, in August, when they considered that his physical health had worsened, and so that he was more likely to die, he was moved to a single room – on St P's.

Day care was the third place where palliative care patients were located in St Z's. About 60 palliative care patients attended day care on one or two days each week, and around 15 patients were at day care on any one day. Day care was on the lower ground floor of St Z's, and was very self-contained, with its own separate entrance. Both patients and workers in day care spoke of being "downstairs," in contrast to "upstairs," by which they meant the wards. If people in day care spoke of a day care patient as being "upstairs," this was highly significant. Day care patients were mostly relatively well and expected to live for at least several months, if not years, although from time to time they were admitted to one or other of the wards for respite care and/or to have specific symptoms addressed. If this happened, people in day care explicitly stated that this was the case. On other occasions, however, day care patients were admitted to a ward on a less clearly defined basis, and for an indefinite length of time. In these situations people in day

care said that that particular patient had “gone upstairs,” with no provisos attached (and often with slightly lowered voices). The implication was that this person was more likely to die.

So, considerable significance was attached to patients’ physical locations within, and/or their movements between, different spaces in St Z’s. Particular places in the hospice, especially single rooms on the wards, were associated with the increased probability of patients’ deaths. Death and dying were thus located in particular, private places in St Z’s. The sense that death was located somewhere other than “here” was reinforced in that people seldom discussed death and dying in shared, public spaces, and in that their talk about death and dying also, metaphorically, located death elsewhere.

“Going down/hill”: metaphoric location and movement in talk about death and dying

Explicit public talk about death and dying was rare in St Z’s, and I never heard such talk between workers and patients. Patients spoke with other patients about (other) patients who they perceived as particularly unwell or who had died recently, and workers discussed such patients with other workers. Day care workers informed day care patients if other day care patients had died at home, but never discussed these patients in any detail at the time. The only other times when I heard workers and patients discussing dead patients in groups of both patients and workers was when people in day care reminisced about patients who had died some time ago (as also observed by Lawton, 2000: 46-9). Otherwise, most workers generally avoided talking about death and dying with patients and sought to “cheer up” patients, sometimes explicitly stating that this was their aim by uttering phrases such as: “we need to cheer you up, Maggie.”

On those occasions when people in St Z's did discuss specific unwell or recently dead patients, they seldom used explicit language. Patients occasionally used the words "death" or "dying," and after a patient's death workers sometimes said that that person had "died." However, workers seldom used the words "death" or "dying" about specific living patients, even when speaking with other workers about their perceptions that particular patients were less well. Workers might discuss patients' deaths in an abstract sense: "she knows she's here to die," but when they wanted to convey their sense that a particular person was likely to die relatively soon, they usually did so with one of two related phrases: "s/he's going down" or "s/he's going downhill." So, for example, Dr Marshall opened a weekly case conference in mid-June by saying:

- 1 Dr Marshall: [*Jimmy M*]. 54 year old man with bronchial carcinoma and cranial metastases. He's gradually going downhill [...] He's very down in the dumps; should we try anti-depressants?

The discussion continued:

- 5 Dr Marshall: he's [...] sleeping longer.
6 Pat: is that [...] because his mood is low?
[...]
9 Dr Marshall: we could give him a wee shot of something to buck him up a bit.

The above illustrates Lakoff and Johnson's (1980: 23-4) comments on the negative associations of DOWN metaphors, and the positive associations of UP, and their claim that "external systematicity" provides coherence between metaphors. Workers in St Z's used DOWN metaphors both to express their perceptions of patients' likely deaths: "he's [...] going downhill" (line 1), and also to talk about their perceptions of patients' distressing emotions: "down in the dumps" (line 1), "low" mood (line 6) (also Dr Marshall's comment that other patients' deaths were "bringing [*Jimmy M*] down," cited earlier). Workers used UP metaphors for the converse: "buck him up a bit" (line 9), "cheer up" (noted earlier).

“Going down/hill” phrases conveyed the sense that patients perceived as more likely to die were metaphorically moving elsewhere. A few people in St Z’s occasionally used other metaphors, such as “slipping away,” or “wanting to go,” to talk about people they perceived as more likely to die, and one of the social workers occasionally said that particular patients were “quite far through.” The key feature of these metaphors to express the perception of the increased likelihood of patients’ deaths, therefore, was movement away; that is, the sense that patients were going elsewhere, somewhere other than “here,” but not necessarily downwards. Most frequently, however, the elsewhere was DOWN.²

The only person I ever heard using a different kind of phrase to express this understanding of patients’ health was “Sister Deborah” (a nun who was the deputy matron). She told me that she felt that workers frequently used negative language when discussing patients who were less well, and said that she deliberately used the phrase “getting weaker” to avoid these negative associations. “Getting weaker” conveys no sense of metaphoric movement elsewhere, and seems less negative than “going down/hill,” while conveying a similarly vague sense of when death is anticipated. However, I never actually heard Sister Deborah use this phrase in conversation with others.

Most commonly, I heard people in St Z’s using “going down/hill” phrases to convey their perceptions that particular patients were more likely to die. This included people “downstairs” in day care, even though, as noted earlier, if they spoke of a day care patient as being “upstairs,” they understood this to mean that s/he was less well. Nevertheless, if people in day care wanted to express that a patient “upstairs” was becoming increasingly unwell, they, like people elsewhere in St Z’s, said that that person was “going down/hill,” not “going up/hill.” Thus, for people in day care, these DOWN metaphors co-existed with the significance attached to patients being physically “upstairs.” The important sense, both physically and metaphorically, was that the

person was in or going somewhere other than “here,” but the sense of death being metaphorically DOWN overrode patients’ specific physical locations.

So, most workers in St Z’s conceptualised life as being “here” and death as being somewhere else, both physically and metaphorically. The metaphors they used most frequently were “going down” and “going downhill,” which, as DOWN metaphors, were strongly negative. People who were perceived to be “going down/hill” were usually in single rooms on the wards, or were moved there, so people usually died in private, not in public, shared spaces. “External systematicity” reinforced the negative associations of “going down/hill.” Unhappiness is also metaphorically located elsewhere: DOWN, below “normality,” and workers spoke of unhappy patients as “down in the dumps,” and needing to be “bucked up” or “cheered up,” that is, as needing to be brought back UP to normality.

Like talk about death and dying, talk about spiritual issues (if it happened at all), also occurred in private, one-to-one situations, that is, elsewhere than in public spaces. Metaphors were also prevalent in such talk, and, similarly, located spirituality elsewhere.

“Getting deeper”: metaphoric location and movement in talk about spirituality and spiritual care

Most workers in St Z’s did not claim to personally provide spiritual care, nor even to be able to define it, other than to say that it was distinct from religious care. Most told me that spiritual care was someone else’s responsibility, although they were usually unclear as to who that other person was (I discuss spiritual care in St Z’s more generally, and in more detail, elsewhere (Vivat, 2004; Vivat, forthcoming)). Only 8 workers told me that they personally provided and/or understood spiritual care. One of these, “Senga” (a nurse on St E’s), responded to my question of what she

thought spiritual care was by saying: “You just love them [*patients*]; you just do.” That is, for Senga, spiritual care meant delivering all aspects of care in a loving manner.³

The other 7 workers in this small group, however, understood spiritual care as distinct from other aspects of care, involving specific action on their part, and having a particular content.⁴ They used physical metaphors to express this understanding, particularly the word “deeper.” So, for example, Helen distinguished between religion and spirituality by saying:

54 I mean for some people their spirituality is purely a religious thing
55 umm but I don't think for the majority of us that it is (.)
56 I think our spirituality is *deeper* (..)

Dr Marshall also located spirituality below other things. During my interview with him, I asked:

BV: If you were to define the spiritual part of a person, how would you?

Dr Marshall: What you're left with when all worldly things are stripped away.
The pragmatic, material things drop off when people are in a crisis situation.
The soul is laid bare.

Thus, for Dr Marshall, the spiritual part of a person was “what you're left with when all worldly things are stripped away,” that is, something beneath or beyond the “worldly.” His comments “the pragmatic, material things drop off” and “the soul is laid bare” also indicated this, as did his statement: “Strip away the ego side,” when I subsequently asked:

BV: ...and how would you define spiritual care?

Dr Marshall: Spiritual care means leading someone to understand themselves.
Strip away the ego side.
Let them understand that they are on a journey to death, as gently as possible.

Here, in his definition of spiritual care as “leading someone to understand themselves” and “that they are on a journey to death,” Dr Marshall used metaphors of movement/travel. His sense that

a person's soul or spirit was located somewhere else, specifically "beneath" other parts of the person, was also conveyed when he distinguished between emotional and spiritual care by saying:

Emotion can be very superficial; relieving the pain of the family by bringing them in.
Perhaps there is ego, a thin layer of emotion and a deeper spiritual self.
It's about getting beneath the skin.

Thus, Dr Marshall identified emotion as "superficial" – literally, "of or pertaining to the surface" (although, for him, below a person's ego) – and overlaying a person's "deeper spiritual self." So, for Dr Marshall, a person's non-physical self comprised "layers," with ego overlaying emotion, in turn overlaying spirituality. Hence, reaching a person's "deeper spiritual self" involved "getting beneath the skin," or beneath the layers of ego and emotion.

"Sue" was a staff nurse on St P's, where she had worked for several years. Like Dr Marshall, she conceptualised the spiritual part of a person as underlying other things or parts of that person, being somewhere inside a person, and reached by or after removing those other things. She told me that she had read that the spiritual part of a person:

16 was (.) what was **left** after everything else had been taken care of (.)
17 so if you had a patient who came in with a lot of pain an' (..)
18 various uncomfortable symptoms (..)
19 it was what was left after those were all removed
20 when you still had a *person* there (..)
21 and (..)
22 and that it's *feelings* (.) it's to do with feelings an' thoughts
23 an' everything that goes on *inside* I think (..)

Thus, Sue understood the spiritual part of a person to be "what was **left**" (line 16) after other things had been "removed" (line 19). For her, these other things were physical: pain and uncomfortable symptoms. The spiritual part of a person was then "everything that goes on

inside" (line 23), that is, within a person's physical self. Sue went on to talk about what she thought was necessary to get "inside" a patient:

48 you need a bit of time an' but you need *closeness*
49 you need to work *closely* with somebody
50 and also for somebody to share anything which is err (.)
51 you know deeper than than just their usual (.)
52 chat (.)
53 there has to be some kind of closeness (.) doesn't there?
54 with anyone
55 it's like any (.) any two people (.)
56 sharing something (.) you know
57 they have to be on a certain level together (.) you know (.)

Here again, Sue's talk is full of physical metaphors. To share talk which was "deeper than [...] usual chat" (lines 51-52), worker and patient needed to be *close* (line 48 "*closeness*;" line 49 "*closely*"), and to be "on a certain level together" (line 57). That is, this metaphoric movement of worker and patient to a particular (metaphoric) location: "deep" required both time (line 48) and a new metaphorical location: "close," and/or on "a certain level."

Sister Deborah also used physical metaphors. I interviewed her when I had just begun questioning whether spiritual care happened in St Z's, and, related to this, wondering who initiated talk about spiritual issues. I asked Sister Deborah whether she ever initiated such talk with patients. She responded that she had read somewhere that Cicely Saunders used to ask patients: "how are you in your spirit?" but at first she had not grasped Saunders' meaning. She continued:

91 but as time went by I began to understand more of what she was
92 actually trying to *get at*
93 that she may well have been trying to get at the step beyond the leg
94 as it were
95 she may well have been trying to get to something deeper than that

[BV: mmm

96 I think she (.)

97 that was the question she used to try and get beyond the (..)
98 the leg

So Sister Deborah also talked about spirituality as “deeper,” and located the spiritual part of a person metaphorically elsewhere: “beyond” (line 97) or “deeper than” (line 95) the physical or the immediately apparent: “the leg” (line 93). Spiritual care for Sister Deborah therefore meant getting to that “something deeper” or “the step beyond the leg,” that is, “beyond” the physical aspects of a person. She had a deliberate strategy for doing this, which involved successive repetitions of “how are you?”:

132 personally one of the (..)
133 my ways of doing it is (..) err (..)
134 you’ve *got* to
135 you’ve **got** to hear the first part of the story (..)
136 you’ve *got* to hear about the leg (..)

[...]

142 how are you today Mrs (.) and how’s the leg err (..)
143 oh this this and this and what I would say after that is and how are *you*? (...)
144 but because we’ve gone through the *preliminary* part of that (..)
145 it’s (..)
146 it’s *obvious* that I’m not *talking* about the leg

[BV: mmm

147 I’m now talking about *you* (..)
148 that seems to me (..)
149 of all the different kind of formulas I’ve used
150 that seems to kind of get us to *you*

[BV: mmm

151 how are *you*?

[BV: mmm

152 err (..)
153 and sometimes you can actually even go (..)
154 *beyond* that again because the *next* stage of that they may well tell you
155 oh I’m feeling a bit worried about this or (..)
156 err it’s our Marion or Colin or whatever
157 and after you’ve gone through **that** level
158 you can *then* go deeper again and say (..)

159 how are **you**? (.....)
160 using a slightly deeper (..)
161 err (..)
162 stronger emphasis (..)
163 you can *then* (..)
164 get maybe more (..)

Sister Deborah’s talk of going through the “level[s]” (line 157) of a person echoes Sue’s comment that worker and patient “have to be on a certain level together,” and resonates with Dr Marshall’s talk of the ego as a “layer” overlaying emotion, in turn overlaying the “deeper spiritual self.” Sister Deborah deliberately went “deeper,” through patients’ “levels”; first physical (“the leg”) (line 146), then emotional (“I’m feeling a bit worried”) (line 155) and social (“our Marion or Colin”) (line 156) levels, to finally reach the spiritual “level.” The sense of DEEP was also present, as Sister Deborah indicated (lines 160-2), in her “deeper” or “stronger” emphasis on each “you” in each repetition of “how are you?” (lines 142, 143, 151, 159).⁵ So, for Sister Deborah, a person’s spiritual self was the deepest, strongest “you,” the self that was most “you.”

“Sarah” (a staff nurse on St P’s) also used “deeper” for spiritual issues, and frequently associated “deeper” with “hard” or “difficult.”⁶ She repeatedly stated that she was finding it “difficult” to express what she was trying to say about spirituality and spiritual care. This was also evident in her frequent pauses, utterances of “emm” and “you know,” and in that her voice became noticeably quieter when she spoke about these “deeper” issues (following Jefferson (1984), degree signs (°) are used in the transcripts below to frame sections of speech which are quieter than surrounding speech, and double degree signs to indicate even quieter speech).

Sarah said that spiritual care happened in St Z’s, and that Helen (with whom she had worked when Helen was a sister on St P’s) provided it, but when she tried to define spiritual care she remarked:

28 ohh I'm terrible amn't I I don't (.)
[...]
31 I find it really difficult to think think of..
32 emm...
33 kind of...
34 spirituality an' what [*Helen*] provided that's...
35 spiritual...

After some discussion of this difficulty, she continued:

62 a lot of the time you know (..)
63 it's (.)
64 it *is* really easy just to keep things (..)
65 emm (..)
66 you know conversations to emm you know °°did you (?) or (?) today or°° (..)
67 cos you know if you **do** get in
68 you know deeper an' deeper then it gets harder and harder an' (..)
69 emm (..)
70 but she was [*Helen*] always had the time so yeah she probably did provide (..)
71 °°sort of spiritual°° as well as emotional an'° (..)
72 mmm is that a bit more clear? ((half-laugh))

So, for Sarah, “getting deeper” was both hard to talk about (with me) and also hard to do (with patients): “deeper an' deeper [...] gets harder and harder” (line 68). “Keep things” in line 64 – “it *is* really easy just to keep things” – implies action (resistance) and indicates Sarah’s perception that workers actively controlled conversations, including choosing whether or not they got “deeper.” Sarah’s comment that Helen “always had the time” (line 70), suggested that getting “deeper” required time (as Sue also commented), and Sarah indicated that she felt that limited time resulted in (only) emotional care (lines 70-71). For her, therefore, spiritual care required having or (lines 86-88 below) “spend[ing]” time.

Sarah went on to illustrate the contrast between what was easy and what (implicitly) was hard:

81 if you go an' have a conversation with somebody an'
82 hiya how're you doing? how did you enjoy your meal? see you later (..)
83 you know (..)
84 and I'm here if you need me for anything (..)
85 that's *easy* to do (..)

[BV: mmm

86 °if you sit down and you spend time with somebody°
87 °the conversation you know becomes° (..)
88 goes down to a deeper level an’ you know they maybe get emotional (..)
89 you know become quite distressed or (..)
90 emm (..)
91 and they’ll start to ask questions (..)
92 you know ((ttt)) want reasons for different things you know (..)
93 a lot of people [*workers*] find that they *can’t* cope with that you know
94 that they will keep things to emm (..)
95 a basic conversation

[BV: mmm

96 whereas (..)
97 emm (..)
98 [*Helen*] was never frightened of anything like that

Like Sister Deborah’s voice getting deeper as she talked of going through the levels, so Sarah’s voice became quieter when she spoke about “deeper” conversation (lines 86-87), contrasting such conversation with what was “*easy* to do” (line 85). Sarah stated that in “deeper” conversations patients might “get emotional” (line 88), by which she meant distressed (line 89). She perceived that “a lot of [*workers*] [...] can’t cope with” (line 93) patients being distressed, and that workers’ response was to “keep things [...] basic” (lines 94-95). Her repetition of “keep things” (from line 64 above) emphasises her sense that some workers actively resisted going “deep.”

Thus, for Sarah, spiritual care was “deeper” and could reveal distressing emotions (which, as noted earlier, were metaphorically located DOWN), in contrast to emotional care, which occurred in “basic” or “easy” conversation and was chatty and cheery, with an UP orientation: “cheer up.” Sarah stated that Helen “was never frightened” (line 98) of patients becoming distressed, which could occur if conversations went down “deeper.” This suggests that Sarah felt that some workers were frightened of the DOWN emotions which they might encounter if they went DEEP with patients.

So, to summarise, most of those few workers who told me that they understood spiritual care metaphorically located spirituality “deeper,” “beneath,” or “beyond,” that is, somewhere other than “here,” or elsewhere than what was immediately evident or apparent. For them, therefore, spiritual care involved a metaphorical movement, from their usual relationships with patients (Sue’s “usual chat” and Sarah’s “easy” or “basic” conversations), “closer” and/or “deeper.” This meant accompanying patients “through the levels;” going somewhere else with them (figure 2).

That is, these workers understood spiritual care to entail some kind of action: “get beneath,” “go beyond,” “get to something deeper.” Since action was involved, providing spiritual care was deliberate, and could not be done unintentionally or passively, as highlighted in Sister Deborah’s purposeful reiterations of “how are you?” Workers chose whether or not they went “deeper” with patients and many instead chose to “cheer up” patients, that is, to actively encourage patients to move away from distressing (DOWN) emotions.

DISCUSSION

This paper illustrates how the use of physical space and physical metaphors by workers in St Z’s were interwoven and mutually reinforcing. Workers attached considerable significance to palliative care patients’ physical location and movement in the hospice, since relatively well people in St Z’s located death both physically and metaphorically elsewhere than “here” (wherever they were). In particular, they expected patients who they thought more likely to die to be in single rooms (that is, private spaces). This privatisation of death was reinforced in the absence of talk about death and dying in public parts of the hospice, and in the use of metaphors

of movement elsewhere to indicate that particular patients were perceived as more likely to die. People in St Z’s spoke of these patients as “going down” or “going downhill,” that is, as metaphorically moving somewhere else: DOWN. The few workers who said they understood spiritual care also frequently used physical metaphors to speak about it, particularly “getting deeper,” a metaphor which similarly located spirituality elsewhere: DEEP.

These DOWN and DEEP metaphors are common within British culture,⁷ so are not unusual of themselves. However, the use of these particular metaphors by people in St Z’s was significant because, as Lakoff and Johnson (1980) argue, metaphors both reflect and create people’s understandings. This co-creation of metaphors and understanding means that examining the metaphors people use for specific concepts provides particular insights into the meanings they associate with those concepts.

“Going down/hill” metaphors could seem euphemistic, enabling people in St Z’s to avoid using the words “death” and “dying.” Nevertheless, these metaphors were not solely euphemistic, nor were they lazy speech. Instead, as with all metaphors (Morgan, 1993: 134), “going down/hill” metaphors served a particular purpose, conveying a precise, specific concept.

In one sense, all palliative care patients in St Z’s could be said to be “dying,” since they all had a life-limiting illness. However, cancer has increasingly become a chronic disease (Kellehear, 1990; Hockey, 2002), and some palliative care patients lived for months or years, particularly those who attended day care. In this context, referring to a particular patient as “dying” would suggest their imminent death. “Going down/hill” metaphors enabled people in St Z’s to convey a rather subtler meaning than this: that a particular patient was likely to die relatively soon, without predicting quite when.

Although the positive associations of UP metaphors and the negative associations of DOWN metaphors link to posture, since lying down may indicate ill health (Lakoff and Johnson

(1980)), not all patients in St Z's who were lying down were said to be "going down/hill." "Going down/hill" metaphors indicated that a particular person who was lying down was metaphorically moving further down, towards death. That is, these metaphors indicated that that person had changed in some way, such that their death was more likely.

The concept of increased likelihood of death is perhaps necessary in hospices (see Reimer et al., 1991), and other situations where people are expected to die (people in a residential home in North East England also spoke of residents "going downhill fast" or being "on their way out" (Hockey, 1990: 172)). However, "going down/hill" has a negative sense which is not present in all metaphors which can express this understanding, including other metaphors with a similar sense of movement elsewhere, such as (in St Z's) "slipping away" or "quite far through," or (in another hospice) "fading away" (Reimer et al., 1991). The negative associations of these "going down/hill" metaphors were reinforced by the use of DOWN metaphors for distressing emotions, and the attempts of many workers in St Z's to "cheer up" patients who were experiencing DOWN emotions.

Spirituality was also located elsewhere. The few workers in St Z's who claimed to understand and/or to provide spiritual care mostly conceptualised it metaphorically as "getting deeper" with patients, that is, as accompanying patients elsewhere: DEEP. Similarly, Stanworth (2003: 219) states that conversations with patients can occur at different "depth[s]" (although she does not reflect on this as a metaphor), and in her book she considers the stories of their experiences which hospice patients may tell in "deeper" conversations (and which are often framed metaphorically). Ross (1998) also uses the metaphor of DEEP when she discusses UK nurses' understandings of spiritual care. She defines "deep" spiritual care as "being with" patients, and this echoes the sense of workers in St Z's that spiritual care involves accompaniment. Some workers in St Z's said that "getting deeper" with patients also meant

getting “close,” a metaphor which is often used to describe intimate relationships by nurses (Savage, 1995) and others in the “West,” as in Finnish hospice workers’ talk of “closeness” with patients (Utriainen, 2004).

The metaphoric location of feelings within a person is also a “Western” trope. Froggatt (1998) discusses UK nurses’ metaphoric understanding of the body as a container for emotions, and Anderson (2001) considers how UK bereavement counsellors locate grief inside a person. Similarly, Rob George (a palliative care consultant) has developed an “egg” concept, with the physical part of a person overlaying the emotional, and, at the centre, the spiritual (Swire & George, 1997). This strongly parallels Dr Marshall’s sense that people comprise layers: “ego, a thin layer of emotion, and a deeper spiritual self.”

Two studies, by Ross (1998) and Utriainen (2004), which consider the perceptions of workers in hospice/palliative care have particular resonances with this study of St Z’s and with each other. As noted, Ross (1998) defines “deep” spiritual care as “being with,” which is a related concept to “being there.” Finnish hospice workers understood “being there” or “closeness” in terms of their own “nakedness,” and said that they found this very difficult (Utriainen, 2004: 134). Workers in St Z’s who defined spiritual care mostly said that it meant “getting deeper” with and/or “closer” to patients, and they also said that this was hard to do. Dr Marshall spoke of spiritual care as removing the outer layers of ego and emotion so that “the soul is laid bare,” a metaphor related to “nakedness.”

However, the Finnish workers defined “nakedness” differently for themselves than for patients. For themselves, “nakedness” meant removing their professional skills and roles, so that they became “nothing but a human being beside another human being” (Utriainen, 2004: 134), and they perceived this “nakedness” positively. In contrast, they perceived patients’ “denuding”

as involving an additional step: the removal of layers of patients' "personal qualities" (ibid.), which they perceived negatively, and sought to resist.

That is, to these Finnish hospice workers "being there" or "closeness" meant a more limited "nakedness" than patients' "bare souls." Although these workers' model of the self was also "layered," with a person's professional persona overlaying their more "personal" qualities, they defined these "personal qualities" as something social; constructed and sustained through social interaction. They sought to preserve patients' "personal qualities" through talk and touch (that is, continuing social interaction), which they conceptualised metaphorically as "wrapping" patients. When these Finnish workers spoke of seeking to become a human being alongside the patient, therefore, this seems to mean a social being. They sought to remove their own professional identities, but to retain (and so not go "deeper" than) patients' (and their own) social personae.

Conversely, those few Scottish hospice workers in my study who felt able to define spiritual care located the spiritual part of a person beneath ego and emotion, or people's more public or social "layers" or "levels." Thus, for them, spiritual care meant accompanying patients "deeper," going through their other "levels" to reach their deepest and strongest "you," which was located beneath or beyond their social/relational "you" (Sister Deborah's "Marion and Colin"). This deepest "you" was hence less social, and perhaps less individualised, but yet the most "you."

This movement "deeper" or "closer," beyond the superficial, or the "usual chat," therefore meant passing through patients' emotional levels/layers, and so could mean encountering distressing (DOWN) emotions. This contradicted the attempts of most workers in St Z's to "cheer up" patients, that is, to counter patients' distress by encouraging their metaphoric movement UP, away from DOWN emotions. These workers sought to keep conversations "basic," and keep

patients “here,” by stopping them metaphorically going elsewhere. Perhaps by doing this these workers, like the Finnish workers, were “wrapping” patients, seeking to retain their social identity. In turn, this suggests that “getting deeper” with a person entails “unwrapping” them and in some way moving beyond their social identity; that is, going through their social and emotional “levels” or “layers” to finally reach the spiritual; their “bare soul.” However, if a person’s emotional “layer” overlays their spiritual “layer,” movement away from emotion also means moving away from spirituality. The majority of workers in St Z’s, in seeking to avoid patients’ distress by “cheering them up,” did not go through patients’ emotional “levels” and, therefore, did not (could not) reach their spiritual “levels.”

CONCLUSION

The micro-analytic techniques of discourse analysis, by paying attention to the detail of what people say, and how they say it, enable us to increase our understanding of their perceptions. Exploring the detail of how workers in one particular hospice (“St Z’s”) used space and spatial metaphors provides particular insights into their attitudes towards and understandings of death and spiritual care, and into how these were interwoven.

Death in St Z’s was privatised, located somewhere other than “here,” both physically: in private spaces, and metaphorically: DOWN, which has strong negative connotations. These connotations were reinforced by the attempts of most workers to “cheer up” patients, and so counter DOWN or distressing emotions. Thus, both death and distress were perceived negatively and as things to be avoided.

Spiritual care was understood as involving “getting deeper” with patients, so spirituality was also metaphorically located elsewhere: DEEP. DEEP can be inwards rather than downwards, so DEEP metaphors are more neutral than DOWN metaphors, and do not share their negative connotations. Nevertheless, workers who went DEEP with patients risked encountering DOWN emotions, and this contradicted “cheering up” patients. Thus, while getting deeper did not have negative connotations of itself, doing so might mean that workers encountered issues which did have such connotations. However, since “getting deeper” with patients meant workers doing something additional to their usual activities: metaphorically going elsewhere with patients or accompanying them “beyond” the “usual chat,” workers could choose whether or not they “got deeper.” Most chose not to, but instead sought to “cheer up” patients and thus to move away from “deep” conversations.

DOWN and DEEP metaphors are common in the UK, but this paper has shown that close examination of their particular use by workers in one Scottish hospice increases understanding of how those workers conceptualised death and spiritual care, and, perhaps, of why most workers did not “get deeper” with patients. Although the findings discussed are specific to this particular hospice, the paper has also highlighted that useful comparisons can be made with other studies of how people use metaphors. Attention to the use of metaphors by people in comparable situations elsewhere might therefore repay further study.

An ethical note: anonymity

The focus of this paper requires giving details of the physical layout of the hospice concerned, and these might enable anyone familiar with the hospice to identify it. However, the research

discussed was conducted during 1998-9, and, at the suggestion of my examiners, my PhD was embargoed for a period of time after my viva. While, therefore, it might be possible to identify the hospice, and so (despite the use of pseudonyms) to identify workers and patients, no patients and few workers remain from when I conducted my fieldwork, and the structure and organisation of the hospice have changed considerably since then. It is also worth noting that after completing my thesis I gave a copy of it to the hospice and asked for any comments. I received no negative feedback from anyone there.

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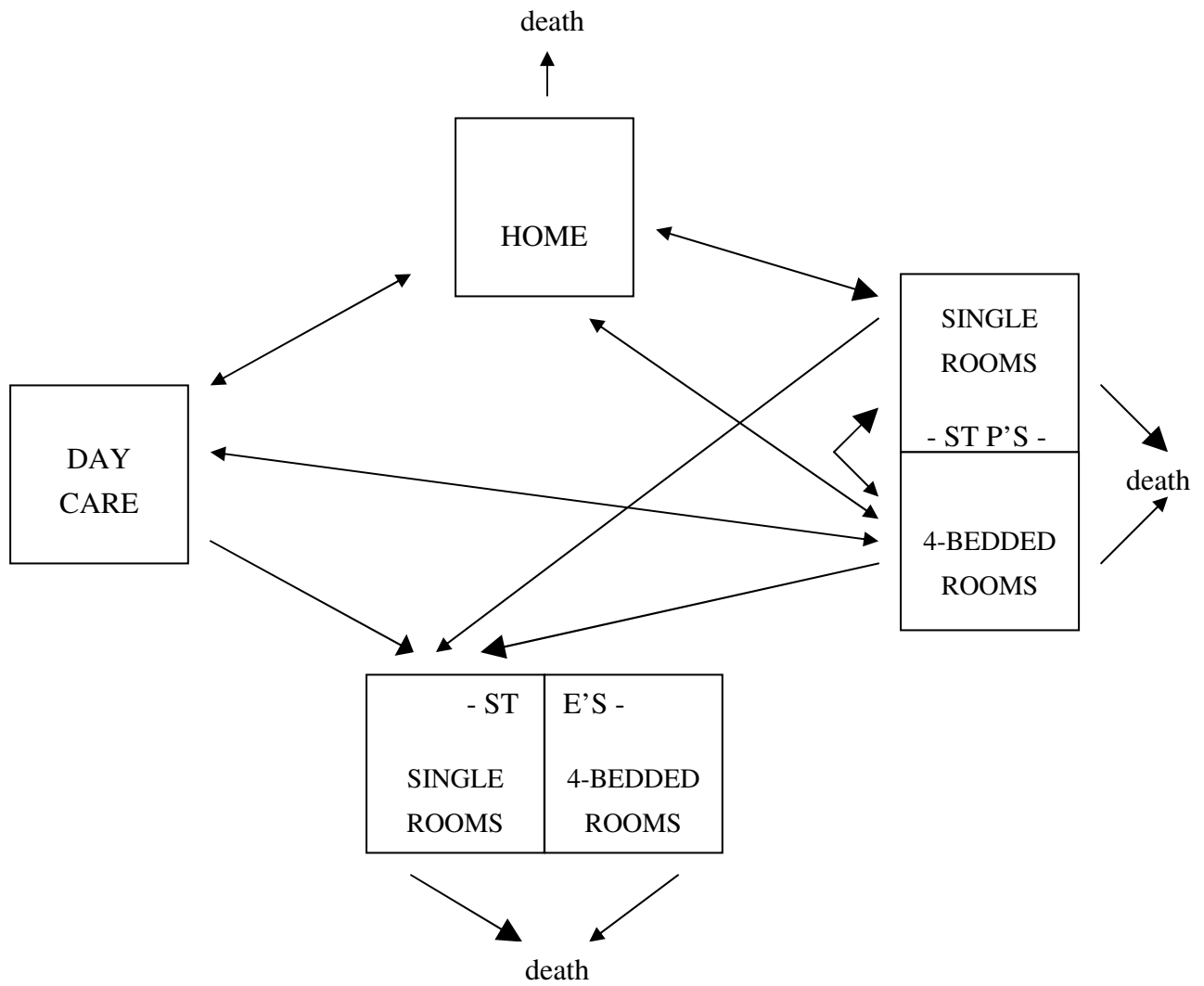
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FIGURE 1: Palliative care patients' physical location and movement in St Z's



NOTES TO FIGURE 1

Arrows track palliative care patients' movement, with size of arrow heads roughly indicating proportions of patients.

“St P’s”: palliative care ward. “St E’s”: elderly care ward.

- Long-term stays rare in 4-bedded rooms on St P’s, common in 4-bedded rooms on St E’s
- Rare for palliative care patients to be in 4-bedded rooms on St E’s
- On both wards patients stayed in single rooms for relatively shorter times
- Few people died in 4-bedded rooms on either ward; most deaths in single rooms
- Patients “going down/hill” in 4-bedded rooms on St P’s were moved to single rooms on that ward

FIGURE 2: Metaphorical location and movement in conceptualising spirituality and spiritual care

<p><u>Spirituality</u></p> <p>What you're left with</p> <p>Everything that goes on inside</p> <p>The pragmatic, material things drop away</p> <p>The soul is laid bare</p>
<p><u>Spiritual care</u></p> <p>Strip away the ego side</p> <p>Getting beneath the skin</p> <p>Get at the step beyond the leg</p> <p>Go beyond</p> <p>Get to something deeper than that</p> <p>Deeper than just your usual chat</p>

¹ I use pseudonyms for all the people I discuss in this paper. These pseudonyms both indicate how people were usually addressed in the hospice, and also, related to this, whether people were workers or patients (the term “patient” is not ideal (Savage, 1995), but convenient for distinguishing these people from workers). Most workers called the medical director and the second medical consultant Dr plus surname, and called the nuns Sister plus first name. All other workers were called by their first names. I follow these patterns for pseudonyms, and indicate professional roles via initial letters, such that the “M” in “Dr Marshall” indicates the medical director, “S” in “Sarah” or “Senga” indicates a staff nurse, and so on. Many patients shared first names, in which case people in St Z’s referred to them by their first name plus surname, so as to distinguish them from one another. I therefore use first names followed by an initial, e.g. “Jimmy M,” to indicate patients.

² This may appear contradictory since, as noted, Christians conceptualise heaven as being UP. However, people go (UP) to heaven after death, so there is no contradiction in death itself being DOWN.

³ This could be conceptualised as care which came from her spirit.

⁴ This could be conceptualised as care for patients’ spirits.

⁵ These repetitions countered the phatic characteristics of “how are you?” which, as Coupland, Coupland & Robinson (1992) note, are powerful even in health care settings. “Phatic” means something which does not seek to convey information but is spoken in order to set a pleasant mood, and Coupland et al. show that even in health care situations “how are you?” is often heard as a conversational opener rather than a request for information.

⁶ This was in relation both to providing spiritual care and also to talking about it with me, possibly because both situations entailed doing similar things (that is, talking about similar issues).

⁷ As is evident, for example, in my own belated recognition that they were in fact metaphors; I understood the meaning of these phrases without it ever being explained to me.