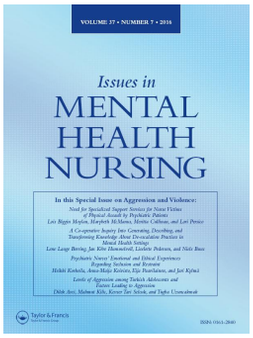

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Navigating between Compassion and Uncertainty – Psychiatric Nurses' Lived Experiences of Communication with Patients Who Rarely Speak

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ABSTRACT

Caring conversations are considered essential in psychiatric and mental health nursing. However, some patients are more or less silent and rarely express themselves verbally. This can be challenging for nurses who also need to find ways of communicating with these patients. Therefore, the aim of this study is to describe psychiatric nurses' lived experiences of communication with patients who rarely speak. Five nurses were recruited from a psychiatric nursing home. Participants were encouraged in interviews to reflect on their experiences of caring for patients who are more or less silent. The transcribed interviews were subject to a phenomenological hermeneutic analysis. The findings are reflected in three main themes: (i) giving space for the unspoken narrative, (ii) remaining in uncertainty, and (iii) being in reflective vigilance. The themes were synthesised and reflected on in the light of Fredriksson's theory of caring conversations. The comprehensive understanding reveals that nurses' understanding of the patient's unspoken narrative relies both on compassion and a willingness to engage, but also on a preparedness to remain in the uncertainty of not knowing. Balancing good intentions and the fear of one's own shortcomings requires reflections not only in actions during encounters with the patient, but on actions. When nurses can apprehend and respond to what the patient expresses non-verbally, a joint narrative can emerge.

Introduction

As a newly graduated nurse, employed at a psychiatric ward in a hospital in a rural area, the first author experienced how listening to patients' narratives was a powerful tool not only for understanding them, but also for establishing trust and providing person-centred psychiatric care. Even though most patients were active in such conversations and appeared willing to share their experiences with the nurses, he also met some who were more reluctant and even silent. This gave rise to questions regarding the predominant understanding of ongoing and trustful dialogues between nurses and patients, dialogues that are so pivotal in psychiatric and mental health nursing (Ådnøy Eriksen et al., 2014; Barker, 2002; Fredriksson & Eriksson, 2001; Freshwater, 2007; Grant et al., 2015; Palmer, 2007). What happens when a joint, caring conversation is difficult, or even impossible? How can the nurse understand patients who do not share their history or express their needs and dreams orally? In what way might caring be different when the patient's communication is non-verbal? Questions like these remained in his head, and when enrolled in a specialist nurse education in mental health and psychiatric nursing. These questions became the point of departure for his master thesis, which in turn was developed into this article.

Background

In the literature there are many explanations explaining why patients suffering from mental health problems do not speak or have difficulties in expressing themselves verbally. Sometimes, such as in patients with severe cognitive impairments and learning disabilities, they have not developed sufficient language skills. Silence might also be understood as part of their mental health problems, such as imperative voices telling patients to be silent or indicate distrust, resistance or other ruptures in the alliance with nurses and other professionals (Middlewick, 2014). Some patients suffer from both intellectual shortcomings and mental illness, making it even more complicated (Bakken et al., 2017). In addition, these patients may also have less or different, non-verbal communication behaviours than others, thus making communication even more challenging (Cohen et al., 2016; Hartley & Birgenheir, 2009; Worswick et al., 2018).

Given these challenges it is not surprising that the importance of being able to interact with patients beyond

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words has been acknowledged for many years (Phillips, 1966). In other words, being silent is not the same as not communicating. However, despite literature stressing the importance of striving to understand patients who do not speak (Blakeman et al., 2013; Ward, 1974), the focus in psychiatric nursing and caring science research has primarily been on non-verbal communication as a complement to the spoken language, rather than viewing it as the patients' primary way to communicate.

In non-psychiatric contexts research has been conducted describing nurses' interactions with patients who have communication disabilities, mainly aphasia (Gordon et al., 2009; Pound & Jensen, 2018; van Rijssen et al., 2019). In psychiatric nursing there is less research focussing on caring for and communicating with patients who never or rarely speak. Previous research highlights non-verbal communication as being especially important in order to get to know patients who have difficulties in expressing themselves verbally (Martin et al., 2012; Phillips, 1966) or with patients who avoid expressing their inner struggle verbally, for example with such things as suicidality, even though they are able to talk about ordinary life (Rytterström et al., 2019). Hence, nurses need to recognise and interpret patients' non-verbal communication and adjust their communicative actions to the situation (Minardi, 2013).

For example, non-verbal communication is important when encountering aggressive behaviour. When nurses can interpret patients' behaviour, and when they have the courage to gently touch them, anxiety and aggressiveness can diminish, as patients become more secure and able to manage their own feelings and behaviour (Burns, 2015). Hence, non-verbal communication is essential in de-escalation techniques (Lavelle et al., 2016). Physical touch, gestures and the tone of the voice also affect the therapeutic interaction with patients suffering from psychosis in a positive way (Bowers et al., 2010). Pounds (2010) observed that when nurses approached patients suffering from schizophrenia in a way that both verbally and nonverbally demonstrated concern, the patients became more open and this increased their communication. It is also important to reflect together with peers about how to understand and approach patients (Lowe, 1992; Price & Baker, 2012).

In addition, validation techniques have been described as valuable when interacting with less verbal adults with intellectual disabilities and mental illness (Bakken et al., 2017). There are also articles describing therapeutic interventions that address patients' communication difficulties from different perspectives such as linguistic methods (Clegg et al., 2007; Hagan & Thompson, 2014), sensory-motoric approaches (Peciccia et al., 2015) and Augmentative and Alternative Communication (Braddock et al., 2017; Mohan et al., 2019; Stans et al., 2018).

Thus, in the vast majority of the studies we have found, non-verbal aspects of communication have been considered primarily as something that occur parallel to the spoken language, either as something that amplifies the verbal message or contradicts it. Focus has mainly been on nurses' use of non-verbal communication in specific situations or on patients' non-verbal expressions, or on specific methods to facilitate communication and support language development. Less focus has been on nurses' experiences of caring for patients without being able to engage in a caring conversation, and on how they approach more or less silent patients in order to understand them and their caring needs. Therefore, the aim of this study is to describe psychiatric nurses' lived experiences of communicating with patients who rarely speak.

Material and methods

Different qualitative approaches have been developed to support research on human existence, and thus to understand peoples lived experiences. Two main approaches are phenomenology and hermeneutics. Both have their roots in philosophy concerned with our being-in-the-world, and how we interpret and make sense of this world (Dahlberg et al., 2008; Thomas & Pollio, 2002). Based on different philosophers' writing, several research methods have been developed. In this study we used a phenomenological-hermeneutical method based on Ricoeur's (1991, 1995) philosophy. The method focuses on interpreting the meaning of the text and expressing it on a general level. During the analysis the text is de-contextualized, and re-contextualized on a general, theoretical level. However, in line with Wiklund et al. (2002) we want to do justice to participants' narratives and avoid depriving them of their context too fast. In the following section we describe the context in more detail than is normally the case. This is motivated as we, in line with Thomas and Pollio (2002) and Dahlberg (2006), perceive the context both as the ground towards which the figure, i.e. participants' experiences appears, and as something that is constituted by participants way of understanding and acting in the world. Hence, a description of the context facilitates further understanding and discussion of the findings.

Participants and settings

As we wanted to find participants who, rather than encountering more or less silent patients once in a while, cared for persons with these difficulties on a regular basis, we recruited participants from a small nursing home where people suffering from severe mental health problems were cared for, often for many years. Patients were often admitted to the nursing home as a last resort, as their long-term caring needs were hard to fulfil in the traditional psychiatric care provided at the hospital as well as in community home care services. In contrast to the medical paradigm that underpins hospital care, the care given at the nursing home was guided by explicit values rooted in a Nordic tradition of caring science. as a human science (Arman et al., 2015; Eriksson, 1990). At the core of this tradition is an effort to understand the patient as a unique human being, where caring is described as a natural phenomenon where the patient's world, health and suffering as well as dignity and vulnerability is given primacy. This became visible when one of the participants described the common area:

Table 1. Example of the thematic structural analysis.

Meaning unit	*Condensation*	*Sub-theme*	*Theme*
It is much more challenging with those (the silent patients) who have difficulties in expressing themselves, because then it is up to you, and you need to decide if you want to view them as a subject or an object.	Make a deliberate decision about how to view the person	Remaining in a "not-knowing" position	Giving space for the unspoken narrative to unfold
It's not only with your gaze, but also how you approach the patient and what you express with your body. You need to be responsive to what the other is comfortable with, when coming to closeness, touch and a proper distance. You can't just step over his borders and think that you know what he needs – even if you want to do good	Being responsive in order to avoid being intrusive	Striving to reduce differences in power	
There is also this dimension, when you just spend time and do things together. Then I usually have this ordinary everyday talk. Even if he doesn't answer I can still … have a conversation when I do my tasks, and he is there with me, without having to give me a lot of answers. (…) I confirmed that person by sitting down, like "you are worth being a part of a community" …	Spending time together in silence, and confirming the other person's value	Strengthening patients' experiences of value and dignity through involvement	

> There, in front of the fireplace, which is an ancient symbol for tranquillity and safety, you can gather and just be together. Some come close, others sit a bit further out, depending on how much closeness they can manage [—] And that is okay, they are appreciated just for being there (Nurse 1).

All meals were cooked on site by a professional chef, and patients and staff ate together. Hence, the caring culture was homelike, although the staff did not live at the nursing home. Even though patients had psychiatric diagnosis and medications, further diagnosis or medical adjustments were not in focus, neither was cognitive assessments nor psychological testing or treatments. Rather the goal was to provide the patients with a meaningful and dignified life despite their illness.

Twelve patients lived at the nursing home. Their diagnoses were often related to psychosis and cognitive disabilities, sometimes in combination with each other. Among them there were several persons who never or rarely spoke. The nature of these patients' language vulnerabilities differed, but a common factor was that they had spoken earlier in life. This does not mean that silence and other communicative challenges are interchangeable. Rather "never or rarely speaks" aims at a general description to exclude communication difficulties related to congenital physical dysfunctions.

Different professions worked at the nursing home, among them eight nurses. When recruiting participants, we deliberately excluded the nurse leader who spent less time with the patients. The remaining seven nurses were informed about the study and five volunteered. The participants consisted of four women and one man, aged between 26-49 years old. They had between 1.5−13 years of experience in nursing.

Data collection and analysis

Brinkmann and Kvale (2014) put forth that interview data are co-created rather than gathered. This means that the quality of data is not only dependent on participants experiences and willingness to share their experiences, but also on the interviewer's preparation. The interviewer should have enough knowledge about the context to be able to enter the world of the participants and ask relevant questions, as well as to listen simultaneously and remain open for participants' narratives. In this study, the interviewer (first author) had knowledge about the nursing home as it was situated in the same county as the hospital where he had worked, even though it had a different organisation. He was also familiar with the nursing-homes caring science perspective and value-base, as well as the environment.

To prepare for the interview, participants were asked to reflect in advance about what happened during caring occasions, together with silent or less verbal patient, and how they understood those occasions, both the positive and the more challenging. The interviews lasted approximately an hour (+/- 10 minutes) and took place at a location chosen by the participants. Two participants preferred a quiet room at the nursing-home, three chose their own homes. The interviews took their point of departure in participants' reflections on the issues above. Participants were asked to describe the scene as vividly as possible, what they found as significant for understanding the world of the patient and his/her personal needs and wishes, as well as their experiences of being able to apprehend a response from the patient on their own verbal as well as non-verbal actions. Other questions focussed on "What happened next?", for example "What did you notice in regard to the patient's reactions?". Further questions, such as "What thoughts guided you in that situation?" and "How did you feel?" were posed in order to explore the topic.

The interviews were digitally recorded, transcribed verbatim and subject to a hermeneutical-phenomenological analysis developed by Lindseth and Norberg (2004) based on Ricoeur's (1991, 1995) philosophy of interpretation of texts as a movement between understanding and explanation, and back to understanding. This approach has three steps. The first, naïve understanding, placed focus on the meaning of the text, i.e. the transcribed interviews as a whole. In the second interpretive step, the thematic structural analysis (Table 1), focus was placed on the parts in order to challenge the naïve interpretation, add new possible interpretations, and create a distance to the researchers' pre-understanding by de-contextualizing the text. The text was divided into meaning units. These were condensed, i.e. the essential meanings were described as concisely as possible, reflected on and abstracted into themes and sub themes. In

Table 2. Overview of themes and subthemes.

Theme	Sub-theme
Giving space for the unspoken narrative to unfold	Acknowledging communicative actions. Striving to reduce differences in power. Strengthening patients' experiences of value and dignity through involvement. Sharing time. Being compliant with the patient's needs and personal preferences.
Remaining in uncertainty	Remaining in a "not-knowing" position. Approaching patients' behaviours as messages rather than problems.
Being in reflective vigilance	Being attentive to one's own non-verbal expressions. Being able to bridle oneself. Being reflective with peers.

line with Ricoeur (1995) this is also understood as an explanatory step that supports the interpretation, before returning to understanding in the following step. In the comprehensive understanding the results from the previous steps were related to each other and synthesised into a new understanding of the whole. This also means that the findings are re-contextual on another level of abstraction, where reflections are not only linked to theory but to human existence. In line with Ricoeur's (1976) thinking this abstraction contributes to the readers understanding of the text in relation to their own lives, rather than putting focus on understanding the lives of the specific participants.

Theoretical frame of reference

As the study originated from an interest to understand challenges associated with caring conversations with patients' who, perhaps for unknown reasons, were more or less silent the theoretical framework is based on Fredriksson's theory about caring conversations (Fredriksson, 1999; Fredriksson & Eriksson, 2003; Fredriksson & Lindström, 2002; Priebe et al., 2018). As Fredriksson describes, caring conversations are communicative acts that go beyond the verbal content, involving three aspects of communication. These are relational, ethical and narrative. These aspects will be integrated with the findings in the comprehensive understanding.

Ethical considerations

The study was conducted in accordance with the Helsinki declaration (World Medical Association, 1964/2013). In line with the Swedish Ethical Review Act, the MSc-project was first subject to ethical procedures at the university. This included a written application, as well as an ethical seminar where the study was discussed with other students as well as with the supervisor and the examiner of the course. After approval at the university a formal request, including ethical considerations and a risk-benefit analysis as well as a declaration about confidentiality and storage of data (in line with GDPR), was sent to the head of the nursing home who approved the data-collection. All nurses were given written information about the study, the right to withdraw and about confidentiality. Due to the specific setting, considerations about confidentiality were also made in line with Damianakis and Woodford's (2012) recommendations for qualitative research with small connected communities. To reduce the risk of other professionals at the nursing home identifying participants and linking quotes to persons, we have only given brief details about the nurses as a group, not as individuals.

Results

The presentation of findings follows the three interpretive steps suggested by Lindseth and Norberg (2004). Hence, the presentation of findings also expresses a hermeneutic movement between the whole and its part, between understanding and explanation, and back.

Naïve interpretation

Caring for—and thus also communication with—patients who rarely speak is experienced as a complex phenomenon. Even though communication is not always explicit, it is still present and affects human relationships. Nurses describe that in order to avoid enhancing patient suffering, non-verbal communication needs to be understood as an expression of mutuality and inter-connectedness between patients and nurses, not reduced to a part of an illness behaviour. In order not only to understand patients' needs, but to support mutual understanding, nurses need to be present and responsive as well as reflective. When nurses succeed in this endeavour, they can learn from the patient and respond adequately to the patient's needs.

Thematic structural analysis

This resulted in three themes and ten sub-themes. The themes are presented in sub-headings, while the sub-themes are referred to in *italics*. The findings are also summarised in Table 2. The themes and sub-themes describe a possible way to interpret and make abstractions from a text based on a few peoples' experiences, in a way that might also have relevance for other persons in other contexts. This also means that the text turns towards explaining (Ricoeur, 1995). Quotations are used to validate the interpretation. Furthermore, assumptions made about patients' reactions describe the participants' understanding of non-verbal communication and their reasoning about it, not the authors' beliefs.

Giving space for the unspoken narrative to unfold

Getting to know a patient who doesn't confide verbally is hard, and the nurses tries to find other possibilities to communicate and share experiences with the patients. Therefore,

it is considered as important *to acknowledge communicative actions*.

This weekend we had a dramatic situation at the home, and this patient became scared. I was doing things in the kitchen, and once in a while he came and stood beside me, shoulder to shoulder. I felt as if he was recharging from me and checking in to a safe place at the same time. Nobody said anything. And sometimes I tapped his shoulder with my hand. I was cutting a salad and perhaps I said that we were about to eat soon, but the meal was not the important thing. It was this shoulder to shoulder connection. And that didn't require any words. So, in his way he is very communicative. We were told that he doesn't have a language, but wow, he has a language if you just open your eyes (Nurse 4).

When nurses demonstrate that they try to understand the patient, the patient appears to be more willing to approach the nurse again. In the long run, this can enable the nurse and the patient to develop a mutual way to communicate.

Nurses are also *striving to reduce differences in power* by means of their own non-verbal communication to confirm the patient. This is related both to a humbleness for the other as a fellow human being that should "be met and valued like anybody else" (Nurse 2), and a special concern for individual challenges. In order to communicate on equal terms glances, touch and gestures can all be used in addition to nurses' verbal communication to assure patients that they are seen and taken care of.

> It is indeed important to sit down and show the patient, who might have been running around all day, that 'everything is okay, we can find some peace and tranquillity together'. It's a question about making yourself available, you need to really be there to be approachable, so that the patient can sense that he is invited on his own terms (Nurse 1).

Even if the nurses do not understand the patients fully, they believe that their active attempts to understand and their willingness to be with the patient even when it is difficult, communicate a concern for the patient's wellbeing. This is also part of *strengthening patients' experiences of value and dignity through involvement*. This involvement stretches beyond patient participation such as making a nursing care plan together. It is rather a question of being engaged with other people. This includes a constant, but undemanding, invitation to take part in different activities together with others. This could, for example, mean that the nurses are open about what will happen during the day, and that it is OK for the patient to be a passive observer of different activities. The patient's presence is acknowledged, but no demands are placed on the patient to be more active. Hence the patient is valued for just being there and being with others in a silent mode.

> There is also this dimension, when you just spend time and do things together. Then I usually have this ordinary everyday talk. Even if he doesn't answer I can still… have a conversation when I do my tasks, and he is there with me, without having to give me a lot of answers. He is listening, and I want to believe that his language development, benefits from it (Nurse 2).

Hence, silence is not viewed as objecting to being involved in community with others. Instead the nurses are challenged to find out what kind of activities or joint conversations appear as interesting and stimulating for the patients and build on that.

This also means an awareness of the importance of *sharing time* as something more than just setting aside time for conversations and other activities. It is a way of communicating to the patient that he/she is valuable and worth investing time in, and that the time patients chose to spend with the nurses is valued. By sharing time with patients, nurses can help patients who might have difficulties relating to and communicating with others, to interact on their own terms.

> The more time you spend together, the more you get some kind of insight into the whole picture, instead of just observing short sequences of something and making conclusions (Nurse 5).

> The times I feel that I have failed are the times I haven't been able to give as much time as needed. I have not been able to give him the time he need to show and make me understand (Nurse 3).

By consciously giving and receiving time, and being reflectively present and attentive to the unspoken, nurses can learn to recognise patients' individual patterns of communication and find ways of connecting to the person. This facilitates understanding and enables nurses to respond to the patient's expression in a way that appears as helpful in the current situation. This is also a way of *being compliant with the patient's needs and personal preferences* rather than striving to get the patient to comply with routines on the unit.

> Of course, there are rules, but you can't be too rigid. Take the kitchen as an example. You must uphold hygiene, and there needs to be a certain order as you prepare food for everybody there, both patients and staff. But sometimes I think that it is more important that this person is there, even if he doesn't have his slippers on. After all, he is not putting his feet where the food is. This breaks from normal routines, but if you notice that he is about to be anxious the most beautiful thing you can do is to ignore that he is in his socks, and let him come in, stay in the background (Nurse 4).

This tolerance is also rooted in an awareness that "these patients might often have problems with closeness. They want to be there, but on their own terms, and at a safe distance" (Nurse 2), and "being seen, more directly, can be scary and make them feel exposed" (Nurse 1). This understanding of the other includes an awareness of when, for example, withdrawal and silence are part of the patient's way of being and managing suffering, and when a similar behaviour increases patient suffering. Thus, nurses strive to interpret and differentiate non-verbal clues, in order to identify the patient's actual state of being as this can fluctuate over time. Based on this understanding, nurses can adjust and choose interventions that are appropriate in relation to current needs, whether it is leaving the patient alone or actively intervening.

Remaining in uncertainty

In situations where verbal communication is limited, it is considered important to remain in the present moment together with the patient. As the patient's non-verbal messages might be ambiguous and difficult to interpret, nurses

are exposed to their own feelings of insecurity and need to have the courage to *remain in a "not-knowing" position* to be open and attentive for the unspoken.

> For those who have most difficulties in verbalizing their needs, we have the greatest obligation to try and figure out what they want to say … to really stop together with the person who is in a vulnerable position and strive to understand (Nurse 4).

This is often more challenging than when the mutual interaction is facilitated by verbal communication. Nurses described that they need to be willing, dedicated and engaged and not resign when the patient does not give a verbal response. This requires attentiveness to everything from the directly visible expressions such as looks, gestures, outreach, touch etc., to more subtle clues such as deliberate silence from a patient who can communicate verbally. The nurses also strive *to approach patients' behaviours as messages rather than problems* in demanding situations that give rise to frustration.

> They often present with behaviours that are challenging for us. Someone might throw things, or pee on the floor instead of going to the toilet. It is easy to see these as problem behaviours, which I don't think is what the patient wants. But maybe that is the only way to act to get attention. [—] For some, closeness and kindness are unfamiliar, and difficult and scary, even though they need it (Nurse 1).

This does not mean that "anything goes". Rather, it is a matter of not focussing on the problematic behaviour but on the situation and what the patient might try to accomplish. This requires nurses' patience, and that they are able to communicate a concern for the patient rather than a critique. This is not easy.

> Sometimes a patient gets under my skin, and most of all I would just jump up and down. Then I have to take many deep breaths and try to be as professional as possible in the situation. But (later on) a soundproof room or something can be effective, as you need to let your frustration get out in order to let it go (Nurse 3).

Being in reflective vigilance

Not only do nurses need to be present and vigilant about what happens with the patients. Nurses also expressed an awareness about their impact on the patient, for good and for worse. This required *being attentive to one's own non-verbal expressions* and how and what one communicates. For example, nurses' non-verbal communication could be a threat to mutual trust and collaboration.

> If he is stressed, and we are stressed, it becomes a vicious circle not only for him, but for all our patients, impacting on the whole atmosphere. If we go quickly, seem stressed, pull our shoulders up and talk fast, just as you do when you are stressed, it is contagious. And our non-verbal communication spreads in a negative way and affects everyone (Nurse 2).

Nurses need to thus be aware of how, for example, their own experiences of shortcomings or insecurity are transferred in encounters with patients. From the nurses' perspective this is especially important when interacting with people who might have difficulties in expressing their ambiguity about what the nurse communicates to them. Without clarification, based on the nurse self-reflection, patients might have to guess what the nurse meant, contributing to anxiety and mistrust.

Being in a reflective vigilance is not only a matter of being attentive to one's own way of being with others. It can also be understood as *being able to bridle oneself,* i.e. to slow down and even take a step backwards. This includes an awareness that even though one might have good intentions as a nurse, the patient might value other things in life. Thus, nurses must take care not to act too quickly on their urge to do good. If the patient is not in danger and others are also safe, nurses need to wait for the patient and strive to find out what the person appreciates and desires, rather than be over-ambitious and make an extensive nursing-care plan.

> What might be a minor issue for me can be overwhelming for the patient. So, in some ways you must constantly try to find out where the patient is. I can't pull the patient into my world. It is I who am a guest in the patient's world (Nurse 4).

If the nurse is too eager to deliver nursing interventions, even interventions that appear as evident and adequate from the nurse's perspective might be experienced as intrusive by the patient. This might contribute to patients experiencing themselves as not being involved in their own care, and to patients withdrawing from relations as well as from different caring activities. Another aspect of bridling oneself is to accept that some patients might more easily connect and communicate with a colleague. When such situations occur, the nurse needs to accept that nurses are all different just like people. This could be understood as a part of our humanity; some people connect and communicate more easily, and if a patient who has difficulties communicating with others finds someone to communicate with, this is understood as a step forward for the patient rather than as a sign of not being good enough or as the patient being manipulative.

As the nurse-patient interaction is demanding, nurses need support from others. Peers are often able to give feedback on one's caring behaviour and acknowledge what works as well as what one might reconsider. By *reflecting together with peers* about one's experiences, it is possible not only to get new perspectives on the patient's caring needs due to different understandings of the patient, but also to be aware of one's own reactions and receive support from others when facing difficulties.

> It is important to set aside time and sit and discuss these things … to really sit down so everybody can reach an understanding of how somebody is working with a patient and how that person succeeds in resolving some situations in a smooth way. Because everybody can't connect to everybody, but if the staff who manage to connect share his or her understanding of the situation and of what works, it can be very valuable. Talking (with each other) is important (Nurse 5).

With a shared understanding of the patient and his/her caring needs, it is easier to find solutions and ways of being with the patient that work and that do not violate the patient's dignity. In order to be helpful, joint reflections need to be dialogues, not debates. In other words, it is a question of letting different perspectives contribute to

finding what is the correct, valid understanding. Such openness to different possible understandings can also generate new, creative solutions in regard to caring.

Comprehensive understanding – Navigating between compassion and uncertainty

To understand the "inside" of another person is challenging even when we are able to speak with each other. When the other person does not use words to communicate it is even more challenging. However, the absence of words does not mean that silent patients do not communicate, only that they communicate in a different way. In order to understand the patient and his/her caring needs, nurses need to engage in "listening" to the silent narrative that is expressed beyond words. In addition, making deliberate use of one's own non-verbal communication skills rather than relying on the spoken word, is also a way of responding to patients' communication on more equal terms. In line with Fredriksson and Eriksson (2003) description of the ethical aspect of the caring communication this could be understood as a means of balancing the asymmetry of the relationship with reciprocity.

Caring communication relies on nurses' ability to 'be-with' the patient compassionately in the present moment (Fredriksson, 1999), despite their own feelings of shortcomings and frustration. This is in contrast to 'ordinary' caring conversations where the spoken language facilitates a mutual understanding of the patient's situation and at least part of his/her inner life. The silence of the other person forces nurses to face an unknown territory where they are unable to receive verbal reassurance that they have understood the patient correctly. Without a preparedness to remain in a sense of uncertainty and doubt in situations where it is hard to reach through or understand the patient, there is a risk that nurses, inadvertently strive to control the situation in order to reduce their own feelings of shortcomings, or that they intervene based on their own assumptions about what is best for the patient or more convenient in relation to house rules.

Hence, responding to an unspoken narrative requires also requires a reflective vigilance towards one's own behaviour. These reflections, on one's own as well as together with peers, are not only about how to interpret the patient's expressions, but also about oneself and how one's own actions contribute to the patient's understanding of him/herself as well as the situation. Even though the patient's narratives of life and suffering (Fredriksson & Eriksson, 2001; Fredriksson & Lindström, 2002) is not evident as a verbal story, a joint narrative emerges during the caring encounters. This silent narrative is understood as contributing to the patient's trust in others as well as in his/her own ability to communicate personal needs (Priebe et al., 2018).

Hence, in this study, both self-reflection and reflection with peers, are understood as a means not only to understand the patient, but to guarantee that nurses' ambition to "do good" and "be understanding" does not take focus away from the patient's message. Rather, nurses need to be patient and bridle their own understanding, as well as strive to make sure and validate their understanding of the patient with the patient, thus constantly supporting the patient's resources and dignity. Even when communication is beyond words it could contribute to the patient's self-understanding and enable the person to view him/her self as a person who others consider as valuable and important.

Therefore, caring for patients who rarely speak could metaphorically be described as experiencing oneself as navigating between compassion and insecurity. The vulnerability of the patient calls for actions to relieve the suffering of the person, but what kind of actions this might be is not clear. In the absence of words nurses are faced with a riddle, a mystery, where the patient provides non-verbal clues. These can be confusing for the nurses, even when reflecting on them together with peers, as there is no obvious answer. But when there is, it is rewarding for both the nurse and the patient.

> And when you are able to listen and follow the signs (—) and you manage to get through and do the right thing and receive that confirmation, a high five, then you become touched as he feels understood (—) and that we have accomplished this together (Nurse 1).

Discussion

As far as we know, research about communicating with more or less silent patients in psychiatric care is sparse. Existing research has focussed on non-verbal communication as part of the interaction in therapeutic relationships, and its importance when striving to understand and diminish aggressive and challenging behaviour (Bowers et al., 2010; Burns, 2015; Lowe, 1992; Pounds, 2010). As in our study, previous research highlights that awareness of patients' non-verbal communication facilitates both the establishment of a therapeutic and caring relationship, as well as the management of complex situations. However, this study also adds understanding of nurses' experiences of non-verbal communication with patients who rarely communicate verbally and are often considered as "difficult" patients. Experiences of not being understood, and/or not being able to influence one's care increases a person's sense of powerlessness and of ill health (Ådnøy Eriksen et al., 2014; Strandmark, 2004). As a contrast nurses' understanding of patients' non-verbal communication can increase patients' experiences of safety and trust (Pounds, 2010)

In this study we also found that working with the patient's narrative of his/her life and suffering is not only a question about nurses gathering information about the patient's history or using verbal approaches to support the patient's self-reflection and reconciliation with suffering. In line with Bakken et al. (2017) we found that nurses might need to communicate in a predominantly non-verbal way, and that this was considered as a means to communicate on equal terms and providing patients who might suffer from experiences of neglect and of not being considered, new experiences of being respected and considered as valuable and worth investing time and engagement in. Such

experience could thus be considered as new building blocks in patients' unspoken narratives, just as valuable as verbal interaction. Thus, being engaged in a reciprocal non-verbal communication has much in common with what has been described as the caring in listening (Koskinen & Lindström, 2015). This is challenging and requires not only a reflective presence, but also what has been described as reflective practice by other researchers (Ekebergh, 2007; Gerace et al., 2018; Jack & Miller, 2008). Such reflection in and on action is not only a question about understanding patients' caring needs, it also has ethical implications as it focuses on vital aspects of human interactions. As the nurses in our study convey, the fact that a person is unable to verbalise his/her needs and desires, does not mean that he/she is not aware of them, nor that the person doesn't have any idea about what is helpful. This has also been described by Birnbaum (2017) who puts forth the importance of joint and embodied activities and nurses' creativity to exchange meaning when conventional language is not available. She describes a way of communicating with patients, gestural bridges, that goes beyond technique and conversational methodologies. These body-based encounters are in line with the way of being and creating meaning together with patients described by the participants, even though Birnbaum's approach is more systematically developed and grounded in theory.

Even though a mutual exchange of meaning is pivotal, we also need to be aware that, from a lifeworld perspective, it is impossible to fully understand another person. And more important, from an ethical point of view it is not even desirable as it would violate the infinity and otherness of the patient (Todres et al., 2014). In line with this understanding it is rather what can be described as "reaching towards" the patient in a communicative act that matters, not a complete understanding.

When we planned this study, the intention was to learn more about how nurses communicate with patients who rarely speak. Participants generously shared their experiences and we went ahead with the phenomenological-hermeneutical analysis as described by Lindseth and Norberg (2004). The themes and sub-themes reflect their experiences – or at least our interpretation of the interview texts. In a way our findings widen the horizon in regard to nurses' communication with more or less silent patients.

Simultaneously there are similarities, both with previous research on communication in general and on caring. This gives rise to questions about whether we have been unable to put our pre-understandings aside, and just confirm what has already been described in other settings. That might, of course, be the case. Another explanation is that this is a matter of interconnectedness between human experiences and thus a phenomenon in caring. In line with the principles of figure and ground, we conceive that communication and caring are simultaneously there, supporting and constituting each other (Thomas & Pollio, 2002), and is impossible to consider one without the other. Yet they are different as communication could also be un-caring (Halldórsdóttir, 1996) and giving rise to what Eriksson (2006) describes as suffering from care. From a lifeworld perspective the essence is the invariant meaning structure of a phenomenon (Dahlberg, 2006). In other words, the similarities could be understood as related to the essence of two interrelated phenomenon, caring and communication. However, there are also nuances expressed in the themes that might be specific for the specific context.

Methodological considerations

Five nurses took part in the interviews. At first glance this might be considered as low.

However, as phenomenological hermeneutic research is not a question of numbers but of meaning, issues about trustworthiness need to address whether data are sufficient, rather than on the number of participants. Given the purposive recruitment of participants and that the results contribute new understanding, data were considered sufficient. Therefore, without claiming that the results represent all nurses, it is transferable, as generalisations are made by abstractions to recognisable themes rather than by numbers. Trustworthiness is also related to truthful narratives of lived experiences (Lindseth & Norberg, 2004). Therefore, the interviewer (first author) strove to engage participants in a dialogue where they felt free to narrate, and to hold back his own pre-understandings, thus being open for participants' perspectives (Wiklund-Gustin, 2010). Finally, trustworthiness is also an issue related to valid interpretations. Hence, joint reflections were made between the researchers throughout the interpretive process. In addition, the interpretation was also reflected on at a seminar with nurses working in and studying psychiatric nursing.

Conclusion

In one way caring for patients who express themselves non-verbally is about applying the caring ideals and ethos that are supposed to guide all nursing care, Yet, it is different and more challenging, as the patient's vulnerability also involves communication difficulties. This requires reflection and creativity from the nurses, who take on a specific responsibility to find ways to reach through to the patients that goes beyond the spoken language. This calls for reflection, not only on the patients' but also on one's own non-verbal communication and contribution to the patients' experienced narrative of him/herself as valuable and capable.

Relevance for clinical practice

This study adds an understanding of nurses' experiences of communication with patients who, as part of their mental health problems, have difficulties with verbal communication.

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