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Caring for individuals with suicidal ideation: rudiments of interpersonal interactions and relationships in mental health nursing

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List of Abbreviations

CoNuPaS	Contact with Nurses from the perspective of Patients with Suicidal ideation
e.g.	exempli gratia (for example)
et al.	et alia (and others)
HCW	healthcare workers
i.e.	id est (that is)
N/A	not applicable
PaCT-PSY	patient participation culture tool for inpatient psychiatric wards
SD	standard deviation
URL	Uniform Resource Locator
WHO	World Health Organization

Chapter 1. General Introduction

Nursing care for individuals with suicidal ideation needs to be an interpersonal endeavour, characterised by meaningful contact, where nurses connect with patients as unique individuals and engage in collaborative and therapeutic interactions. Unfortunately, in mental health (nursing) practice, policy, and education, interpersonal aspects of care are often overlooked, partly because they are difficult to grasp in research and not appreciated in healthcare cultures dominated by medicalised, observation-led, and containment-oriented approaches. It is therefore of paramount importance to better understand the rudiments of interpersonal interactions and relationships in the context of providing nursing care for individuals with suicidal ideation. This knowledge can drive reforms in suicide prevention and treatment of suicidal ideation, and support a context wherein patients can participate in their care and treatment by accessing nurses who interact with them as unique individuals, in sensitive and competent ways.

1.1. Definitions and language relevant to caring for individuals with suicidal ideation

In this dissertation, the focal point of research is not suicidality *per se*. Rather, suicidality was the area of application for examining the interactions and relationships between nurses and individuals with suicidal ideation. Therefore, it is important from the outset to consider the language and definitions used to refer to suicidality, the study population, and the studied constructs. Given the nature and goals of the studies in this dissertation, some definitions and wordings are preferred over others.

1.1.1. Definitions concerning suicidality

The nomenclature concerning suicidality has been the subject of considerable international debate (Klonsky et al. 2016). Is his early work, Shneidman (1985, p. 203) defined **suicide** as: ‘a conscious act of self-induced annihilation, best understood as a multidimensional malaise in a needful individual who defines an issue for which the suicide is perceived as the best solution’. De Leo and colleagues (2006, p. 12) defined suicide as ‘an act with fatal outcome, which the deceased knowing, or expecting a potentially fatal outcome, has initiated and carried out with the purpose of bringing about wanted changes’. This latter definition includes a focus on ‘intent to die’ (i.e. wanted changes), thereby capturing the common ambivalence

of individuals regarding life and death. This definition is used most often internationally and is also used by the World Health Organisation (Goodfellow et al. 2018).

In addition to suicide deaths, **suicide attempt** is defined as: 'any non-fatal suicidal behaviour and refers to intentional self-inflicted poisoning, injury or self-harm which may or may not have a fatal intent or outcome' (WHO 2014, p. 17). According to Van Orden and colleagues (2010, p. 3), a suicide attempt includes the following components: self-initiated, potentially injurious behaviour, presence of intent to die, and non-fatal outcome. Furthermore, a common description used in research and practice is **suicidal ideation,** which is defined as thinking about, considering, or planning suicide (Klonsky et al. 2016, p. 309). According to Jobes and Joiner (2019, p. 27), suicidal ideation includes specific plans to die and explicit intent to die imminently.

Further adding to the diversity of suicide research terminology, some authors use **suicidality** or **suicidal behaviour** as general terms encompassing any suicidal thought, feeling, or attempt (Goodfellow et al. 2018). In this dissertation, the term suicidal behaviour was considered unsuitable to the study objectives because it indicates observable events that require and encourage a focus on preventative actions and behavioural control (Jobes & Joiner 2019). Therefore, the term is limited within the context of interpersonal interactions and relationships, where the need for openness and understanding regarding the individual's thoughts, feelings, behaviours, and experiences (e.g. hopelessness) in an interpersonal context (e.g. disconnecting from others) is essential (Berg et al. 2017; Talseth & Gilje 2018). In this dissertation, 'suicidal ideation' and 'suicidality' were used in place of 'suicidal behaviour' as a stand-alone term, because they allow more attention to the spectrum of suicidal thoughts, feelings, and behaviours; the spectrum that was also voiced by the research participants.

Moreover, this dissertation embraced the notion that suicide attempts and suicidal ideation can be part of a common **suicidal process** that can develop over a shorter or longer period (Retterstøl et al. 1993). According to van Heeringen (2001), the suicidal process starts with suicidal ideation that can progress to suicidality that evolves through suicidal ideation, suicide plans, and communication regarding suicidal ideation, growing through often recurrent suicide attempts with increasing lethality and suicide intent, and ending with suicide. This understanding of suicidality as a dynamic phenomenon rather than a static event is consistent with the multidimensional nature of suicide (Shneidman 1985), and the recovery processes described by individuals with suicidal ideation (Lakeman & FritzGerald 2008).

1.1.2. The use of inclusive language in an interpersonal context

Using inclusive and person-first language to refer to the study population was preferable and necessary. With respect to the dignity and worth of each individual and their lived experiences, 'patients/persons/individuals with suicidal ideation' was preferred over 'suicidal patients/persons/individuals' because the latter description is potentially impersonal and stigmatising since it defines persons by their suicidality. Such a description is less appropriate within the context of this dissertation, where it is acknowledged that every human being is a unique **person**, that is 'an individual who stands in the world in her or his own subjective way, feels, thinks, imagines, values, gives meaning, independently acts and makes choices, is responsible, and has her or his own value and dignity' (Deproost 2018). Additionally, the term **'nurses'** is used throughout this dissertation to refer to nurses employed on psychiatric hospital wards, except for the instrument development and validation study in Chapter 2—which focused on mental healthcare professionals more broadly—and the international systematic review in Chapter 6, which also included emergency and community-based care.

This dissertation focuses on interactions and relationships. This acknowledges that interactions influence relationships but also that interactions do not necessarily or automatically lead to interpersonal relationships. In this sense, the term **interpersonal** connotes: 'from person to person'. Additionally, it is important to know how the studies operationalised the concepts and constructs. Chapters 2 and 3 present two quantitative studies that focus on **patient participation** in the context of psychiatric wards in hospitals. Based on their concept analysis, Castro and colleagues (2016) proposed the following definition: 'patient participation revolves around a patient's rights and opportunities to influence and engage in the decision-making about his care through a dialogue attuned to his preferences, potential and a combination of his experiential and the professional's expert knowledge'. While the two studies with a patient participation focus were developed based on existing conceptual models, the other constructs in this dissertation, such as **'contact'** and **'working alliance'** were not defined in advance, but emerged and were conceptualised from the perceptions and experiences of the research participants. This openness was important and particularly prioritised in the qualitative research data collection and analysis.

1.2. The occurrence of suicide, suicide attempts, and suicidal ideation

This doctoral study emerged from a national and international context where the occurrence and burden of suicide, suicide attempts, and suicidal ideation are considerably high.

1.2.1. Occurrence of suicidality in the world

Worldwide, suicide is the eighteenth leading cause of death, accounting for 1.4% of all deaths (WHO 2019). More than 800 000 people die by suicide each year, which equates to one suicide every 40 seconds (WHO 2019). In addition to suicide deaths, suicide attempts and suicidal ideation warrant global attention. For every individual who dies by suicide, it is estimated that up to 30 individuals attempt suicide and even more individuals experience suicidal ideation (Bachmann 2018). Cross-national studies report an estimated one-year prevalence of 0.4% for suicide attempts and 2% for suicidal ideation; plus a lifetime prevalence of 3% for suicide attempts and 9% for suicidal ideation (Borges et al. 2010; Nock et al. 2008). Suicidal ideation and suicide attempts are predictive of suicide deaths. This is especially the case for suicide attempts as there is evidence indicating that a history of suicide attempts is the strongest risk factor for suicide and holds strong predictive value. For suicidal ideation, the evidence indicates an increased risk but a lower predictive value. Furthermore, when the suicidal ideation contains suicidal plans, the suicide risk increases substantially (Franklin et al. 2017).

Suicidal ideation and suicide attempts result in long-lasting burdens for those affected and closely involved (e.g. relatives and healthcare professionals) and lead to adverse consequences at the personal, economic, and community levels, including injury, disability, and hospitalisation (WHO 2014). Given the profound impact of suicide, many countries and regions have developed national or regional suicide prevention plans containing several prevention strategies and actions (Zalsman et al. 2016).

1.2.2. Occurrence of suicidality in Belgium

Belgium is among the countries with a very high suicide rate. The age-standardised suicide rate of 16.9 per 100.000 population is above the global average and one and a half times higher than the mean within the European Union (van Landschoot et al. 2018). In Flanders (northern part of Belgium), 978 people died from suicide in 2017, which is nearly three suicides per day, and suicide is the leading cause of death in young people and adults between the ages of 15 and 49 (Agentschap zorg en gezondheid 2017). In addition to suicide deaths, the national Health Interview Survey in 2018 showed that around 13.9% of the Belgian population aged 15 years and older have seriously thought of suicide at least once in their lives, with 4.3% having such thoughts in the past year (Gisle et al. 2020). Furthermore, 4.3% of the population aged 15 and older reported that they have attempted suicide at least once in their lives, with 0.2% attempting suicide in the past year (Gisle et al. 2020).

Given Belgium's ongoing high occurrence of suicide, suicide attempts, and suicidal ideation, suicide prevention has become a priority. In Flanders, suicide prevention was put on the policy agenda in 2006 when the first of two Flemish Action Plans for Suicide Prevention were published (2006-2010 and 2012-2020) (Department of Welfare, Public Health and Family 2012). The second Action Plan focused on five strategies, including: (1) mental health promotion (e.g. encouraging help-seeking, reducing stigma); (2) provision of helplines and online help; (3) educating (mental) health professionals and community facilitators about suicide prevention; (4) developing programs targeting high-risk groups; and (5) developing and implementing guidelines for suicide prevention (Department of Welfare, Public Health and Family 2012). An evaluation of the second Flemish Action Plan will take place in the second half of 2020. The development of the third Flemish Action Plan is planned for 2021.

1.3. Mental healthcare and the priority of suicide prevention and treatment

Within the scope of this dissertation, it was important to consider contemporary evolutions within national and international mental healthcare as well as in suicide prevention and treatment of suicidal ideation.

1.3.1. Contemporary evolutions in mental healthcare

Internationally, mental healthcare has implemented significant reforms characterised by restructuring mental healthcare service delivery and implementation of strategies to reduce stigma, encourage person-centred treatment, and improve continuity of care (Thornicroft et al. 2016). One common element in the reforms is the shift from hospital-based care toward community-based care (Thornicroft et al. 2016). A factor driving this shift is the international evidence that individuals frequently report negative experiences with inpatient mental health services, indicating that care and treatment within this context does not meet their needs (Cutcliffe et al. 2015). Patients often do not feel involved in care planning and risk management decisions (Coffey et al. 2019). Moreover, their experiences are often devoid of warm respectful interactions, information and choice about treatment, and therapeutic relationships. Instead, their experiences are often characterised by stigma, coercive practices, and professionals who impose controlling interventions. This is not to say that all interactions are negative. For example, positive experiences have been described where patients were allowed to share their distress and were involved in care planning (Cutcliffe et al. 2015, Frueh et al. 2005, Kontio et al. 2012, Waldemar et al. 2019).

In Belgium, mental healthcare has also undergone several reforms over the last decades with a focus on (Lorant et al. 2016, Mistiaen et al. 2019, p. 50):

- shifting from hospital-based toward community-based care to enhance the treatment of people with mental health problems in the community
- supporting the (re)socialisation of mental healthcare to change society's perception of mental health (e.g. reduce stigma)
- encouraging a shift from a medical model toward a holistic biopsychosocial model of care
- promoting person-centred care tailored to patients' needs
- specialising care for specific sub-groups

To date, despite the increase in community-based care, the residential nature of services (including day hospital care) continues to dominate mental healthcare in Belgium (Mistiaen et al. 2019). Indeed, Belgium has the second highest ratio of inpatient psychiatric beds among countries within the Organisation for Economic Co-operation and Development (OECD) (Mistiaen et al. 2019). Beyond the movement toward community-based care, other directions of the mental healthcare reform become increasingly visible. For example, in line with the World Health Organization's priorities (WHO 2013), the Belgian Federal Government has drawn ongoing attention to the importance of patient participation in the quality of care and patient safety. Three multi-annual programmes (2007-2012; 2013-2017; 2018-2022) were funded to improve patient participation, in particular, through educating and training healthcare professionals (Federal Public Service Health, Food Chain Safety and Environment 2020).

Furthermore, the aim of fostering patient participation and person-centred care is evident in several initiatives within mental healthcare, including the development of quality-indicators pertaining to shared decision-making (Mistiaen et al. 2019), and research focusing on recovery in mental health (De Ruysscher et al. 2020), patient participation during multidisciplinary team meetings (Berben et al. 2019, Vandewalle et al. 2016), and developing peer worker roles (Vandewalle & Debyser et al. 2017). However, several recent studies in Flanders suggest that the mental healthcare system is still dominated by a narrow medical model, characterised by medicalising approaches (e.g. high prevalence of psychotropic medication use) (Mistiaen et al. 2019), as well as patient experiences of coercion and power (Verbeke et al. 2017), and stigma and shame in relation to help-seeking, care, and treatment (Reynders et al. 2014, Sercu & Bracke 2017).

From an overarching perspective, the literature reveals contradictions in the extent to which inpatient mental health services include principles of holistic, collaborative, and person-centred care. A large number of psychiatric hospitals still find it challenging to align such

principles with existing medical ideologies, psychotherapeutic treatments, and surveillance and containment-oriented measures (e.g. seclusion and restraint). Given these insights, it is clear that national and international mental healthcare would benefit from new research-based knowledge that is consistent with transformations toward patient participation and person-centred care.

1.3.2. Suicide prevention and treatment of suicidal ideation in mental healthcare

While acknowledging that suicide prevention and suicidal ideation treatment are not limited to inpatient mental healthcare, psychiatric hospitals are important help-seeking avenues for persons with suicidal ideation (Stene-Larsen & Reneflot 2017). Patients admitted to psychiatric hospitals represent a high risk population, with a suicide risk of 40–50 times higher than the average population (Madsen et al. 2012, Walsh et al. 2015). Moreover, previous research indicates that patients discharged from psychiatric wards are at higher risk than the average population for suicide and a range of other fatal and non-fatal adverse outcomes (Chung et al. 2017, Walter et al. 2019).

In Belgium, suicide prevention and suicidal ideation treatment are significant issues in psychiatric hospitals. Local studies suggest that suicide is common in this context (Meyfroidt et al. 2020), which was confirmed by Martens and colleagues (2016) cross-sectional study showing that psychiatrists and nurses commonly encounter suicide (attempts) and that these adverse events have a great impact on them. Consistent with such insights, suicide prevention is a priority in inpatient mental healthcare policies and this is evident in several initiatives. For example, quality indicators focusing on suicide prevention policy implementation have been developed and accreditation programmes increasingly incorporate an evaluation of interventions to prevent suicide, and to detect and treat suicidal ideation (Mistiaen et al. 2019). Furthermore, the Flemish Centre of Expertise in Suicide Prevention launched the ‘Multidisciplinary guideline for the detection and treatment of suicidal behaviour’ (Aerts et al. 2017). Similar to its counterpart in the Netherlands (van Hemert et al. 2012), the guideline is based on four basic principles: making contact, promoting safety, involving relatives, and ensuring continuity of care.

This guideline has relevance to this dissertation’s objectives, since it is meant for nurses working in healthcare, in addition to physicians, psychologists, and therapists (Aerts et al. 2017). The literature suggests that nurses have an advantaged and crucial position to make contact with individuals experiencing suicidal ideation. This is because they provide most of the direct care, can identify warning signs of emerging suicidal ideation, and can develop therapeutic engagement with patients (Hagen et al. 2017, Lees et al. 2014). At the same time, there is a body of evidence that describes nursing care for patients with suicidal

ideation as complex and demanding. Indeed, nurses frequently express feelings of distress, anxiety, and helplessness when caring for patients with suicidal ideation, and assert that they lack support and training in several areas of patient contact (Hagen et al. 2017, Morrissey & Higgins 2019). Moreover, previous research highlights that nurses might refrain from assessing suicide (Meerwijk et al. 2010) or withdraw from patients with suicidal ideation, for instance, because of feeling emotional discomfort or being afraid to talk about suicide (Bolster et al. 2015, Talseth & Gilje 2011). Again, such insights reflect a need for critical research focusing on interactions and relationships in the context of nursing care for individuals with suicidal ideation.

1.4. Different ways of understanding and approaching suicidality

There are different ways of understanding and approaching suicidality that are broadly relevant to mental healthcare, and more specifically relevant to nursing care for patients with suicidal ideation. In this section, two influential national and international mental healthcare perspectives are briefly discussed: the medical model and the recovery model (Fitzpatrick & River 2018, Heller 2015). The aim is not to exhaustively explore and contrast these models, but rather to describe them in a way that illuminates different ways of understanding and approaching suicidality.

1.4.1. The continued dominance of the medical model in mental health (nursing) care

The medical model continues to dominate mental healthcare delivery. This model understands and approaches suicidality from the perspective of diagnostic categorisations, objective measurement, causal explanations (e.g. neuro-biological), medical treatments, and behavioural/environmental control and observation (Fitzpatrick & River 2018, Slemon et al. 2017). The medical model has driven important developments in research (e.g. identifying suicide-related risk factors) as well as changes in treatment options, such as pharmacological therapies and environmental interventions focused on restricting access to lethal means (Franklin et al. 2017, Zalsman et al. 2016).

At the same time, the medical model has been increasingly criticised, particularly because it promotes mental healthcare that is overly characterised by medicalised, coercive, objectifying, and impersonal approaches (Cutcliffe et al. 2015, Fitzpatrick & River 2018, Lees et al. 2014, Michel & Jobes 2011). Indeed, within the strict adherence to a medical model, professionals are predominantly focused on treating underlying disorders, assessing suicide risk and screening for risk factors, and managing suicide risk through pharmacological,

custodial, and observation-led interventions (Belsher et al. 2019, Bowers et al. 2008, Runeson et al. 2017, Slemon et al. 2017). This is also seen in suicide-related research, which predominantly focuses on epidemiology and risk factors for suicide, neuro-biological issues, and efficacy of formal experiments (Franklin et al. 2017). This is often at the expense of understanding the subjective experiences of individuals with suicidal ideation within an interpersonal context (Hjelmeland & Knizek 2010).

The literature increasingly highlights the continued inability of the suicidology field to accurately predict suicide and argues that professionals must not over-rely on prediction models and assessment instruments (Bolton et al. 2015, Carter et al. 2017, Runeson et al. 2017). Alongside this inability to predict suicide, research indicates that suicide risk management procedures, such as formal observations, restraint, and seclusion, can be anti-therapeutic and their suicide prevention effectiveness is questionable (Bowers et al. 2008, Huber et al. 2016, Slemon et al. 2017). While formal observations have been associated with disempowerment and distress in people with suicidal ideation (e.g. through invasion of personal space) (Cox et al. 2010), restraint and seclusion have been associated with reduced autonomy, stigma, and traumatic experiences (Frueh et al. 2005, Kontio et al. 2012). The lack of interpersonal and collaborative engagement from professionals may contribute to patients reporting that risk management practices compound their feelings of isolation and objectification (Cox et al. 2010, Lees et al. 2014). This is evident in patients' perception of their interactions with nurses, indicating that 'nurses sit behind glass and watch you steady' (Taylor 2019, p. 7), 'make sure you're properly medicated', or 'bring you somewhere where you feel like you're isolated and locked away' (Lees et al. 2014, p. 309-310).

Within the strict adherence to a medical model, nurses fulfil subservient roles that involve upholding rules and performing tasks and protocols focused on control and observation (Barker 2001), while at the same time exercising paternalism and professional power in their interactions with patients (Fitzpatrick & River 2018, Waldemar et al. 2019). Under this model, patients with suicidal ideation are deemed passive in their interactions and relationships with nurses; they are expected to comply with treatment and must be managed and controlled (Cutcliffe & Stevenson 2008, Slemon et al. 2017). However, this focus leaves patients disempowered and disconnected because it undermines their autonomy, self-expression, and opportunities to participate in their care and treatment as well as in the community (Barker 2001, Sellin et al. 2017).

The medical model poorly equips nurses to understand the experiences of individuals with suicidal ideation and to respond to their complex and sophisticated care needs (Cutcliffe & Stevenson 2008, Fitzpatrick & River 2019, Michel & Jobes 2011). This is evident in previous literature where patients with suicidal ideation reported not being sufficiently cared for by

nurses. They described nurses as lacking respect, empathy, and compassion, who do not truly listen or acknowledge them as individuals (Samuelsson et al. 2000, Lees et al. 2014).

1.4.2. Toward a recovery-oriented mental health (nursing) care

A body of evidence is emerging regarding the importance of embracing and promoting a recovery model in mental healthcare (Farkas 2007, Leamy et al. 2011, Slade et al. 2014). From the perspective of persons with mental health problems, recovery includes a focus on clinical aspects and outcomes, such as symptom alleviation (Slade et al. 2014), and involves a range of unique processes on personal, interpersonal, and social levels (Anthony 1993). These processes often include: dealing with and overcoming difficulties; developing meaning in life, hope, and empowerment; constructing a positive identity; and experiencing connectedness and social inclusion (Leamy et al. 2011, Lloyd et al. 2008, Stuart et al. 2017).
Within the broader formulations of recovery, the literature increasingly highlights the place of social recovery (Lloyd et al. 2008). Social recovery is concerned with changing social dynamics that adversely affect an individual's life, like exclusion, stigma, and poverty, and instead support an individual's ability to develop a meaningful life by community participation and inclusion in diverse social networks, such as family, friends, and peers (Lloyd et al. 2008, Wyder and Bland 2014). A particular feature of social recovery is that it emphasises the need to transcend individualistic approaches. For example, Wyder and Bland (2014) applied the recovery framework to enable the understanding of the experiences of family members of persons with mental health problems and the impact they can have on recovery outcomes, such as helping the person to regain hope and reconnect with society. Additionally, the notion of social recovery represents an attentiveness for the development and pursuit of life-oriented goals, including goals related to employment, housing, education, and social activities (Lloyd et al. 2008).
The recovery model has been influential in the delivery and design of mental healthcare internationally (Slade et al. 2014). Mental healthcare services based on the recovery model encompass core values, including person involvement, choice and self-determination, personal responsibility, individualised goals, growth and self-development, and social inclusion (Farkas 2007). From this perspective, the recovery model contributes to a shift away from organisational cultures that are overly professionally-led, medically-oriented, and problem-focused, toward cultures that promote humanistic approaches and interpersonal relationships where the focal point of care and treatment is the lived experience of individuals with mental health problems and their relatives (Barker 2001, Heller 2015).
The recovery model suits the multidimensional nature of suicide, which includes biopsychosocial elements on personal and interpersonal levels (Leenaars 2006, Shneidman

1985, Van Orden et al. 2010). Approaching suicidality in a recovery-oriented manner requires care and treatment methods that are fundamentally relational and radically person-centred. From this perspective, professionals need to acknowledge patients as persons (Berg et al. 2017), recognise their need for trust and human connectedness (Lakeman & FritzGerald 2008), take their perspectives of suicidality into account (Hagen et al. 2018), emphasise their resources and capacity for self-management and growth (Sellin et al. 2017), and work collaboratively with their family and friends (SANE Australia 2016). These aspects reflect the evidence that interpersonal relationships can be therapeutic in themselves and should provide the grounding for more specific interventions to prevent suicide and treat suicidal ideation (Berg et al. 2017, Michel and Jobes 2011).

The importance of relationship-based care and treatment is highlighted from different perspectives and across various contexts. Burgess and colleagues' study (2000) on preventable suicides showed that 19% of suicides were found to be a consequence of poor staff-patient relationships, including relationships with low levels of empathy, compassion, support, and consideration of patients as whole persons. Furthermore, research on psychotherapy for people with mental health problems more broadly, and suicidality more specifically, shows that the therapeutic relationship/alliance and person-centred conditions (e.g. empathy, warmth) are common factors that determine psychotherapy outcomes, irrespective of the specific therapy method (Leenaars 2006, Wampold 2015).

The need for interpersonal and collaborative approaches is also reflected in specific interventions for suicide prevention and suicidal ideation treatment. There is an increasing focus on collaborative suicide risk assessment, safety planning, and crisis response planning (Bryan et al. 2017, Jobes 2012, Stanley & Brown 2012). These interventions require professionals to shift power imbalances and fully engage with individuals through partnerships and shared decision-making. Thereby, professionals can create opportunities to explore the meaning of suicidal ideation, support and negotiate resources and responsibilities, and assisting patients in developing self-understanding (Jobes 2012, Michel & Jobes 2011).

In addition, there is a rapidly increasing body of evidence regarding the effectiveness of brief contact interventions for reducing a person's suicidal ideation and behaviour. Brief contact interventions include face-to-face follow-up contacts, but can also take the form of personalised postcards, caring letters, emails, or text messages (Fleischmann et al. 2008, Comtois et al. 2019). In essence, the effectiveness of brief contact interventions is based on interpersonal and collaborative processes, including communicating care and concern, enhancing connectedness, and supporting patient-clinician engagement (Duhem et al. 2018; Milner et al. 2016, Riblet et al. 2017).

The recovery model also suits mental health nursing practice, especially because it underscores the traditional assumptions concerning the centrality of interpersonal interactions and relationships (Barker 2001, Peplau 1997). This orientation is crucial in mental health nursing, where self, interactions, and relationships are therapeutic means to affect favourable change and improve health outcomes (Cleary et al. 2012, Delaney et al. 2017, Peplau 1997). Rather than engaging with the patient as an object, a disorder, or an illness, the recovery model encourages nurses to make contact with the person and validate their experiences, as part of an interpersonal endeavour (Barker 2001), and this is particularly valuable in caring for persons with suicidal ideation (Cutcliffe & Stevenson 2008, Sellin et al. 2017).

For individuals with suicidal ideation, having access to interactions and relationships with nurses where they feel listened to, accepted, understood, empowered, and recognised as a unique individual can be lifesaving (Berg et al. 2017). In such an atmosphere, individuals with suicidal ideation are more likely to approach nurses and feel enabled to narrate their suicidal thoughts, feelings, and experiences (Berg et al. 2017). This, in turn, might help them to alleviate distress, resolve their suicidal crises, and guide them in a process of reconnecting to others and life (Cutcliffe and Stevenson 2008, Lakeman & FritzGerald 2008, Sellin et al. 2017).

1.5. General objectives and outline of this dissertation

The insights and reflections presented in the previous sections indicate that there is a need to further examine the nurses' role in and contribution to suicide prevention and treatment of suicidal ideation. In particular, the existing evidence in the context of nursing, and the limitations of current services and treatments, exemplify a clear need to explore the interactions and relationships between nurses and individuals who experience suicidal ideation.

The overarching objective of this dissertation was to enhance the understanding concerning the rudiments of interpersonal interactions and relationships between nurses and individuals with suicidal ideation, primarily in, but not limited to, psychiatric hospitals. This objective was approached from the perspective of both nurses and patients, thereby enabling the process of incorporating their perceptions and experiences into nursing care, and the evidence-base of suicide prevention and treatment of suicidal ideation. In line with recommendations for suicide-related research, both qualitative and quantitative research designs and methods were used (Abrutyn & Mueller 2019), with a particular focus on gaining understanding through qualitative research (Hjelmeland & Knizek 2010).

The dissertation is divided into nine Chapters that represent the introduction (Chapter 1), seven studies (Chapters 2-8), and a general discussion (Chapter 9). Each individual study is presented in a separate Chapter, relying on a manuscript that is published in an international peer-reviewed journal. An overview of the main parts and Chapters is presented in Table 1.

The studies begin with a focus on patient participation. More specifically, Chapters 2 and 3 present two studies on patient participation in the context of patient safety within psychiatric hospitals. The studies examined the patient participation culture in hospitals and at a micro level, explored healthcare workers' involvement, including nurses, in facilitating patient participation.

The study presented in Chapter 2 included a three-stage process to develop and psychometrically evaluate the patient participation culture tool for psychiatric wards (PaCT-PSY). The objective was to develop a validated tool to measure the patient participation culture on psychiatric wards by inventorying factors that influenced healthcare workers' willingness to share power and responsibility with patients. The 60-item tool includes two items related to suicide (e.g. 'patients need to be encouraged to identify situations or conditions that increase their risk of suicide').

Chapter 3 presents a cross-sectional study of nurses on psychiatric wards (n = 705). In this study, a multilevel model was used to analyse data gathered with the PaCT-PSY. The objective was to investigate the demographic and contextual factors that influence the

willingness of nurses to share power and responsibility concerning patient safety with patients.

Following the studies on patient participation, five studies were conducted to uncover and understand the interactions and relationships between nurses and individuals who experience suicidal ideation. Chapters 4 and 5 focus on the interactions between nurses and patients with suicidal ideation on psychiatric wards, from the perspective of nurses. Two qualitative studies were conducted to gain both broad and in-depth insights into the meanings of the nurses' experiences, and to uncover and understand the concepts and processes underpinning nurse-patient interactions. The studies were based on grounded theory, including detailed analyses and constant data comparisons (Glaser & Strauss 1967).

The objective of the study in Chapter 4 was to uncover and understand the nurses' actions and aims in their interactions with patients with suicidal ideation. This study enhanced the insight into the nurses' role in and contribution to suicide prevention and treatment of suicidal ideation. Moreover, the study highlighted that there are micro-elements in the contact between nurses and patients that needed further exploration. Therefore, the objective of the study in Chapter 5 was to uncover and understand the core elements of how nurses make contact with patients who experience suicidal ideation.

Chapters 6 and 7 focus on nurse-patient interactions from the perspective of people with suicidal ideation. The findings in the studies with nurses highlighted the complexities of nurse-patient interactions and indicated that nurses are not necessarily proficient in developing interpersonal and collaborative interactions. This called for a systematic review from the patient perspective to gain a fuller understanding of the reciprocal nature of nurse-patient interaction, and how nurse-patient interactions influence patients' experiences.
The objective of the study in Chapter 6 was to synthesise the perceptions and experiences of persons with suicidal ideation and behaviour regarding their interactions with nurses. For this purpose, a systematic review of qualitative and quantitative studies was conducted within inpatient, community mental health, and emergency services contexts. This scope was broader than this dissertation's individual studies to address community and emergency services as important help-seeking avenues for persons with suicidal ideation (Stene-Larsen & Reneflot 2017). The systematic review revealed a lack of numerical data regarding nurse-patient interaction and provided the foundation for developing an instrument.
The objective of the study in Chapter 7 was to develop and psychometrically evaluate an instrument to explore the contact with nurses from the perspective of patients with suicidal ideation (CoNuPaS). Such instrument could facilitate the numerical visibility of patient-nurse

contact in suicide prevention and suicidal ideation treatment, and in the quality of care (McAndrew et al. 2014). The qualitative study and the systematic review (Chapters 5-6) provided the point of departure for the development of the CoNuPaS, but neither of these studies were conducted with this narrow perspective *a priori* in mind. Rather, these studies were approached from an open perspective and the insights emerged and were conceptualised from the perspective of the research participants.

Chapter 8 focuses on creating a better understanding of the relationships that nurses develop with patients experiencing suicidal ideation on psychiatric wards. The insights emerging from the qualitative studies (Chapters 4-5) and the systematic review (Chapter 6) suggested that a study on nurse-patient relationships should address how nursing care interacts with predominant approaches to suicide prevention and treatment of suicidal ideation. Similar to the studies in Chapters 4 and 5, the study used a qualitative grounded theory design. Through examining the underlying dynamics, concepts, and processes of nurse-patient relationships from the nurses' perspective, the working alliance emerged as the construct from which nursing care for patients with suicidal ideation can be understood.
The dissertation ends with a general discussion (Chapter 9) that elaborates the findings from patients' and nurses' perspectives and considers factors that mediate the findings on a micro, meso, and macro level. The discussion also presents critical reflections on the study methodology and it provides recommendations for nursing practice, policy, education, and further research.

Table 1. Overview of the dissertation Chapters, including the study objectives and methods

Chapter	Study title and objective	Methods
1	General introduction	
Patient participation in psychiatric wards		
2	Title: The development and validation of the Patient Participation Culture Tool for Inpatient Psychiatric Wards (PaCT-PSY) Objective: to develop and validate the patient participation culture tool for psychiatric wards (PaCT-PSY). The tool measures the patient participation culture by inventorying the healthcare worker factors that influence their willingness to share power and responsibility with patients.	A psychometric validation study to develop and psychometrically evaluate a self-reporting instrument. Sample: 603 healthcare workers employed in psychiatric wards
3	Title: Patient safety on psychiatric wards: A cross-sectional, multilevel study of factors influencing nurses' willingness to share power and responsibility with patients Objective: to investigate the demographic and contextual factors that influence the willingness of nurses to share power and responsibility with patients concerning patient safety.	Quantitative study with a cross-sectional design using multilevel modelling. Sample: 705 nurses employed in 173 psychiatric wards within 37 hospitals
Nurse-patient interaction: nurse perspective		
4	Title: Promoting and preserving safety and a life-oriented perspective: A qualitative study of nurses' interactions with patients experiencing suicidal ideation Objective: to uncover and understand the nurses' actions and aims in their interactions with patients experiencing suicidal ideation.	Qualitative study Individual interviews with 19 nurses Grounded Theory approach
5	Title: Contact and communication with patients experiencing suicidal ideation: A qualitative study	Qualitative study

	of nurses' perspectives Objective: to uncover and understand the core elements of how nurses 'make contact' with patients experiencing suicidal ideation.	Individual interviews with 26 nurses Grounded Theory approach
Nurse-patient interaction: patient perspective		
6	Title: The perspectives of adults with suicidal ideation and behaviour regarding their interactions with nurses in mental health and emergency services: a systematic review Objective: to synthesise the perceptions and experiences of persons with suicidal ideation and behaviour regarding their interactions with nurses.	Systematic review of empirical qualitative studies and quantitative studies (n = 26). A systematic search of electronic databases in PubMed, Web of Science, Embase, and PsycARTICLES/ additional hand searching
7	Title: Contact between patients with suicidal ideation and nurses in mental health wards: Development and psychometric evaluation of a questionnaire Objective: to develop and validate an instrument to explore the Contact with Nurses from the perspective of Patients experiencing Suicidal ideation (CoNuPaS).	A psychometric validation study to develop and psychometrically evaluate a self-reporting instrument. Sample: Delphi expert-panel (n=14); cognitive interviews with patients (n=12); adult patients with suicidal ideation in the past year (n=405)
Nurse-patient relationship: nurse perspective		
8	Title: The working alliance with people experiencing suicidal ideation: a qualitative study of nurses' perspectives Objective: to enhance the conceptual understanding of nurses' working alliance with patients experiencing suicidal ideation.	Qualitative study Individual interviews with 28 nurses Grounded Theory approach
9	General discussion	

References

Abrutyn, S. & Mueller, A. S. (2019). Toward a robust science of suicide: Epistemological, theoretical, and methodological considerations in advancing suicidology. *Death Studies*, 1-6. doi.org10.1080/07481187.2019.1660081

Aerts, S., Dumon, E., Van Heeringen, K. & Portzky, G. (2017). *Detectie en behandeling van suïcidaal gedrag: multidisciplinaire richtlijn voor hulpverleners in de gezondheidszorg*. Brussel: Politeia.

Agentschap Zorg en Gezondheid. *Evolutie van sterfte door zelfdoding (2017)*. Brussel, geraadpleegd op 25.06.2020. Beschikbaar via: *https://www.zorg-en-gezondheid.be/evolutie-van-sterfte-door-zelfdoding-2017*

Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal*, 16, 11-23. doi.org/10.1037/h0095655

Bachmann S. (2018). Epidemiology of Suicide and the Psychiatric Perspective. International *Journal of Environmental Research and Public Health*, 15, 1425. doi.org/10.3390/ijerph15071425

Barker, P. (2001). The Tidal Model: developing an empowering, person-centred approach to recovery within psychiatric and mental health nursing. *Journal of Psychiatric and Mental Health Nursing*, 8, 233-240. doi.org/10.1046/j.1365-2850.2001.00391.x

Belsher, B. E., Smolenski, D. J., Pruitt, L. D. et al. (2019). Prediction Models for Suicide Attempts and Deaths: A Systematic Review and Simulation. *JAMA Psychiatry*, 76, 642-651. doi.org/10.1001/jamapsychiatry.2019.0174

Berben, K., Verhaeghe, S., Dierckx, E. & Van Hecke, A. (2019). *Participation of (in)patients during Multidisciplinary Team Meetings in Mental Healthcare*. CARE4-2019 abstract book (pp. 116-116). Presented at the CARE4 International Scientific Nursing and Midwifery Congress, third edition.

Berg, S. H., Rørtveit, K. & Aase, K. (2017). Patients experiencing suicidal ideation' experiences regarding their safety during psychiatric in-patient care: a systematic review of qualitative studies. *BMC Health Services Research*, 17, 73. doi.org/10.1186/s12913-017-2023-8

Bolster, C., Holliday, C., Oneal, G. & Shaw, M. (2015). Suicide assessment and nurses: What does the evidence show? *The Online Journal of Issues in Nursing*, 20, 2. doi.org/10.3912/OJIN.Vol20No01Man02

Bolton, J. M., Gunnell, D. & Turecki, G. (2015). Suicide risk assessment and intervention in people with mental illness. *British Medical Journal*, 351, h4978. doi.org/10.1136/bmj.h4978

Bowers, L., Whittington, R., Nolan, P. et al. (2008). Relationship between service ecology, special observation and self-harm during acute in-patient care: City-128 study. *British Journal of Psychiatry*, 193, 395-401. doi.org/10.1192/bjp.bp.107.037721

Borges, G., Nock, M. K., Haro Abad, J. M. et al. (2010). Twelve-month prevalence of and risk factors for suicide attempts in the World Health Organization World Mental Health Surveys. *The Journal of Clinical Psychiatry*, 71, 1617-1628. doi.org/10.4088/JCP.08m04967blu

Bryan, C. J., Mintz, J., Clemans, T. A. et al. D. (2017). Effect of crisis response planning vs. contracts for safety on suicide risk in U.S. Army Soldiers: A randomized clinical trial. *Journal of Affective Disorders*, 212, 64-72. doi.org/10.1016/j.jad.2017.01.028

Burgess, P., Pirkis, J., Morton, J. & Croke, E. (2000). Lessons from a comprehensive clinical audit of users of psychiatric services who committed suicide. *Psychiatric Services*, 51, 1555-1560. doi.org/10.1176/appi.ps.51.12.1555

Carter, G., Milner, A., McGill, K., Pirkis, J., Kapur, N. & Spittal, M. J. (2017). Predicting suicidal behaviours using clinical instruments: systematic review and meta-analysis of positive predictive values for risk scales. *British Journal of Psychiatry*, 210, 387-395. doi.org/10.1192/bjp.bp.116.182717

Castro, E. M., Van Regenmortel, T., Vanhaecht, K., Sermeus, W. & Van Hecke, A. (2016). Patient empowerment, patient participation and patient-centeredness in hospital care: A concept analysis based on a literature review. *Patient Education and Counseling*, 99, 1923-1939. doi.org/10.1016/j.pec.2016.07.026

Chung, D. T., Ryan, C. J., Hadzi-Pavlovic, D., Singh, S. P., Stanton, C. & Large, M. M. (2017). Suicide rates after discharge from psychiatric facilities: A systematic review and meta-analysis. *JAMA Psychiatry*, 74, 694-702. doi.org/10.1001/jamapsychiatry.2017.1044

Cleary, M., Hunt, G. E., Horsfall, J. & Deacon, M. (2012). Nurse-patient interaction in acute adult inpatient mental health units: a review and synthesis of qualitative studies. *Issues in Mental Health Nursing*, 33, 66-79. doi.org/10.3109/01612840.2011.622428

Coffey, M., Hannigan, B., Barlow, S. et al. (2019). Recovery-focused mental health care planning and co-ordination in acute inpatient mental health settings: a cross national comparative mixed methods study. *BMC Psychiatry*, 19, 115. doi.org/10.1186/s12888-019-2094-7

Comtois, K. A., Kerbrat, A. H., DeCou, C. R. et al. (2019). Effect of Augmenting Standard Care for Military Personnel With Brief Caring Text Messages for Suicide Prevention: A Randomized Clinical Trial. *JAMA Psychiatry*, 76, 474-483. doi.org/10.1001/jamapsychiatry.2018.4530

Cox, A., Hayter, M. & Ruane, J. (2010). Alternative approaches to 'enhanced observations' in acute inpatient mental health care: a review of the literature. *Journal of Psychiatric and Mental Health Nursing*, 17, 162-171. doi.org/10.1111/j.1365-2850.2009.01507.x

Cutcliffe, J. R. & Stevenson, C. (2008). Feeling our way in the dark: the psychiatric nursing care of people experiencing suicidal ideation--a literature review. *International Journal of Nursing Studies*, 45, 942-953. doi.org/10.1016/j.ijnurstu.2007.02.002

Cutcliffe, J. R., Santos, J. C., Kozel, B., Taylor, P. & Lees, D. (2015). Raiders of the Lost Art: A review of published evaluations of inpatient mental health care experiences emanating from the United Kingdom, Portugal, Canada, Switzerland, Germany and Australia. *International Journal of Mental Health Nursing*, 24, 375-385. doi.org/10.1111/inm.12159

Delaney, K. R., Shattell, M. & Johnson, M. E. (2017). Capturing the Interpersonal Process of Psychiatric Nurses: A Model for Engagement. *Archives of Psychiatric Nursing*, 31, 634-640. doi.org/10.1016/j.apnu.2017.08.003

De Leo, D., Burgis, S., Bertolote, J. M., Kerkhof, A. J. & Bille-Brahe, U. (2006). Definitions of suicidal behavior: lessons learned from the WHO/EURO multicentre Study. *Crisis*, 27, 4-15. doi.org/10.1027/0227-5910.27.1.4

Department of Welfare, Public Health and Family (2012). Voorstel voor de gezondheidsdoelstelling: preventie van zelfdoding & een Vlaams actieplan voor de preventie van zelfdoding 2012-2020. Retrieved from: www.zorg-en gezondheid.be/sites/default/files/atoms/files/Vlaams%20Actieplan%20Suïcidepreventie %202012-2020.pdf

Deproost, E. (2018). Verpleegkunde in een nieuwe geestelijke gezondheidszorg: uitdagingen en een visie voor de toekomst. *Psychiatrie en Verpleging*. Afscheidsnummer, 24-51.

De Ruysscher, C., Vandevelde, S., Tomlinson, P. & Vanheule, S. (2020). A qualitative exploration of service users' and staff members' perspectives on the roles of inpatient settings in mental health recovery. *International Journal of Mental Health Systems*, 14, 15. doi.org/10.1186/s13033-020-00347-w

Duhem, S., Berrouiguet, S., Debien, C. et al. (2018). Combining brief contact interventions (BCI) into a decision-making algorithm to reduce suicide reattempt: the VigilanS study protocol. *BMJ Open*, 8, e022762. doi.org/10.1136/bmjopen-2018-022762

Farkas, M. (2007). The vision of recovery today: what it is and what it means for services. *World Psychiatry: Official Journal of the World Psychiatric Association (WPA)*, 6, 68-74.

Federal Public Service Health, Food Chain Safety and Environment (2020). Patiëntenparticipatiecultuur op microniveau in algemene en psychiatrische ziekenhuizen. Retrieved from: https://www.health.belgium.be/sites/default/files/ugent_23.01.2020.pdf

Fitzpatrick, S. J. & River, J. (2018). Beyond the Medical Model: Future Directions for Suicide Intervention Services. *International Journal of Health Services*, 48, 189-203. doi.org/10.1177/0020731417716086

Fleischmann, A., Bertolote, J. M., Wasserman, D. et al. (2008). Effectiveness of brief intervention and contact for suicide attempters: a randomized controlled trial in five countries. *Bulletin of the World Health Organization*, 86, 703-709. doi.org/10.2471/BLT.07.046995

Franklin, J. C., Ribeiro, J. D., Fox, K. R. et al. (2017). Risk factors for suicidal thoughts and behaviors: A meta-analysis of 50 years of research. *Psychological Bulletin*, 143, 187-232. doi.org/10.1037/bul0000084

Frueh, B. C., Knapp, R. G., Cusack K. J. et al. (2005). Patients' reports of traumatic or harmful experiences within the psychiatric setting. *Psychiatric Services*, 56, 1123-1133. doi.org/10.1176/appi.ps.56.9.1123

Gisle L, Drieskens S, Demarest S, Van der Heyden J. (2020). Geestelijke gezondheid: gezondheidsenquête 2018. Brussel, België: Sciensano, Rapportnummer: D/2020/14.440/4. Retrieved from: https://www.gezondheidsenquete.be

Glaser, B. & Strauss, A.L. (1967). *The Discovery of Grounded Theory: strategies for Qualitative Research*. Chicago, IL: Aldine.

Goodfellow, B., Kõlves, K. & Leo, D. (2018). Contemporary nomenclatures of suicidal behaviors: A systematic literature review. *Suicide and Life-Threatening Behavior*, 48, 353-366. doi.org/10.1111/sltb.12354

Hagen, J., Knizek, B.L. & Hjelmeland, H. (2017). Mental Health Nurses' Experiences of Caring for Suicidal Patients in Psychiatric Wards: An Emotional Endeavor. *Archives of Psychiatric Nursing*, 31, 31-37. doi.org/10.1016/j.apnu.2016.07.018

Hagen, J., Knizek, B. L. & Hjelmeland, H. (2018). Former suicidal inpatients' experiences of treatment and care in psychiatric wards in Norway. *International Journal of Qualitative Studies on Health and Well-being*, 13, 1461514. doi.org/10.1080/17482631.2018.1461514

Heller, N. R. (2015). Risk, Hope and Recovery: Converging Paradigms for Mental Health Approaches with Patients experiencing suicidal ideation. *The British Journal of Social Work*, 45, 1788-1803. doi.org/10.1093/bjsw/bcu007

Hjelmeland, H. & Knizek, B. L. (2010). Why we need qualitative research in suicidology. *Suicide and Life-Threatening Behavior*, 40, 74-80. doi.org/10.1521/suli.2010.40.1.74

Huber, C. G., Schneeberger, A. R., Kowalinski, E. et al. (2016). Suicide risk and absconding in psychiatric hospitals with and without open door policies: a 15 year, observational study. *The Lancet Psychiatry*, 3, 842-849. doi.org/10.1016/S2215-0366(16)30168-7

Jobes, D. A. (2012). The Collaborative Assessment and Management of Suicidality (CAMS): an evolving evidence-based clinical approach to suicidal risk. *Suicide and Life-Threatening Behavior*, 42, 640-653. doi.org/10.1111/j.1943-278X.2012.00119.x

Jobes, D. A. & Joiner, T. E. (2019). Reflections on suicidal ideation. *Crisis*, 40, 227-230. doi.org/10.1027/0227-5910/a000615

Klonsky, E. D., May, A. M. & Saffer, B. Y. (2016). Suicide, Suicide Attempts, and Suicidal Ideation. *Annual Review of Clinical Psychology*, 12, 307-330. doi.org/10.1146/annurev-clinpsy-021815-093204

Kontio, R., Joffe, G., Putkonen, H. et al. (2012). Seclusion and restraint in psychiatry: patients' experiences and practical suggestions on how to improve practices and use alternatives. *Perspectives in Psychiatric Care*, 48, 16-24. doi.org/10.1111/j.1744-6163.2010.00301.x

Lakeman, R. & FitzGerald, M. (2008). How people live with or get over being suicidal: a review of qualitative studies. *Journal of Advanced Nursing*, 64, 114-126. doi.org/10.1111/j.1365-2648.2008.04773.x

Leamy, M., Bird, V., Le Boutillier, C., Williams, J. & Slade, M. (2011). Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. *The British Journal of Psychiatry*, 199, 445-452. doi.org/10.1192/bjp.bp.110.083733

Leenaars, A. (2006). Psychotherapy with Suicidal People: The Commonalities. *Archives of Suicide Research*, 10, 305-322, doi.org/10.1080/13811110600790710

Lees, D., Procter, N. & Fassett, D. (2014). Therapeutic engagement between patients in suicidal crisis and mental health nurses. *International Journal of Mental Health Nursing*, 23, 306-315. doi.org/10.1111/inm.12061

Lloyd, C., Waghorn, G. & Williams, P. L. (2008). Conceptualising Recovery in Mental Health Rehabilitation. *British Journal of Occupational Therapy*, 71, 321-328. doi.org/10.1177/030802260807100804

Lorant, V., Grard, A., Van Audenhove, C., Helmer, E., Vanderhaegen, J. & Nicaise, P. (2016). Assessment of the priority target group of mental health service networks within a nation-wide reform of adult psychiatry in Belgium. *BMC Health Services Research*, 16, 187. doi.org/10.1186/s12913-016-1434-2

Madsen, T., Agerbo, E., Mortensen, P. B. & Nordentoft, M. (2012). Predictors of psychiatric inpatient suicide: a national prospective register-based study. *The Journal of Clinical Psychiatry*, 73, 144-151. doi.org/10.4088/JCP.10m06473

Martens, J., Van Gerven, E., Lannoy, K. et al. (2016). Serious reportable events within the inpatient mental health care: Impact on physicians and nurses. *Revista De Calidad Asistencial*, 31, 26-33. doi.org/10.1016/j.cali.2016.04.004

McAndrew, S., Chambers, M., Nolan, F., Thomas, B. & Watts, P. (2014). Measuring the evidence: reviewing the literature of the measurement of therapeutic engagement in acute mental health inpatient wards. *International Journal of Mental Health Nursing*, 23, 212-220. doi.org/10.1111/inm.12044

Meerwijk, E. L., van Meijel, B., van den Bout, J., Kerkhof, A., de Vogel, W. & Grypdonck, M. (2010). Development and evaluation of a guideline for nursing care of suicidal patients with schizophrenia. *Perspectives in Psychiatric Care*, 46, 65-73. doi.org/10.1111/j.1744-6163.2009.00239.x

Meyfroidt, N., Wyckaert, S., Bouckaert, F., Wampers, M., Mazereel, V. & Bruffaerts, R. (2020). Suicide in Belgian psychiatric inpatients. A matched case-control study in a Belgian teaching hospital. *Archives of Psychiatric Nursing*, 34, 8-13. doi.org/10.1016/j.apnu.2019.12.004

Michel, K. & Jobes, D. A. (2011). *Building a therapeutic alliance with the suicidal patient*. Washington, DC: American Psychological Association.

Milner, A., Spittal, M. J., Kapur, N., Witt, K., Pirkis, J. & Carter, G. (2016). Mechanisms of brief contact interventions in clinical populations: a systematic review. *BMC Psychiatry*, 16, 194. doi.org/10.1186/s12888-016-0896-4

Mistiaen, P., Cornelis. J., Detollenaere, J., Devriese, S., Farfan-Portet, M. I. & Ricour, C. (22 October 2019). Organisation of mental health care for adults in Belgium. Brussels: Belgian Health Care Knowledge Centre. Retrieved from: https://kce.fgov.be/content/about-copyrights-for-kce-publications

Morrissey, J. & Higgins, A. (2019). "Attenuating Anxieties": A grounded theory study of mental health nurses' responses to patients with suicidal behaviour. *Journal of Clinical Nursing*, 28, 947-958. doi.org/10.1111/jocn.14717

Nock, M. K., Borges, G., Bromet, E. J. et al. (2008). Cross-national prevalence and risk factors for suicidal ideation, plans and attempts. *The British Journal of Psychiatry*, 192, 98-105. doi.org/10.1192/bjp.bp.107.040113

Peplau, H. E. (1997). Peplau's Theory of Interpersonal Relations. *Nursing Science Quarterly*, 10, 162-167. doi.org10.1177/089431849701000407

Retterstøl, N. (1993). The suicidal process. In *Suicide: A European Perspective* (pp. 135-141). Cambridge: Cambridge University Press.

Reynders, A., Kerkhof, A. J., Molenberghs, G. & Van Audenhove, C. (2014). Attitudes and stigma in relation to help-seeking intentions for psychological problems in low and high suicide rate regions. *Social Psychiatry and Psychiatric Epidemiology*, 49, 231-239. doi.org/10.1007/s00127-013-0745-4

Riblet, N. B. V., Shiner, B., Young-Xu, Y. & Watts, B. V. (2017). Strategies to prevent death by suicide: meta-analysis of randomised controlled trials. *British Journal of Psychiatry*, 210, 396-402. doi.org/10.1192/bjp.bp.116.187799

Runeson, B., Odeberg, J., Pettersson, A., Edbom, T., Jildevik Adamsson, I. & Waern, M. (2017). Instruments for the assessment of suicide risk: A systematic review evaluating the certainty of the evidence. *PLoS One*, 12, e0180292. doi.org/10.1371/journal.pone.0180292

Samuelsson, M., Wiklander, M., Asberg, M. & Saveman, B. I. (2000). Psychiatric care as seen by the attempted suicide patient. *Journal of Advanced Nursing*, 32, 635-643. doi.org/10.1046/j.1365-2648.2000.01522.x

SANE Australia (2016). Suicide Prevention and Recovery Guide: A resource for mental health professionals. Retrieved from: www.sane.org/images/PDFs/2779_SANE_SPRG_2016_06.pdf

Sellin, L., Asp, M., Wallsten, T. & Wiklund Gustin, L. (2017). Reconnecting with oneself while struggling between life and death: The phenomenon of recovery as experienced by persons at risk of suicide*. International Journal of Mental Health Nursing*, 26, 200-207. doi.org/10.1111/inm.12249

Sercu, C. & Bracke, P. (2017). Stigma, Social Structure, and the Biomedical Framework: Exploring the Stigma Experiences of Inpatient Service Users in Two Belgian Psychiatric Hospitals. *Qualitative Health Research*, 27, 1249-1261. doi.org/10.1177/1049732316648112

Shneidman E.S. (1985). *Definition of Suicide*. Northvale, Jason Aronson, New Jersey.

Slade, M., Amering, M., Farkas, M. et al. (2014). Uses and abuses of recovery: implementing recovery-oriented practices in mental health systems. *World Psychiatry: Official Journal of the World Psychiatric Association (WPA)*, 13, 12-20. doi.org/10.1002/wps.20084

Slemon, A., Jenkins, E. & Bungay, V. (2017). Safety in psychiatric inpatient care: The impact of risk management culture on mental health nursing practice. *Nursing Inquiry*, 24. doi.org/10.1111/nin.12199

Stanley, B. & Brown, G.K. (2012). Safety Planning Intervention: A Brief Intervention to Mitigate Suicide Risk. *Cognitive and Behavioral Practice*, 19, 256-264. doi.org/10.1016/j.cbpra.2011.01.001

Stene-Larsen, K. & Reneflot, A. (2019). Contact with primary and mental health care prior to suicide: A systematic review of the literature from 2000 to 2017. *Scandinavian Journal of Public Health*, 47, 9-17. doi.org/10.1177/1403494817746274

Stuart, S.R., Tansey, L. & Quayle, E. (2017). What we talk about when we talk about recovery: a systematic review and best-fit framework synthesis of qualitative literature. *Journal of Mental Health*, 26, 291-304. doi.org/10.1080/09638237.2016.1222056

Talseth, A. G. & Gilje, F. L. (2011). Nurses' responses to suicide and suicidal patients: a critical interpretive synthesis. *Journal of Clinical Nursing*, 20, 1651-1667. doi.org/10.1111/j.1365-2702.2010.03490.x

Talseth, A. G. & Gilje, F. L. (2018). Responses of persons at risk of suicide: A critical interpretive synthesis. *Nursing Open*, 5, 469-483. doi.org/10.1002/nop2.169

Taylor, P. (2019). System entrapment: Dehumanization while help-seeking for suicidality in women who have experienced intimate partner violence. *Qualitative Health Research*, 1-17, doi.org/10.1177/1049732319857671

Thornicroft, G., Deb, T. & Henderson, C. (2016). Community mental health care worldwide: current status and further developments. *World Psychiatry: Official Journal of the World Psychiatric Association (WPA)*, 15, 276-286. doi.org/10.1002/wps.20349

Vandewalle, J., Debyser, B., Beeckman, D. et al. (2017). "Constructing a positive identity": A qualitative study of the driving forces of peer workers in mental health care systems. International *Journal of Mental Health Nursing*, 27, 378-389. doi.org/10.1111/inm.12332.

Vandewalle, J., Vercruysse, L., Dhondt, T. (2016). Patiënten op de teamvergadering: Inspiratiegids Kliniek Sint-Jozef Pittem. https://www.sintjozefpittem.be/fileadmin/media/pdf/Documenten/inspiratiegids_patient_op_team_FINALE_VERSIE.pdf

van Heeringen, K. (2001). *Understanding Suicidal Behaviour: The Suicidal Process Approach to Research, Treatment and Prevention*. Chichester, UK: John Wiley & Sons.

Van Hemert, A. M., Kerkhof, A. J. F. M., De Keijser, J. et al. (2012). Multidisciplinaire richtlijn diagnostiek en behandeling van suïcidaal gedrag. Utrecht: De Tijdstroom. Retrieved from: https://www.ggzrichtlijnen.nl/suicidaal-gedrag

van Landschoot, R., van Heeringen, K., Portzky, G. (2018). Epidemiologisch rapport. De Vlaamse suïcidecijfers in een national en international context. Retrieved from: https://www.vlesp.be/assets/pdf/epidemiologisch-rapport-2018-nl-114841.pdf

Van Orden, K. A., Witte, T. K., Cukrowicz, K. C., Braithwaite, S., Selby, E. A. & Joiner, T. E. (2010). The Interpersonal Theory of Suicide. *Psychological Review*, 117, 575-600. doi.org/10.1037/a0018697

Verbeke, E., Vanheule, S., Cauwe, J., Truijens, F. & Froyen, B. (2019). Coercion and power in psychiatry: A qualitative study with ex-patients. *Social Science & Medicine*, 223, 89-96. doi.org/10.1016/j.socscimed.2019.01.031

Waldemar, A. K., Esbensen, B. A., Korsbek, L., Petersen, L. & Arnfred, S. (2019). Recovery-oriented practice: Participant observations of the interactions between patients and health professionals in mental health inpatient settings. *International Journal of Mental Health Nursing*, 28, 318-329. doi.org/10.1111/inm.12537

Walsh, G., Sara, G., Ryan, C. J. & Large, M. (2015). Meta-analysis of suicide rates among psychiatric in-patients. *Acta Psychiatrica Scandinavica*, 131, 174-184. doi.org/10.1111/acps.12383

Walter, F., Carr, M. J., Mok, P. L. H. et al. (2019). Multiple adverse outcomes following first discharge from inpatient psychiatric care: a national cohort study. *The Lancet Psychiatry*, 6, 582-589. doi.org/10.1016/S2215-0366(19)30180-4

Wampold B. E. (2015). How important are the common factors in psychotherapy? An update. *World Psychiatry: Official Journal of the World Psychiatric Association (WPA)*, 14, 270-277. doi.org/10.1002/wps.20238

World Health Organization (2013). Exploring patient participation in reducing health-care-related safety risks. Retrieved from: www.euro.who.int/data/assets/pdf_file/0010/185779/e96814.pdf

World Health Organization (2014). Preventing Suicide. A Global Imperative. Geneva, Switzerland: WHO Press. Retrieved from: https://apps.who.int/iris/bitstream/handle/10665/131056/9789241564779_eng.pdf

World Health Organisation (2019). Suicide data. Retrieved from: https://www.who.int/mental_health/prevention/suicide/suicideprevent/en/

Wyder, M., & Bland, R. (2014). The recovery framework as a way of understanding families' responses to mental illness: balancing different needs and recovery journeys. *Australian Social Work, 67*, 179-196. doi.org/10.1080/0312407X.2013.875580

Zalsman, G., Hawton, K., Wasserman, D. et al. (2016). Suicide prevention strategies revisited: 10-year systematic review. *The Lancet Psychiatry*, 3, 646-659. doi.org/10.1016/S2215-0366(16)30030-X

Chapter 2. The development and validation of the patient participation culture tool for inpatient psychiatric wards (PaCT-PSY)

Based on:
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Abstract

Patient participation is an important topic in mental health and receives increased attention along with deinstitutionalisation. No tool exists to measure healthcare worker-related factors that influence patient participation. A three-staged study was conducted to develop and validate the 'Patient Participation Culture Tool for inpatient PSYchiatric wards' (PaCT-PSY), and to analyse its psychometric properties (n = 603). The 60-items tool, comprising thirteen components, showed content validity, strong psychometric properties, and a high internal consistency. The PaCT-PSY measures the patient participation culture on psychiatric wards by exploring healthcare worker's factors influencing patient participation. It can enable researchers, practitioners and administrators to develop tailored actions to promote patient participation.

2.1. Introduction

2.1.1. Background

The evidence-based recovery model highlights the opportunities for individuals with mental health problems to live a meaningful existence and to fully participate in the community (Bird et al. 2014; Storm & Edwards 2013). Since the 1970's (Talbot 1979), this emphasis on social inclusion and participation is reflected in the ongoing deinstitutionalisation of mental health services and the establishment of community-based care (Liégois & Van Audenhove 2005). To adapt to these evolutions, mental health services are expected to be responsive for patients' needs and to include the patients' perspective (Boutillier et al. 2011; Farkas et al. 2005). When meeting these expectations, mental health services can recognise the desire of patients toward active participation in care and decision making, and the patient's potential to contribute to the quality of mental health services (Adams et al. 2007; Grundy et al. 2015, Hamann et al. 2005; Storm & Edwards 2013; Stringer et al. 2008).

Enhanced patient participation implies that mental healthcare workers (HCWs) facilitate opportunities for active involvement of patients in their care and treatment (Stringer et al. 2008). In addition to recognising the patient's right to be involved in the care process (Tambuyzer et al. 2011), patient participation induces several clinical advantages, such as reduced seclusion and restraint, enhanced self-management of medication, and a decreased number of readmissions (De las Cuevas et al. 2012; Gagnon et al. 2013; Sledge et al. 2011). Moreover, patients can feel a sense of empowerment and involvement in their care process (Tambuyzer & Van Audenhove 2015). Additionally, more patient participation can increase the HCWs' self-awareness and positive communication, improve their care planning, decision-making, and the solution-orientation of the care they provide (Byrne et al. 2013; Vahdat et al. 2014; Wand 2010).

The HCWs have an essential role in facilitating and promoting patient participation. As shown in the model of Longtin et al. (2010), it is the HCW's willingness to share power and responsibility with the patient that enables patient participation. Partially based on this behaviour, the patient decides to engage in patient participation or to adopt a passive and recipient role (Arora & McHorney 2000; Biley 1992; Sims 1999). Based on this evidence, it is deemed important to identify the HCWs' factors influencing patient participation whilst enhancing the understanding of the patient participation culture on psychiatric wards. However, according to the systematic review of Phillips et al. (2015), no validated tool is at hand to measure these factors, leaving a void in mapping the essential factors influencing the reciprocal process of patient participation in inpatient psychiatric settings.

2.1.2. Belgian context

In 2013, the Federal Government in Belgium announced a programme to improve patient participation in general and psychiatric hospitals, with a particular attention for patient safety issues. One of the first steps in this programme was the assessment of the patient participation culture on hospital wards. As no tool was available (Phillips et al. 2015), a tool was developed and validated first to measure the patient participation culture in general hospitals: the Patient Participation Culture Tool for Healthcare Workers (PaCT-HCW) (Malfait et al. 2016). To apprehend the clinical and specific circumstances of inpatient psychiatric wards, it was neccesary to adapt this original tool.

2.2. The study

2.2.1. Aim

The study constitutes a three-stage process to develop and validate the Patient Participation Culture Tool for inpatient PSYchiatric wards (PaCT-PSY). First, regarding the tool development, the validated tool PaCT-HCW was used as design for the PaCT-PSY. This preliminary construct was further elaborated through identifying additional items by conducting a literature review and a focus group interview. These additions were deemed necessary in order to capture the specific characteristics of inpatient psychiatric care. In the second stage, the content of the PaCT-PSY was validated by means of a Delphi procedure and a pilot study. Finally, an exploratory factor analysis and a calculation of the internal consistency were performed to determine the psychometric properties of the PaCT-PSY and to validate its construct. An overview of the development process is outlined in Figure 1. The PaCT-PSY and factor loadings are presented in Addendum 1 and 2.

2.2.2. Ethical considerations

The Ethics Committees of the Ghent University Hospital and the participating hospitals approved this study (B670201421350). All participants were fully informed prior to the study and gave their informed consent. They were assured of the voluntary character of their participation and of the anonymity of the data.

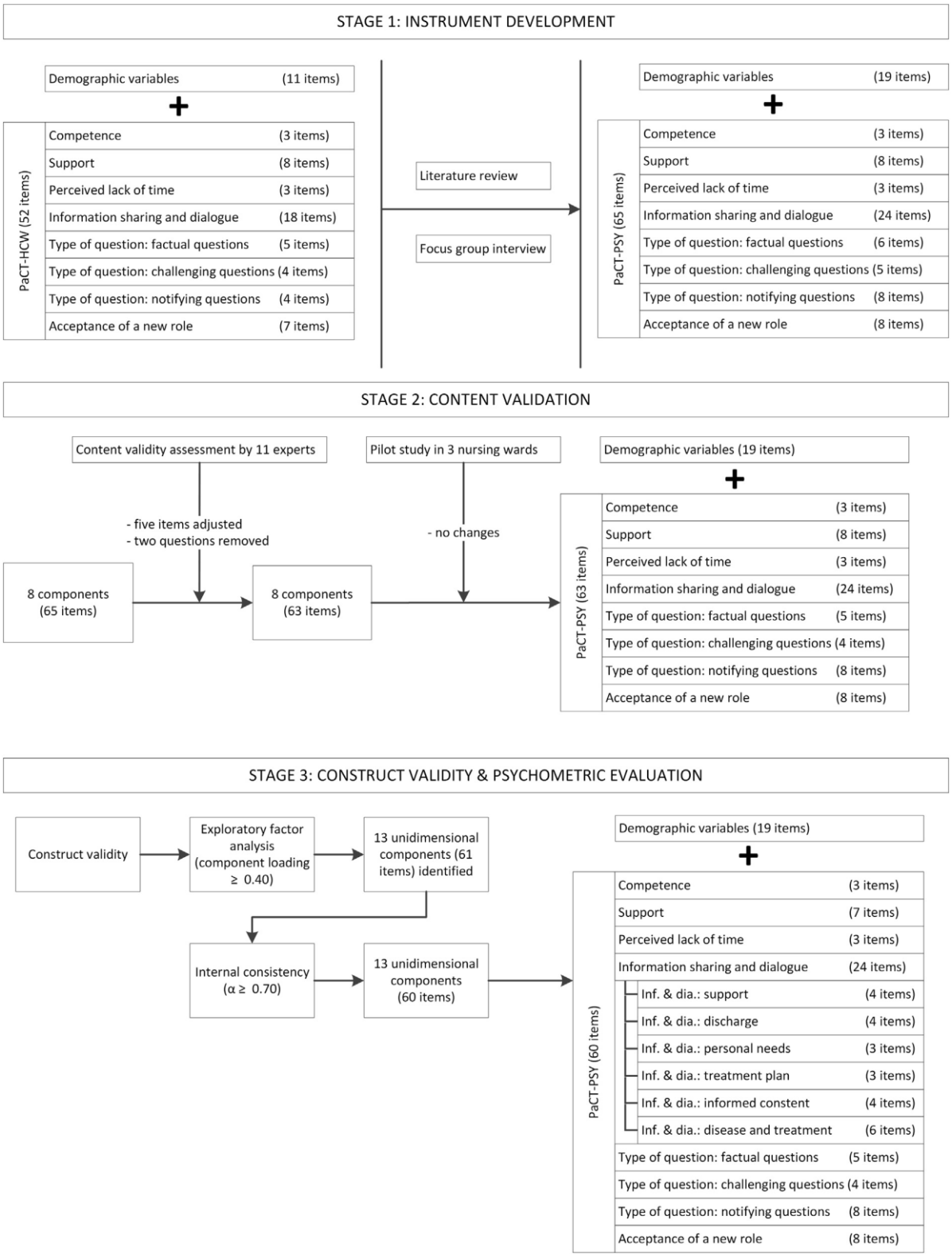

Fig. 1. An overview of the development process of the PaCT-PSY

2.2.3. Stage 1: Instrument development

The preliminary construct, based on the design of the original tool 'PaCT-HCW', was further elaborated upon through conducting a literature review and a focus group interview. During this stage, 13 items were added to the components in the PaCT-PSY and eight items were added to the demographic variables.

Design of the original instrument

The PaCT-PSY is based on the PaCT-HCW, a validated tool to measure the patient participation culture from the HCW's perspective on general hospitals wards (Malfait et al. 2016). The PaCT-HCW measures a ward's patient participation culture by inventorying HCWs' factors that influence patient participation in general and university hospitals. The PaCT-HCW was developed and validated through a rigorous, four-stage process. First, the tool was constructed based on 'the conceptual model of patient participation in error prevention' of Longtin et al. (2010) and 'the comprehensive model of patient involvement' of Tambuyzer et al. (2011). Components from both models were included in the tool, which reflects the particular interest for patient participation and its connection with patient safety. In addition, three focus groups and six individual interviews were conducted to identify possible additional components. Second, the items of each component were elaborated by reviewing relevant literature. Third, the content of the original tool was validated by 11 experts in a Delphi procedure and tested on three pilot wards. Fourth, 1.329 participants on 163 wards in 15 general and university hospitals completed the PaCT-HCW. These data were analysed using an exploratory factor analysis and calculation of the internal consistency. Psychometric evaluation of the PaCT-HCW showed strong construct validity and internal consistency.

In total, a tool with eight unidimensional components comprising of 52 items was found. The eight components are 'competence', 'support', 'perceived lack of time', 'information sharing and dialogue', 'factual questions', 'challenging questions', 'notifying questions', and 'acceptance of a new role'. All items have to be answered on a four-point Likert-scale (fully disagree - partially disagree - partially agree - fully agree). The items of the component 'information sharing and dialogue' had an answer option 'not applicable'. Because the PaCT-HCW showed strong psychometric values and the topics were assessed by the researchers to be relevant in the context of inpatient psychiatric care, it was decided that no items of the PaCT-HCW would be removed to construct the PaCT-PSY. As such, the basis of the PaCT-PSY consists of 52 items.

Literature review

To identify additional items while designing the PaCT-PSY, a literature review was conducted using the terms 'patient participation' (including synonyms) and 'mental health' (including synonyms). Electronic databases (PubMed, Cumulative Index to Nursing and Allied Health Literature, and Web of Science) and grey literature (e.g. legislation and research reports) were consulted. Literature reviews, and concept analysis and grounded theory studies were of particular interest to enhance understanding of the range, meaning, and conceptual foundation of items related to patient participation. No date limits were used in the search. Based on the questionnaire of Happell et al. (2010), the component 'information sharing and dialogue' was expanded with the 'communication between HCW and patient concerning the planning of their treatment' (i.e. discussing expectations about treatment, informing about treatment discussions, preparing of treatment plan) and the 'patient's personal needs' (i.e. collective living agreements, individual agreements, and tailored therapy programme).

Furthermore, items were added in the component 'type of question'. This component is divided into three types of questions patients can ask to HCWs. The type of these questions, being either factual (e.g. 'How long do I have to stay in the hospital?'), challenging (e.g. 'Is this the right medication?'), or notifying (e.g. 'Could it be that my wound is infected?'), can influence the degree to which HCWs accept and promote patient participation (Van den Brinck-Muinen et al. 2006). Based on the Belgian legislation for mental healthcare institutions (2008), four items were added to the 'notifying questions' section. Reflecting some specific characteristics of inpatient psychiatric care (e.g. risk and safety management), the new items were related to suicide (2 items), aggression (1 items), and self-harm (1 item). Additionally, one item was added in the components 'factual questions' and 'challenging questions' based on patient participation in the use of psychopharmaca, as this is linked to improved self-management (Buus et al. 2010). Furthermore, based on the Belgian legislation for mental healthcare institutions (2008), the researchers added one question concerning the presence of seclusion rooms on the psychiatric ward, and three questions related to the organisation of the ward (e.g. length of admission). Finally, one item was added to the component 'acceptance of a new role'.

Focus group

A focus group interview was conducted in order to identify additional items or components. The dynamic nature of focus groups was particularly useful because it allowed the participants to build on each other's thoughts and opinions, and to generate new ideas (Holloway & Wheeler 2010). To receive varied and comprehensive feedback, 10 experts were purposefully selected on their knowledge of mental healthcare and their affinity with patient participation. These individuals were recruited from different hospitals. Reflecting

variety in the experts' background, the focus group included one patient-expert, two nursing managers, two nurses, and five quality supervisors. During the focus group, the interviewer and the participants discussed the relevance of the components (e.g. 'Is this item important for patient participation?'), the completeness of the tool (e.g. 'Are there any items missing in the tool?'), and the clarity of the items and components (e.g. 'Do you understand the meaning of this question?').

Based on the comments in the focus group interview, five items were added to the demographic variables including (1) whether the ward was open or closed, (2) the presence of seclusion rooms, (3) the use of coercive measures with or (4) without permission of the patient, and (5) the percentage of patients who are admitted involuntary on the ward. Finally, the list of multidisciplinary professionals was expanded to reflect the more differentiated range of professions in psychiatric hospitals compared to general hospitals (e.g. employment of creative therapists and occupational therapists).

In summary, although the original tool (PaCT-HCW) already included a wide range of items, the literature review and the focus group interview led to specific additions in the process of developing the PaCT-PSY. Moreover, in formulating the items, much attention was given to patient safety issues because of their relevance to the psychiatric context (e.g. suicide, self-harm, aggression). Overall, the participants in the focus group interview described the tool as useful, practical and profound.

2.2.4. Stage 2: Content validation

In the second stage, content validity of the PaCT-PSY was tested by means of a Delphi procedure and a pilot study.

Delphi procedure

A Delphi procedure was organised as this is a useful approach to assess the content validity of research tools by transforming individual opinions into a group consensus (Hasson et al. 2000; McKenna 1994). Of all invited experts, 16 were involved in the Delphi procedure. The group of experts included four nursing managers, two nurse specialists, one patient expert, two nurses, one psychologist, one behavioural therapist, one physician, one non-verbal therapist, one nursing teacher in mental health, and two academic researchers. In this study, individuals were identified as experts based upon their profound knowledge of mental healthcare and/or a good understanding of patient participation. They were recruited in different mental health settings, including psychiatric hospitals, mental health nursing education programmes, and patient organisations in mental health.

The experts were asked to rate each question on a dichotomous scale for relevance, formulation, and readability. Questions assessed as not relevant were removed. In addition, experts were asked to propose adjustments and new questions. Reflecting the iterative nature of the procedure, the rates and responses of each expert in the first round were summarised and communicated back to the same experts. To apprehend the level of expert agreement, the Content Validity Index was used (Lynn 1986). After performing the second Delphi-round, the intended Content Validity Index of 0.90 was obtained. Overall, two items concerning the use of coercive measures were removed, and five items in the ward's characteristics were adjusted (e.g. size of the ward).

Pilot study

A pilot study was performed as this is an important step in developing and pre-testing a measurement instrument (van Teijlingen & Hundley 2002). The PaCT-PSY was tested and evaluated by 20 participants on three criteria including: (1) the clarity of the items, (2) the format of the tool, and (3) the time needed to complete. Potential organisational differences were taken into account by recruiting the participants in three psychiatric wards from three different hospitals. These wards represented one acute inpatient ward, one day clinic, and one ward for resocialisation. On each ward, a multidisciplinary team of at least six HCWs completed the tool. Reflecting differences in their professional background, the group of HCWs comprised 10 nurses (nine psychiatric and one general nurse), two psychiatrists, and eight paramedical HCWs. One participant had a secondary school degree, four had a graduate degree, seven had a bachelor degree, and eight participants had a master degree.
The participants perceived the tool as plain, and the items as distinct and clearly articulated. The completion of the tool took between 22 and 42 minutes, which some participants perceived as time consuming. No substantive adjustements were made in the PaCT-PSY based on the participants' feedback during the pilot study.

2.2.5. Stage 3: Construct validation and psychometric evaluation

In the final stage, an exploratory factor analysis and a calculation of the internal consistency were performed to determine the psychometric properties of the PaCT-PSY and to validate its construct.

Data collection and sampling procedure

The data were collected between February and April 2015. Response forms wherein less than 75% of questions were answered were removed from data collection. All forms were

checked on response patterns in order to identify acquiescence response bias. When such patterns were identified, all related answers were deleted.

The data were analysed using SPSS Statistics 21.0 (IBM SPSS statistics 2013). The 24 items with 'not applicable'-answers (available in the component 'information sharing and dialogue') were excluded from statistical analysis via case wise deletion. One item ('A more important role for patients in patient safety issues could have negative effects on the HCW-patient relationship') had to be recoded as it had a reversed scale.

To test the construct validity and internal consistency of the PaCT-PSY, a stratified random sample of four psychiatric hospitals and four psychiatric wards in general hospitals was taken to obtain the necessary numbers of participants to conduct the analyses. As a rule of thumb, ten participants were included for each item in the tool.

A stratified random sample of 603 participants was taken. To stratify the data, the distribution of types of inpatient psychiatric wards and the healthcare workers' profession was used. An overview of the most important demographic variables of the participants is given in Table 1.

Table 1
An overview of respondents' characteristics.

Respondents		
Characteristic	%	$n = 603$
Gender		
Male	29.2%	176
Female	70.8%	427
Profession		
Nurse	58.1%	350
Paramedic	38.9%	235
Physician	3.0%	18
Type of ward		
Psychiatric ward in general hospital	15.3%	92
Psychiatric hospital	84.7%	511
Short stay	35.3%	180
Intensive treatment	31.3%	160
Rehabilitation	29.8%	152
Long stay	3.6%	19

Construct validation

The construct validity was analysed by means of an exploratory factor analysis through SPSS's 'dimension reduction'-option. Principal axis factoring method and varimax rotation were used. The Kaiser-Meyer-Olkin measure of sampling adequacy (≥ 0.80) and the Bartlett test of sphericity ($p < 0.05$) were used to determine the appropriateness of an exploratory

factor analysis. Eigenvalues > 1 and a scree plot were applied to determine the number of extracted factors.

Within the exploratory factor analysis, both Kaiser-Meyer-Olkin measure of sampling adequacy (0.888) and Bartlett's test of sphericity (χ = 17637.099; df = 1830; $p < 0.001$) were satisfied. The scree plot indicated 13 components. Items that had a cross-loading or a low loading (< 0.40) were removed to obtain unidimensional components (Mortelmans & Dehertogh 2008). An overview of the components is given in Table 2.

Internal consistency

To assess the internal consistency, both the number of items and the mean inter-item correlations were taken into account (Gliem & Gliem 2003). The Cronbach's alpha was calculated as measure for the internal consistency. A cronbach's alpha higher than 0.70 was considered 'acceptable', and a cronbach's alpha higher than 0.80 was considered 'good' (George & Mallery 2013). In addition, based on the psychometric analysis, all items considered for removal were first assessed by the authours on their relevance within the scope of the study before they could be removed. One item ('My supervisor is responsible for building partnerships with other healthcare services that can promote patient participation') was deleted from the component 'support' based on the internal consistency calculations. The overall Cronbach's alpha of the PaCT-PSY was 0.90. A 13-component model with 60 items remained, explaining 66.67% of the variance. An overview of the components, their Cronbach's alpha's and the variance explained is presented in Table 2.

Table 2

Overview of the components, their Cronbach's alpha and the explained variance

Component	Nr of items	Nr of respondents	Scale mean	SD	Inter-item correlations	Cronbach's α	Cronbach's α if item deleted	% explained variance	Cumulative %
Competence	3	607	10.15	1.511	0.662–0.852	0.87	0.77	4.10	4.1
Support	7	571	23.37	3.619	0.486–0.679	0.82	0.80	8.11	12.21
Perceived lack of time	3	570	7.28	1.760	0.259–0.505	0.63	0.42	2.91	15.12
Information sharing and dialogue: support	4	398	11.43	2.581	0.413–0.709	0.73	0.73	3.92	19.04
Information sharing and dialogue: discharge	4	399	12.34	2.676	0.537–0.713	0.81	0.81	3.69	22.73
Information sharing and dialogue: personal needs	3	360	8.43	2.128	0.462–0.611	0.72	0.72	3.39	26.12
Information sharing and dialogue: treatment plan	3	466	9.94	2.437	0.584–0.852	0.87	0.73	4.16	30.28
Information sharing and dialogue: informed consent	4	396	12.91	2.425	0.391–0.749	0.80	0.79	4.58	34.86
Information sharing and dialogue: disease and treatment	6	365	16.18	3.899	0.496–0.708	0.83	0.83	5.59	40.45
Type of question: Factual questions	6	532	20.66	2.924	0.742–0.789	0.92	0.90	7.37	47.82
Type of question: Challenging questions	4	504	14.24	1.960	0.640–0.800	0.86	0.79	3.87	51.69
Type of question: Notifying questions	8	504	29.63	3.181	0.659–0.858	0.94	0.93	10.97	62.66
Acceptance of a new role	5	508	15.09	2.471	0.500–0.558	0.76	0.70	4.21	66.87
Total	60	365	188.31	18.589	0.259–0.858	0.93	0.92	66.67	66.67

2.3. Discussion

Despite the scientific evidence that patients and HCWs can benefit from patient participation, not all countries advance at the same speed in stimulating patient participation (Tambuyzer et al. 2011), not all wards offer the same opportunities for patient participation (Robins et al. 2005), and not all age groups of patients can participate equally (Benbow 2012). These inequalities might be a consequence of several complex intermediating factors at the basis of patient participation. However, based on their systematic review, Phillips et al. (2015) found that there are no validated tools to measure the factors that influence patient particiation. Additionally, although there are a few tools that focus on specific areas of patient participation (e.g. dyadic OPTION instrument of Melbourne et al. 2011), no tools are at hand to measure the overall patient participation culture on a ward.

In addition, it is noteworthy that tools often do not take the perspective of HCWs into account. Therefore, this perspective was addressed in the present study, with a particular attention for the HCW's willingness to share power and responsibility with patients (Longtin et al. 2010). More specifically, the goal of this study was to develop and validate a tool which could examine the patient participation culture on psychiatric wards by inventorying the HCWs' factors of influence to patient participation. Although a validated tool to measure the patient participation culture on general hospitals wards was already available (PaCT-HCW), adjustments to this tool were necessary to make the tool suitable for inpatient psychiatric wards.

2.3.1. Psychometrical and content issues

The PaCT-PSY comprises 13 components which explain 66.67 % of the variance. Based on thorough evaluations, the PaCT-PSY has a high construct validity and internal consistency. Caution is needed in using and interpreting the component 'perceived lack of time'. This component has a Cronbach's alpha lower than 0.70, which is less than the standard (George & Mallery 2013). As this component was considered relevant to the context of patient participation, and it only comprises three items, no items could be deleted (Mortelmans & Dehertogh 2008).

In contrast with the original tool (Malfait et al. 2016), the component 'information sharing and dialogue' could be split into six subcomponents based on the psychometrical data. This strengthens the specificity of the PaCT-PSY as a high number of included items could put the component at risk of measuring different aspects within the same component (Tavakol & Dennick 2011). Furthermore, as articulated by the participants in a pilot study, the 60 item-

tool might be viewed as long and time consuming to complete. The use of this type of tools might be subject to lower response rates and non-completion (Sahlqvist et al. 2011). However, no further removal of items was possible based on the psychometrical data. Moreover, evidence suggests that shortening a tool is only effective until a certain degree, and, thus, further reduction might have had an adverse effect (Mond et al. 2004). Because the removal of questions is not the best option, other strategies must be considered to ensure sufficient response rates when using the PaCT-PSY. In this respect, using an accessible online format (e.g. website) with an ease of administration might partially compensate for the length of the PaCT-PSY (Subar et al. 2001).

Regarding the tool's content, it is important to underline that patient participation is a reciprocal process between HCWs and patients in which several HCW-related factors can influence patient participation (Longtin et al. 2010). Concerning these factors, the researchers believe that the list of HCW-related factors in the PaCT-PSY might not be exhaustive. It is likely that HCW-related factors beyond those included in the tool influence patient participation. Although the content of the tool can be subject to limitations, its opportunities must be recognised. In particular, as the tool covers a range of items related to patient safety, using the tool can enhance the attention for patient participation in risk and safety management. This perspective is highly relevant in mental healthcare where collaborative approaches in risk and safety management have the potential to promote patient safety (WHO 2013).

2.3.2. Implications for practice, education and research

The PaCT-PSY has the potential to expand the knowledge about the patient participation culture on psychiatric wards by inventorying the HCWs' factors that influence patient participation. As underlined, this focus is important because patient participation is strongly related to the HCW's willingness to share power and responsibility with patients (Longtin et al. 2010). By the inclusion of 13 components, the PaCT-PSY can facilitate an in-depth and differentiated perspective of the patient participation culture on psychiatric wards. This offers researchers, HCWs, and administrators the opportunity to develop specific interventions and strategies to improve patient participation.

At the same time, it must be emphasised that the process of patient participation calls for a reciprocal exploration and evaluation. This implies that in addition to the HCWs' perspectives highlighted in the PaCT-PSY, initiatives to promote patient participation must always reflect a careful consideration of the patients' experiences, preferences, expectations, and capabilities regarding participation in their own care and treatment (Appelbaum & Grisso 1998). Evidence suggests that patients can articulate clear and concrete preferences on how they

want to be involved in the planning and development of their care and treatment process. Therefore, their perspectives should be recognised at all levels of mental health service delivery (Grundy et al. 2015; Restall & Strutt 2008). Simultaneously, not all patients wish an equal level of active involvement in their care and treatment. Therefore, HCWs' initiatives to facilitate patient participation should be based on a genuine effort to include and attune to the patient's perspective (Levinson et al. 2005; Kiesler & Auerbach 2006).

Measurements with the PaCT-PSY can provide meaningful content for education programmes, and render visible to policymakers and hospital leaders the competencies of HCWs required to facilitate patient participation. In this regard, there should be particular attention for psychiatric nurses, as they have an important role in and make essential contributions to promoting patient participation. This is because psychiatric nurses' daily interactions and relationships with patients reflect a wealth of opportunities to respond to patients' needs and preferences, and to include and attune to their perspective (Dziopa & Ahern 2009; Grundy et al. 2015; Perraud et al. 2006; Stringer et al. 2008; Tambuyzer et al. 2011).

Future research should focus on the design and implementation of effective strategies and interventions to support and promote patient participation. This particular focus can be informed by quantitative data gained through measurements with the PaCT-PSY. These data can be complemented with qualitative research of stakeholders' perceptions and experiences of patient participation. Finally, as this tool exclusively focuses on patient participation in inpatient psychiatric settings, future research efforts should encourage a focus on the patient participation culture in a range of contexts. For instance, influencing factors for patient participation can also be assessed when involving patients in community-based mental healthcare systems, in educational programmes for HCWs, and in mental health research (Elstad & Eide 2009; Happell et al. 2015; Syrett et al. 2011). Considering this, efforts are required for a cross-contextual adaptation and psychometric evaluation of the PaCT-PSY. In accordance with the guideline of Sousa and Rojjanasrirat (2011), such efforts require a comprehensive process, where the development of conceptual understanding about patient participation in the specific context is prioritised. This should be followed by rigorous evaluations by experts, including patients, who are knowledgeable about patient participation within the targeted context (Sousa and Rojjanasrirat 2011).

2.4. Conclusion

The goal of this study was to develop and validate a tool that measures the patient participation culture on inpatient psychiatric wards by inventorying the HCWs' factors influencing their willingness to share power and responsibility with patients. The PaCT-PSY

contains 13 unidimensional components measured by 60 items. Based on a thorough development and psychometric evaluation process, the construct validity and internal consistency of the tool were found to be adequate. Using the PaCT-PSY can enhance the knowledge about the factors that play a role in the patient participation process and stimulate the creation of tailored actions to improve patient participation.

References

Adams, J. R., Drake, R. E. & Wolford, G. L. (2007). Shared decision-making preferences of people with severe mental illness. *Psychiatric Services*, 58, 1219-1221. doi.org/10.1176/ps.2007.58.9.1219

Appelbaum, P. S. & Grisso, T. (1988). Assessing patients' capacities to consent to treatment. *The New England Journal of Medicine,* 319, 1635-1638. doi.org/10.1056/NEJM198812223192504

Arora, N. & McHorney, C. (2000). Patient preferences for medical decision making: Who really wants to participate? *Medical Care*, 39, 335-341. doi.org/10.1097/00005650-200003000-00010

Benbow, S. (2012). Patient and carer participation in old age psychiatry in England: Part 1: a systemic perspective of the historical and political context. *International Psychogeriatrics*, *24*, 175-184. doi.org/10.1017/S1041610211001864

Biley, F. (1992). Some determinants that effect patient participation in decision-making about nursing care. *Journal of Advanced Nursing*, 17, 414-421. doi.org/10.1111/j.1365-2648.1992.tb01924.x

Bird, V., Leamy, M., Tew, J., Le Boutillier, C., Williams, J. & Slade, M. (2014). Fit for purpose? Validation of a conceptual framework for personal recovery with current mental health consumers. *Australian and New Zealand Journal of Psychiatry*, 48, 644-653. doi.org/10.1177/0004867413520046

Buus, N., Angel, S., Traynor, M. & Gonge, H. (2010). Psychiatric hospital nursing staff's experiences of participating in group-based clinical supervision: an interview study. *Issues in Mental Health Nursing,* 31, 654-661. doi.org/10.3109/01612840.2010.489991

Byrne, L., Happell, B., Welch, T. & Moxham, L. J. (2013). 'Things you can't learn from books': teaching recovery from a lived experience perspective. *International Journal of Mental Health Nursing*, 22, 195-204. doi.org/10.1111/j.1447-0349.2012.00875.x

De las Cuevas, C., Rivero-Santana, A., Perestelo-Péreze, L., Pérze-Ramos, J. & Serrano-Aguilar, P. (2012). Attitudes towards concordance in psychiatry: a comparative, cross-sectional study of psychiatric patients and mental health professionals. *BMC Psychiatry*, 12, 53, doi.org/10.1186/1471-244X-12-53.

Dziopa, F. & Ahern, K. (2009). What Makes a Quality Therapeutic Relationship in Psychiatric/Mental Health Nursing: A Review of the Research Literature. *The Internet Journal of Advanced Nursing Practice*, 10, Retrieved from: ispub.com/IJANP/10/1/7218

Elstad, T. A. & Eide, A. H. (2009). User participation in community mental health services: exploring the experiences of users and professionals. *Scandinavian Journal of Caring Sciences*, 23, 674-681. doi.org/10.1111/j.1471-6712.2008.00660.x

Farkas, M., Gagne, C., Anthony, W. & Chamberlin, J. (2005). Implementing recovery oriented evidence based programs: identifying the critical dimensions. *Community Mental Health Journal*, 41, 141-158. doi.org/10.1007/s10597-005-2649-6

Gagnon, M.-P., Desmartis, M., Dipankui, M., Gagnon, J. & St-Pierre, M. (2013). Alternatives to Seclusion and Restraint in Psychiatry and in Long-term Care Facilities for the elderly: Perspectives of Service Users and Family Members. *Patient - Patient Centered Outcome Research*, 6, 269-280. doi.org/10.1007/s40271-013-0023-2

Gliem, J. A. & Gliem, R. R. (2003). Calculating, Interpreting and Reporting Cronbach's Alpha Reliability Coefficient for Likert-Type Scales. *Midwest Research to Practice Conference in Adult, Continuing and Community Education*, 82-88, Retrieved from: www.ssnpstudents.com/wp/wp-content/uploads/2015/02/Gliem-Gliem.pdf

George, D., Mallery, P. (2013). *IBM SPSS Statistics 21 Step by Step: A Simple Guide and Reference*. Pearson Higher Education.

Grundy, A., Bee, P., Meade, O. et al. (2015). Bringing meaning to user involvement in mental health care-planning: a qualitative exploration of service user perspectives. *Journal of Psychiatric and Mental Health Nursing*, 23, 12-21. doi.org/10.1111/jpm.12275

Hamann, J., Cohen, R., Leucht S., Busch, R. & Kissling, W. (2005). Do patients with schizophrenia wish to be involved in decisions about their medical treatment? American Journal of Psychiatry, 162, 2382-2384. doi.org/10.1176/appi.ajp.162.12.2382

Happell, B., Bennetts, W., Platania-Phung, C. & Tohotoa, J. (2016). Exploring the Scope of Consumer Participation in Mental Health Nursing Education: Perspectives From Nurses and Consumers. *Perspectives in Psychiatric Care*, 52,169-77. doi.org/10.1111/ppc.12113

Happell, B., Moxham, L. & Platania-Phung, C. (2010). A psychometric analysis of the Mental Health Consumer Participation Questionnaire. *International Journal of Mental Health Nursing*, 19, 377-384. doi.org/ 0.1111/j.1447-0349.2010.00692.x

Hasson, F., Keeney, S. & McKenna, H. (2000). Research guidelines for the Delphi survey technique. *Journal of Advanced Nursing,* 32**,** 1008-1015.

Holloway, I. & Wheeler, S. (2010). *Qualitative research in nursing and healthcare*, third ed. Oxford: Wiley-Blackwell.

IBM SPSS statictics (2013). *Statistical Program for Social Sciences*. Chicago, USA.

Kiesler, D. J. & Auerbach, S. M. (2006). Optimal matches of patient preferences for information, decision-making and interpersonal behavior: Evidence, models and interventions. *Patient Education and Counseling*, 61, 319-341. doi.org/10.1016/j.pec.2005.08.002

Levinson, W., Kao, A., Kuby, A. & Thisted, R. A. (2005). Not all patients want to participate in decision making: A national study of public preferences. *Journal of General Internal Medicine,* 20, 531-535. doi.org/10.1111/j.1525-1497.2005.04101.x

Le Boutillier, C., Leamy, M., Bird, V., Davidson, L., Williams, J., Slade, M. (2011). What does recovery mean in practice? A qualitative analysis of international recovery-oriented practice guidance. *Psychiatric Services*, 62, 1470-1476. doi.org/0.1176/appi.ps.001312011

Liégois, A. & Van Audenhove, C. (2005). Ethical dilemmas in community mental health care. J*ournal of Medical Ethics*, 31, 452-456. doi.org/10.1136/jme.2003.006999

Longtin, Y., Sax, H., Leape, L., Sheridan, S., Donaldson, L. & Pittet, D. (2010). Patient Participation: Current Knowledge and applicabiliy to Patient Safety. *Mayo Clinical Proceedings*, 85, 53-62. doi.org/10.4065/mcp.2009.0248

Lynn, M. (1986). Determination and quantification of content validity. *Nursing Research*, 35, 382-385.

Malfait, S., Eeckloo, K., Van Daele, J. & Van Hecke, A. (2016). The Patient Participation Culture Tool for healthcare workers (PaCT-HCW) on general hospital wards: A development and psychometric validation study. *International Journal of Nursing Studies*, 61, 187-197. doi.org/10.1016/j.ijnurstu.2016.05.015

McKenna, H. P. (1994). The Delphi technique: a worthwhile research approach for nursing? *Journal of Advanced Nursing*, 19**,** 1221-1225. doi.org/10.1111/j.1365-2648.1994.tb01207.x

Melbourne, E., Roberts, S., Durand, M. A., Newcombe, R., Legare, F. & Elwyn, G. (2011). Dyadic OPTION: Measuring perceptions of shared decision-making in practice. *Patient Education and Counseling*, 83, 55-57. doi.org/10.1016/j.pec.2010.04.019

Mond, J. M., Rodgers, B., Hay, P. J., Owen, C. & Beumont, P. J. (2004). Mode of delivery, but not questionnaire length, affected response in an epidemiological study of eating disorder behaviour. *Journal of Clinical Epidemiology*, 57, 1167-1171.

Mortelmans, D. & Dehertogh, B. (2008). *Factoranalyse*. Leuven: Acco.

Perraud, S*,* Delaney, K*.,* Carlson-Sabelli, L. & Johnson, M. (2006). Advanced practice psychiatric mental health nursing, finding our core: the therapeutic relationship in 21st century*. Perspectives* in *Psychiatric Care*, 42, 215-226. doi.org/0.1111/j.1744-6163.2006.00097.x

Phillips, N., Street, M. & Haesler, E. (2015). A systematic review of reliable and valid tools for the measurement of patient participation in healthcare. *BMJ Quality & Safety*, 1-8, doi.org/10.1136/bmjqs-2015-004357

Restall, G. & Strutt, C. (2008). Participation in planning and evaluating mental health services: Building capacity. *Psychiatric Rehabilitation Journal*, 31, 234-238. doi.org/10.2975/31.3.2008.234.238

Robins, C., Sauvageot, J., Cusack, K., Suffoletta-Maierle, S. & Frueh, C. (2005). Special Section on Seclusion and Restraint: Consumers' Perceptions of Negative Experiences and "Sanctuary Harm" in Psychiatric Settings. *Psychiatric Services*, 56, 1134-1138. doi.org/10.1176/appi.ps.56.9.1134

Sahlqvist, S., Song, Y., Bull, F., Adams, E., Preston, J. & Ogilve, D. (2011). Effect of questionnaire length, personalisation and reminder type on response rate to a complex postal survey: randomised controlled trial. *BMC Medical Research Methodology*, 11, 62. doi.org/10.1186/1471-2288-11-62

Sims, J. (1999). What influences a patient's desire to participate in the management of their hypertension? *Patient Education and Counseling,* 38, 185-194. doi.org/10.1016/s0738-3991(98)00126-8

Sledge, W., Lawless, M., Sells, D., Wieland, M., O'Connell, M. & Davidson, L. (2011). Effectiveness of Peer Support in Reducing Readmissions of Persons With Multiple Psychiatric Hospitalizations. *Psychiatric Services*, 62, 541-544. doi.org/10.1176/ps.62.5.pss6205_0541

Sousa, V.D. & Rojjanasrirat, W. (2011). Translation, adaptation and validation of instruments or scales for use in cross-cultural health care research: a clear and user-friendly guideline. *Journal of Evaluation in Clinical Practice,* 17*,* 268-274. doi.org/10.1111/j.1365-2753.2010.01434.x

Storm, M. & Edwards, A. (2013). Models of user involvement in the mental health context: intentions and implementation challenges. *Psychiatric Quarterly,* 84, 313-327. doi.org/10.1007/s11126-012-9247-x

Stringer, B., Van Meijel, B., De Vree, W. & Van der Bijl, J. (2008). User involvement in mental health care: the role of nurses. A literature review. *Journal of Psychiatric and Mental Health Nursing*, 15, 678-683. doi.org/10.1111/j.1365-2850.2008.01285.x

Subar, A. F., Ziegler, R. G., Thompson, F. E. et al. (2001). Is shorter always better? Relative importance of questionnaire length and cognitive ease on response rate and data quality for two dietary questionnaires. *American Journal of Epidemiology*, 153, 404-409. doi.org/10.1093/aje/153.4.404

Syrett, M. (2011). Service user involvement in mental health research: a user's perspective. *Advances in Psychiatric Treatment,* 17, 201-205. doi.org/10.1192/apt.bp.110.008003

Talbot, J. (1979). Deinstituzionalization: Avoiding the disasters of the past. *Hospital and Community Psychiatry*, 30, 621-624. doi.org/10.1176/ps.30.9.621

Tambuyzer, E., Pieters, G. & Van Audenhove, C. (2011). Patient involvement in mental health care: one size does not fit all. *Health Expectations*, 17, 138-150. doi.org/10.1111/j.1369-7625.2011.00743.x

Tambuyzer, E. & Van Audenhove, C. (2015). Is perceived patient involvement in mental health care associated with satisfaction and empowerment? *Health expectations*, 18, 516-526. doi.org/10.1111/hex.12052

Tavakol, M. & Dennick, R. (2011). Making sense of Cronbach's alfa. *International Journal of Medical Education*, 2, 53-55.

Vahdat, S., Hamzehgardeshi, L., Hessam, S. & Hamzehgardeshi, Z. (2014). Patient involvement in health care decision making: a review. *Iranian Red Crescent Medical Journal*, 16. doi.org/10.5812/ircmj.12454

Van den Brinck-Muinen, A., van Dulmen, S., de Haes, H. V., Schellevis, F. & Bensing, J. (2006). Has patients' involvement in the decision-making process changed over time? *Health Expectations*, 9, 333-342. doi.org/10.1111/j.1369-7625.2006.00413.x

van Teijlingen, E. & Hundley, V. (2002). The importance of pilot studies. *Nursing Standard*, 16**,** 33-36. doi.org/10.7748/ns2002.06.16.40.33.c3214

Wand, T. (2010). Mental health nursing from a solution focused perspective. *International Journal of Mental Health Nursing*, 19, 210-219. doi.org/10.1111/j.1447-0349.2009.00659.x

World Health Organization (2013). E*x*ploring patient participation in reducing health-care-related safety risks*.* Retrieved from: www.euro.who.int/__data/assets/pdf_file/0010/185779/e96814.pdf

Chapter 3. Patient safety on psychiatric wards: A cross- sectional, multilevel study of factors influencing nurses' willingness to share power and responsibility with patients

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Abstract

The World Health Organization highlights the need for more patient participation in patient safety. In mental healthcare, psychiatric nurses are in a frontline position to support this evolution. The aim of the present study was to investigate the demographic and contextual factors that influence the willingness of psychiatric nurses to share power and responsibility with patients concerning patient safety. The patient participation culture tool for inpatient psychiatric wards was completed by 705 nurses employed in 173 psychiatric wards within 37 hospitals. Multilevel modelling was used to analyse the self-reported data. The acceptance of a role wherein nurses share power and responsibility with patients concerning their safety is influenced by the nurses' gender, age, perceived competence, perceived support, and type of ward. To support nurses in fulfilling their role in patient participation, basic and continuing education specific for patient participation should be provided. Managers and supervisors should recognise and fulfil their facilitating role in patient participation by offering support to nurses. Special attention is needed for young nurses and nurses on closed psychiatric wards, because these particular groups report being less willing to accept a new role. Ward characteristics that restrict patient participation should be challenged so that these become more stimulating towards patient participation. More research is needed to explore the willingness and ability of psychiatric nurses to engage in collaborative safety management with patients who have specific conditions, such as suicidal ideation and emotional harm.

3.1. Introduction

3.1.1. Background

In mental health, there is a global tendency towards more active involvement of patients in care, in policies of mental healthcare systems, and in the community (Storm & Edwards 2013). This movement represents an enhanced recognition of the patients' perspective, and the patients' right to be involved in decisions concerning their own health (Snyder & Engstrom 2016). One particular model that fosters patient participation in mental healthcare is the recovery model (Anthony 1993; Storm & Edwards 2013). The foundations of this model represent the belief that individuals with mental health problems are self-determining persons with the right and ability to make decisions, take responsibility, and to participate at all levels of mental healthcare systems (Farkas et al. 2005; Leamy et al. 2011).

This particular attention for collaboration and participation challenges the paternalistic nature of the traditional biomedical model, wherein patients are perceived as passive recipients of care (Coulter 1999). Despite this evolution, the enhancement of patient participation has been largely ignored in the domain of patient safety (Kanerva et al. 2013). Many safety policies and practices in mental healthcare systems remain embedded in a culture of control, risk avoidance, and coercion, with few opportunities for patients to participate (Higgins et al. 2015). It seems evident that the culture behind these policies and practices restricts the role that patients can play in improving patient safety, as recommended by the World Health Organization (WHO 2013). Literature on the patient's role in patient safety suggests that, when being supported and encouraged to do so, patients can prevent healthcare harm and challenge work routines by asking questions, engaging in dialogue with healthcare workers, and raising awareness of adverse events (Davis et al. 2011; Vincent & Coulter 2002).

In mental healthcare, psychiatric nurses are in a frontline position to facilitate patient participation (Stringer et al. 2008). Compared to other healthcare workers, nurses tend to have more frequent, longer, and more continuous interactions with patients who have safety-specific conditions, including self-harm and suicidal ideation (Cutcliffe et al. 2006; James et al. 2012). Psychiatric nurses can establish therapeutic relationships with patients, in which they have a wide range of opportunities to enter into dialogue, and to include and validate patients' perspectives (Peplau 1997; Shattell et al. 2007). According to Sahlsten et al. (2008), patient participation can only exist when nurses shift power imbalances and facilitate patient empowerment through partnership. Such a considerate approach towards managing professional power is a prerequisite for a collaborative risk assessment and safety management, where nurses and patients engage in shared decision-making and negotiating shared responsibilities (Higgins et al. 2015).

Over the past years, new models and approaches have emerged with particular attention for power and autonomy in nurse-patient interaction. Such models and approaches can inform the nature and direction of patient participation in patient safety and the role of psychiatric nurses. One comprehensive framework is offered by the Safewards model of Bowers (2014). This model provides explanations for the variation in conflict (e.g. aggression, self-harm, suicide) and containment (e.g. restraint, coerced medication, seclusion) on inpatient psychiatric wards. Regarding the exercise of power, the Safewards model highlights that some professional responses to conflicts might help enhance patients' coping strategies, while other responses, especially authouritarian ones, could induce patients' distress and disempowerment, or trigger new conflicts. As a result, and in line with principles of trauma-informed care, the Safewards model emphasises the importance for nurses to establish a mutually respectful partnership with patients, to work in a way that facilitates patient empowerent, and to eliminate the indiscriminate use of coercive practices (Bowers 2014; Muskett 2014).

One particular approach that emphasises collaborative nurse-patient relationships in patient safety is 'positive risk-taking'. This innovative approach emphasises the sharing of power and responsibilities, and patients' independence and potential for growth (Morgan 2004; Stickley & Felton 2006). When psychiatric nurses engage in positive risk-taking, they work collaboratively with patients to identify potential risks, weigh up the potential benefits and harms, and develop actions that reflect the potential and priorities of patients (Morgan 2004). With regard to patient outcomes, Birch et al. (2011) studied positive risk-taking in a women's mental health service and found that positive risk-taking reduces the frequency of self-harm. In addition, the conceptual framework of Leamy et al. (2011) suggests that positive risk-taking offers opportunities for patients to take personal responsibility, which is an important aspect of patients' empowerment and personal recovery. Despite these potential beneficial outcomes, Higgins et al. (2015) found that 25% of psychiatric nurses never or rarely consider positive risk-taking.

The aforementioned literature emphasises a need for nurses to share power and responsibility with patients in order to facilitate empowerment of patients and to promote the patient's role in patient safety. This literature fits well with Longtin et al.'s (2010) model, in which patient participation in patient safety depends on the willingness of healthcare workers to share power and responsibility with patients. However, the empirical understanding of factors influencing this collaborative behaviour is limited in the context of care provided by psychiatric nurses. Enhancing this understanding is necessary in order to support the potential of psychiatric nurses to facilitate the participation of patients in patient safety (Kanerva et al. 2014).

3.1.2. Aim

The aim of the present study was to investigate the demographic and contextual factors that influence the willingness of nurses on psychiatric wards to share power and responsibility with patients concerning their safety.

3.2. Methods

3.2.1. Design

This quantitative study adopted a cross-sectional design using multilevel modelling (Heck et al. 2014; Hox 2002). The multilevel aspect was reflected in the hierarchical structure of the data, whereby nurses were nested within inpatient psychiatric wards, which in turn were nested within hospitals.

3.2.2. Setting and participants

In Belgium, there is currently a reform of mental healthcare focussing on deinstitutionalisation and establishing community services. Despite this evolution, basic mental healthcare is still mainly provided in psychiatric wards within hospitals and in consultation with primary care physicians (Lorant et al. 2016). In the current study, all psychiatric hospitals and psychiatric wards in general hospitals which are situated in Flanders (the Dutch-speaking part of Belgium) were invited to participate. Psychiatric nursing homes and outpatient and community mental healthcare systems were excluded. Overall, the study included a convenience sample of 705 nurses employed in 173 psychiatric wards within 37 hospitals. The inclusion criteria were: having regular patient contact and working at least six months on the same ward.

3.2.3. Data collection

The Belgian Federal Government initiated a quality and patient safety programme with special attention to patient participation. As a first step towards improving patient participation, self-assessment tools were developed and validated to assess the patient participation culture on wards in general and psychiatric hospitals (Malfait et al. 2016). In the current study, data were collected between February and April 2015 by means of the patient participation culture tool for inpatient psychiatric wards (PaCT-PSY) (Malfait et al. 2017). This

tool measures the patient participation culture on psychiatric wards by inventorying healthcare workers' factors that influence patient participation. According to Phillips et al.'s (2015) systematic review, no tools were at hand that could provide valid and reliable measures of these factors.

The PaCT-PSY was established through a three-stage development and validation study. In the first stage, a literature review and focus group interviews with experts were conducted to develop the instrument. In the second stage, a Delphi procedure and a pilot study were performed to validate the content of the tool. Finally, in the third stage, a sample of 603 mental healthcare workers was established in order to determine the tool's construct validity and psychometric properties. An exploratory factor analysis indicated 13 components. The overall Cronbach's alpha of the PaCT-PSY was 0.90. All components ranged from 0.63 to 0.94. A 13-component model remained, comprising 60 items answered on a four-point Likert scale (1 = strongly disagree; 4 = strongly agree). With regard to formulating the aim of the present study, the researchers paid particular attention to the components 'acceptance of a new role', 'factual questions', 'challenging questions', and 'notifying questions'.

The 'acceptance of a new role' component represents collaborative behaviour of healthcare workers towards patient safety. The five items of this component operationalise foundational aspects of patient participation, including nurses' willingness to share information with the patient, and nurses' attitudes towards sharing power and responsibility with patients. The 'factual questions', 'challenging questions', and 'notifying questions' components represent three types of questions patients can ask healthcare workers about a variety of issues, problems, and risks. The focus on these components was considered important, because a central strategy to enhance patient participation in patient safety is to encourage patients to ask questions and to identify potential risks to themselves (Vaismoradi et al. 2015). More specifically, evidence suggests that the degree to which psychiatric nurses engage in patient participation can be influenced by nurses' willingness and ability (i.e. receptivity) to deal with different risks and questions of patients (van den Brink-Muinen et al. 2006; Davis et al. 2011; Longtin et al. 2010). In the current study, it was assumed that nurses are more receptive to factual questions than to challenging and notifying questions, which are more related to issues of patient safety (e.g. suicidality, healthcare workers' hand hygiene). To test this assumption, the items of the 'factual questions' component were included as comparators. An overview of the included PaCT-PSY components and items is provided in Table 1.

Data collection was initiated by sending an e-mail to the quality coordinator of each hospital, with an URL of the electronic version of the tool. These gatekeepers forwarded the e-mail to the nurses on the psychiatric wards, along with instructions for completion. As part of the tool, text fragments were included to inform the participants about the meaning of the components and the key concepts (e.g. patient safety). Participants were informed that they

were required to answer all items for valid participation. Fourteen days after launching the tool, the gatekeepers sent a reminder e-mail. All data were checked for acquiescence response bias. When such bias was identified, all answers of the participants were deleted.

3.2.4. Data analysis

Descriptive statistics and a multilevel analysis were performed using SPSS Statistics 23.0 (SPSS, Chicago, IL, USA). The construct of the statistical models was informed by the model of patient participation in error prevention (Longtin et al. 2010) and the comprehensive model of patient involvement (Tambuyzer et al. 2014). More specifically, the inclusion of variables was based on the key understanding that psychiatric nurses should share power and responsibility with patients in order to facilitate patient participation in patient safety. In the first model, a multivariate linear regression was performed with the sum score of the component 'acceptance of a new role' as a continuous outcome variable. Psychiatric wards and hospitals were employed as random factors, and gender, age, diploma (graduate, bachelor, master or higher), education (qualified as nurse or psychiatric nurse), type of ward, perceived competence, and perceived support were the fixed predictors. The 'type of ward' variable represented the ward's nature in terms of being either open (the ward entrance is open), semi-open (the ward entrance is closed, but the patient can request to go outside), or closed (the ward entrance is closed).

In the second model, multivariate binary logistic regressions were performed with separate items of the 'factual questions' and 'challenging questions' components as outcome variables. To improve its interpretation, the items were recoded as dichotomous variables, including the codes 1 ('strongly disagree' and 'partially disagree') and 2 ('partially agree' and 'strongly agree'). The descriptive statistics presented in Table 1 show that the majority of nurses scored positive on all the items of the factual questions, challenging questions, and notifying questions components. For questions with a very high percentage of positive answers (> 97%), no multivariate logistic regression model was applied, because the number of negative answers (nonevents) was too low relative to the number of predictor variables. This restricted the possibility to obtain valid parameter estimates. Therefore, as noted in Table 1, the final analysis included no items of the notifying questions, and only three items of the factual questions and one item of the challenging questions. The included items represent the factual questions: 'How long do I have to stay in the hospital?', 'How long will my pain/illness last?', and 'Which signals could indicate that I am not recovering as it should?', and the challenging question: 'Have you washed/disinfected your hands?'. In the multivariate binary logistic regressions, psychiatric ward and hospitals were employed as random factors. The 'acceptance of a new role' variable was applied as a predictor variable

next to gender, age, and type of ward. An outline of the multilevel models is provided in Figure 1.

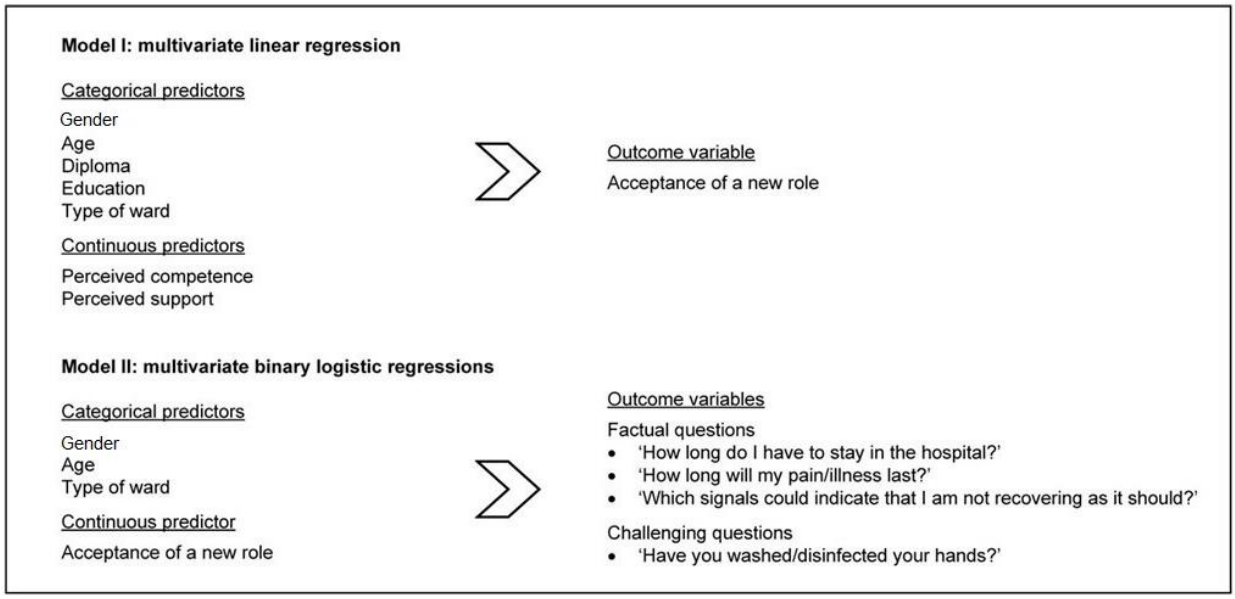

Fig. 1: Overview of the statistical models of the multilevel study. Categorical and continuous predictor variables (left), outcome variables (right). Outcome variable in the multivariate linear regression (i.e. 'acceptance of a new role') is a continuous variable representing the sum score of five items. In the multivariate binary logistic regressions, the outcome variables are binary variables representing separate items of the 'factual questions' and 'challenging questions' components.

3.2.5. Ethical considerations

The ethics committees of the participating hospitals approved this study (B670201421350). Hospitals willing to participate had to provide informed consent signed by the chief executive officer. All participants were fully informed prior to the study. They were assured of the voluntary nature of their participation and of the anonymity of the data. All participants provided electronic informed consent.

3.3. Results

The tool was completed by 705 nurses, of which the majority were female (70.8%) and aged between 25 and 44 years (57%). More than half had a bachelor degree (56.7%), and the majority had a specific qualification in psychiatric nursing (76%). The characteristics of the nurses are summarised in Table 2.

3.3.1. Descriptive statistics

The descriptive statistics of the nurses' responses are provided in Table 1. These statistics indicate that most nurses strongly or partially agreed to being competent to inform patients (97%), to ask advice from patients (97%), and to share power with patients (93%). In terms of perceived support, a minority of nurses strongly or partially disagreed that their supervisors express appreciation when they facilitate opportunities for patient participation (9%). In addition, 26% of nurses strongly or partially disagreed that the hospital management facilitated a work context that supports patient participation. At the same time, almost half (49%) of the nurses strongly or partially disagreed that the actions of the hospital management illustrated that patient participation is an important issue. Regarding the 'acceptance of a new role', the majority of nurses strongly or partially agreed with being willing to stimulate patients to ask questions concerning patient safety (74%), and to inform patients about a safety incident (88.5%). Furthermore, the majority of nurses (> 89%) strongly or partially agreed being receptive to a patient's factual, challenging, or notifying questions. The challenging question, 'Have you washed/ disinfected your hands?', received the least positive response.

TABLE 1: Included components and descriptive statistics of nurses' responses on all items

Included components of the PaCT-PSY	Items	Four-point Likert-scale (1) Strongly disagree *n* (%)	(2) Partially disagree *n* (%)	(3) Partially agree *n* (%)	(4) Strongly agree *n* (%)	Mean (SD)
Perceived competence	○ I feel competent to inform the patient	0 (0.0)	18 (2.6)	366 (51.9)	321 (45.5)	3.4 (0.5)
Perceived competence of HCW to facilitate patient participation	○ I feel competent to ask advice to the patient (to consult the patient)	0 (0.0)	17 (2.4)	371 (52.6)	317 (45.0)	3.4 (0.5)
	○ I feel competent to delegate power to the patient concerning topics of the healthcare process	0 (0.0)	48 (6.8)	429 (60.9)	228 (32.3)	3.3 (0.6)
	Total scale score (/12)	N/A	N/A	N/A	N/A	10.1 (1.5)
Perceived support	○ The hospital management facilitates a work context that supports patient participation	13 (1.8)	174 (24.7)	442 (62.7)	76 (10.8)	2.8 (0.6)
HCW perceived support from the hospital's management, supervisors, and peers to facilitate patient participation	○ The actions of the hospital management illustrate that patient participation is an important issue	40 (5.7)	308 (43.7)	303 (43.0)	54 (7.7)	2.5 (0.7)
	○ My supervisor has a positive attitude towards patient participation on the ward	2 (0.3)	59 (8.4)	441 (62.6)	203 (28.8)	3.2 (0.6)
	○ My supervisor expresses appreciation when I offer opportunities for patient participation	1 (0.1)	61 (8.7)	443 (62.8)	200 (28.4)	3.2 (0.6)
	○ My supervisor considers suggestions of employees to improve patient participation on the ward	2 (0.3)	77 (10.9)	439 (62.3)	187 (26.5)	3.2 (0.6)
	○ My supervisor reveals the results we achieve with regard to patient participation	21 (3.0)	263 (37.3)	327 (46.4)	94 (13.3)	2.7 (0.7)
	○ My colleagues support each other to facilitate patient participation in the health-care process	5 (0.7)	116 (16.5)	444 (63.0)	140 (19.9)	3.0 (0.6)
	○ My supervisor is involved in shaping a mission/vision that embraces patient participation	22 (3.1)	152 (21.6)	287 (40.7)	244 (34.6)	3.3 (1.0)
	Total scale score (/32)	N/A	N/A	N/A	N/A	23.9 (3.7)
Factual questions	○ I feel positive towards patients asking how long they have to stay in the hospital	5 (0.7)	39 (5.5)	339 (48.1)	322 (45.7)	3.4 (0.6)
HCW perception of their receptivity to factual questions of patients	○ I feel positive towards patients asking how long their pain/illness will last	5 (0.7)	46 (6.5)	348 (49.4)	306 (43.4)	3.4 (0.6)
	○ I feel positive towards patients asking which signals could indicate that they are not recovering as they should	6 (0.9)	42 (6.0)	341 (48.4)	316 (44.8)	3.4 (0.6)
	○ I feel positive towards patients asking when they can resume their normal activities†	3 (0.4)	17 (2.4)	336 (47.7)	349 (49.5)	3.5 (0.6)
	○ I feel positive towards patients asking how a certain procedure is executed†	3 (0.4)	11 (1.6)	316 (44.8)	375 (53.2)	3.5 (0.6)
	○ I feel positive towards patients asking what the policy is on the ward regarding medication specific to their situation†	4 (0.6)	13 (1.8)	295 (41.8)	393 (55.7)	3.5 (0.6)
	Total scale score (/24)	N/A	N/A	N/A	N/A	20.6 (3.0)

(*Continued*)

TABLE 1: (Continued)

Included components of the PaCT-PSY	Items	Four-point Likert-scale (1) Strongly disagree *n* (%)	(2) Partially disagree *n* (%)	(3) Partially agree *n* (%)	(4) Strongly agree *n* (%)	Mean (SD)
Challenging questions HCW perception of their receptivity to challenging questions of patients	○ I feel positive towards patients asking whether the medications they receive are correct†	3 (0.4)	6 (0.9)	206 (29.2)	490 (69.5)	3.7 (0.5)
	○ I feel positive towards patients asking what the name of the HCW is and what they are about to do†	1 (0.1)	7 (1.0)	210 (29.8)	487 (69.1)	3.7 (0.5)
	○ I feel positive towards patients asking why a HCW removes an apparatus (e.g. monitoring device)†	3 (0.4)	10 (1.4)	239 (33.9)	453 (64.3)	3.6 (0.5)
	○ I feel positive towards patients asking if the HCW has washed/disinfected his or her hands		4 (0.6)	67 (9.5)	257 (36.5)	377 (53.5)
	Total scale score (/16)	N/A	N/A	N/A	N/A	14.4 (1.9)
Notifying questions HCW perception of their receptivity to notifying questions of patients	○ Patients need to be encouraged to say if they have not received the results of their tests yet†	0 (0.0)	9 (1.3)	257 (36.5)	439 (62.3)	3.6 (0.5)
	○ Patients need to be encouraged to say if they think an error has occurred in the care they receive†	0 (0.0)	4 (0.6)	203 (28.8)	498 (70.6)	3.7 (0.5)
	○ Patients need to be encouraged to say if they think their wound is infected†	0 (0.0)	4 (0.6)	176 (25.0)	525 (74.5)	3.7 (0.5)
	○ Patients need to be encouraged to say if there are conditions that increase their risk of suicide or self-harm†	0 (0.0)	2 (0.3)	151 (21.4)	552 (78.3)	3.8 (0.4)
	○ Patients need to be encouraged to say if the HCW actions in managing aggression are unsafe or inappropriate†	1 (0.1)	13 (1.8)	227 (32.2)	464 (65.8)	3.6 (0.5)
	○ Patients need to be encouraged to say if another patient is at risk of self-harm or suicide†	0 (0.0)	16 (2.3)	215 (30.5)	474 (67.2)	3.6 (0.5)
	○ Patients need to be encouraged to say if they experience side-effects of psychotropic drugs†	0 (0.0)	2 (0.3)	142 (20.1)	561 (79.6)	3.8 (0.4)
	○ Patients need to be encouraged to say if there are unsafe situations due to the behaviour of other patients†	0 (0.0)	1 (0.1)	164 (23.3)	540 (76.6)	3.8 (0.4)
	Total scale score (/32)	N/A	N/A	N/A	N/A	29.7 (3.1)
Acceptance of a new role HCW willingness to stimulate patient participation and to engage in a collaborative role with the patient concerning patient safety	○ I feel positive if patients ask questions or offer suggestions concerning patient safety	3 (0.4)	11 (1.6)	368 (52.2)	323 (45.8)	3.4 (0.6)
	○ I stimulate patients to ask questions concerning patient safety	9 (1.3)	175 (24.7)	354 (50.3)	167 (23.7)	3.0 (0.7)
	○ I perceive it important to inform patients about the hospital results regarding patient safety (e.g. medication errors)	74 (10.5)	308 (43.7)	251 (35.6)	72 (10.2)	2.5 (0.8)
	○ I perceive it important to inform patients about a safety incident when they are involved in this incident	14 (2.0)	67 (9.5)	414 (58.7)	210 (29.8)	3.2 (0.7)
	○ Patients should be supported to make their own notes regarding patient safety (e.g. their medication schedule)	20 (2.8)	131 (18.6)	395 (56.0)	159 (22.6)	3.0 (0.7)
	Total scale score (/20)	N/A	N/A	N/A	N/A	15.0 (2.4)

†For items with a very high percentage of positive answers (>97%), no multivariate logistic regression model was applied, because the number of negative answers (non-events) was too low relative to the number of predictor variables to obtain valid parameter estimates. HCW, health-care workers; N/A, not applicable; PaCT-PSY, patient participation culture tool for inpatient psychiatric wards; SD, standard deviation.

Table 2: Overview of the nurses' characteristics

	N=705	%
Gender		
Female	497	70.8
Male	208	29.2
Age		
< 25	52	7.4
25 – 34	233	33
35 – 44	169	24
45 – 54	162	23
≥ 55	89	12.6
Education		
Psychiatric nurse	538	76.3
Nurse	167	23.7
Diploma (education level)		
Graduate	256	36.3
Bachelor	400	56.7
Master or higher	49	7
Type of ward †		
Closed	95	13.5
Semi-open	152	21.5
Open	458	65

† 'Type of ward' represents the ward's nature in terms of being either open (the ward entrance is open), semi-open (the ward entrance is closed, but the patient can request to go outside), or closed (the ward entrance is closed).

3.3.2. Multilevel analysis

Acceptance of a new role (model I)

Significant predictors for the 'acceptance of a new role' outcome variable were gender, age, perceived competence, perceived support, and type of ward. Education (qualified as a nurse or psychiatric nurse) and level of education (graduate, bachelor, master, or higher) had no significant influence on nurses' acceptance of a new role. Female nurses were less willing than male nurses to accept a new role (B = -0.439, p = 0.026). Similarly, nurses < 25 years were less willing than nurses ≥ 55 years to accept a new role (B = -0.965, p = 0.018). In addition, the nurses' perceived competence to facilitate patient participation was positively associated with their willingness to accept a new role (B = 0.224, p < 0.001). Furthermore, the nurses' perceived support from their peers, supervisors, and managers to facilitate patient participation was positively associated with their willingness to accept a new role (B =

0.105, p < 0.001). Finally, nurses on closed wards were more reluctant to accept a new role than nurses on open wards (B = -0.719, p = 0.016). Results of the multivariate linear regression are shown in Table 3.

TABLE 3: Results of the multivariate linear regression (model I)

	Outcome: 'Acceptance of a new role'		
	Coefficient (*B*)	*P*-value	95% CI
Gender			
Female	—0.439	0.026*	—0.825–0053
Male (ref)	-	-	-
Age (years)			
<25	—0.965	0.018*	—1.766–0.163
25–34	—0.511	0.081	—1.087–0.064
35–44	—0.485	0.116	—1.089–0.120
45–54	0.081	0.794	—0.526–0.688
≥55 (ref)	-	-	-
Education			
Nurse	—0.173	0.417	—0.592–0.246
Psychiatric nurse (ref)	-	-	-
Diploma			
Graduate	—0.573	0.120	—1.294–0.149
Bachelor	—0.346	0.329	—1.039–0.348
Master or higher (ref)	-	-	-
Perceived competence	0.224	<0.001**	0.099–0.350
Perceived support	0.105	<0.001**	0.055–0.156
Type of ward			
Closed	—0.719	0.016*	—1.302–0.136
Semi-open	—0.139	0.579	—0.633–0.354
Open (ref)	-	-	-

*$P < 0.05$, **$P < 0.001$. CI, confidence interval;
ref, reference category.

Factual questions and challenging questions (model II)

Nurses who are more willing to stimulate patient participation and to engage in a collaborative role with the patient concerning patient safety (i.e. acceptance of a new role), perceived themselves less receptive to the patients' factual questions: 'How long will my pain/illness last?' (odds ratio (OR) = 0.842, 95% confidence interval (CI) = 0.748-0.949, p = 0.005) and 'Which signals could indicate that I am not recovering as it should?' (OR = 0.857,

95% CI = 0.761-0.966, p = 0.012), and the challenging question: ‘Have you washed/disinfected your hands?’ (OR = 0.786, 95 CI% = 0.703-0.878, p < 0.001).

In addition, compared to nurses ≥ 55 years, nurses < 25 years perceived themselves as more receptive to the patients’ factual questions: ‘How long do I have to stay in the hospital?’ (OR = 5.393, 95% CI = 1.528-19.037, p = 0.009) and ‘Which signals could indicate that I am not recovering as it should’ (OR = 3.475, 95% CI = 1.107-10.902, p = 0.033), and the challenging question: ‘Have you washed/disinfected your hands?’ (OR = 3.406, 95% CI = 1.167-9.937, p = 0.025). The results of the multivariate binary logistic regressions are shown in Table 4.

TABLE 4: Results of the multivariate binary logistic regressions (model II)

	Outcome: 'Factual questions'									Outcome: 'Challenging question'		
	'How long do I have to stay in the hospital?'			'How long will my pain/illness last?'			'Which signals could indicate that I am not recovering as I should?'			'Have you washed/disinfected your hands?'		
	P-value	OR	95% CI	*P*-value	OR	95% CI	*P*-value	OR	95% CI	*P*-value	OR	95% CI
Gender												
Female	0.210	0.680	0.371–1.250	0.336	1.374	0.718–2.628	0.469	0.801	0.438–1.463	0.125	1.597	0.879–2.901
Male (ref)	-	-	-	-	-	-	-	-	-	-	-	-
Age (years)												
<25	0.009*	5.393	1.528–19.037	0.079	2.998	0.879–10.230	0.033*	3.475	1.107–10.902	0.025*	3.406	1.167–9.937
25–34	0.184	2.163	0.692–6.760	0.151	2.146	0.756–6.093	0.412	1.522	0.557–4.160	0.305	1.624	0.642–4.108
35–44	0.683	1.293	0.376–4.453	0.982	1.013	0.317–3.240	0.723	0.815	0.263–2.527	0.279	1.695	0.651–4.412
45–54	0.669	1.314	0.375–4.599	0.768	1.189	0.375–3.766	0.897	1.076	0.356–3.251	0.657	0.785	0.271–2.280
≥55 (ref)	-	-	-	-	-	-	-	-	-	-	-	-
Type of ward												
Closed	0.221	0.534	0.196–1.459	0.415	0.702	0.702–1.643	0.401	0.680	0.276–1.674	0.341	0.688	0.318–1.488
Semi-open	0.923	0.966	0.484–1.930	0.601	0.831	0.415–1.664	0.885	1.051	0.535–2.062	0.624	0.858	0.465–1.583
Open (ref)	-	-	-	-	-	-	-	-	-	-	-	-
Acceptance of a new role	0.144	0.915	0.811–1.031	0.005*	0.842	0.748–0.949	0.012*	0.857	0.761–0.966	<0.001**	0.786	0.703–0.878

*$P < 0.05$, **$P < 0.001$. CI, confidence interval; OR, odds ratio; ref, reference category.

3.4. Discussion

The conceptually-informed multilevel models provide new understanding of the demographic and contextual factors influencing psychiatric nurses' acceptance of a role, wherein they share power and responsibility with patients concerning patient safety.

3.4.1. Acceptance of a new role (model I)

The willingness of psychiatric nurses to accept a new role is positively associated with being male, older, employed on an open ward, and perceiving personal competence and support to facilitate patient participation.

The 'acceptance of a new role' component does not include items about specific patient safety situations and conditions, such as aggression, self-harm, or suicidal ideation. Acknowledging this general focus on patient safety, overarching gender differences in the perception of risk and safety can be considered to explain the gender difference in the willingness to accept a new role. For example, studies in the context of aggression highlight that male and female nurses have different perceptions of aggression incidents in terms of acceptance, tolerance, and coping (Jonker et al. 2008; Verhaeghe et al. 2014). Different perceptions of risk and safety issues might in turn impact the extent to which nurses share power and responsibility with patients in patient safety-related situations.

In addition, younger nurses (< 25 years) are more reluctant than their older colleagues (≥ 55 years) to accept a new role. Benner's (1982) model can provide an explanation for this finding. In this model, the processes of learning and gaining experience are emphasised as the ways through which student and novice nurses can become more competent, develop into proficient nurses, and eventually become experts. Based on this theoretical insight, it can be argued that younger nurses might be less prepared to share power and responsibility with patients because of immature skill development (e.g. risk communication).

Nurses are more willing to accept a new role when they perceive higher support from peers, supervisors, and hospital management to engage in patient participation. When applying Bandura's (1971) social learning theory, it can be argued that supervisors, managers, and peers are important role models. If nurses can observe that patient participation-stimulating behaviour is practiced and preached by supervisors, managers, and peers, then they might be encouraged to learn and perform this behaviour. Moreover, when nurses experience support and approval from their supervisors when performing patient participation-stimulating behaviour, they might gain confidence and positive attitudes towards facilitating patient participation.

In addition, the concept of self-efficacy (Bandura 1977) can partly explain why nurses are more willing to accept a new role when they perceive themselves as more competent to facilitate patient participation. Bandura (1977, p. 194) states: 'Given appropriate skills and adequate incentives, efficacy expectations are a major determinant of people's choice of activities, how much effort they will expend, and of how long they will sustain effort in dealing with stressful situations.' Therefore, in light of our study, it can be argued that when nurses perceive themselves more competent to share power and responsibility with patients, they might be better enabled to initiate and sustain this patient participation-stimulating behaviour, even in stressful situations. This statement is particularly relevant for the present study, which focusses on patient safety. It is known that psychiatric nurses often deal with high-risk situations (e.g. patients' self-harm, suicidal behaviour). Such situations can induce emotional and aversive experiences, which can trigger defensive attitudes. Thus, based on Bandura's (1977) study, when nurses perceive and develop personal competencies to perform patient participation-stimulating behaviour, this might also challenge their defensive, risk-avoidant approaches to patient safety.

Furthermore, it was found that nurses on closed wards were less willing than nurses on open wards to accept a new role. One explanation for this finding is that closed wards are inherently less patient-participation friendly. In their review focusing on locked wards, van der Merwe et al. (2009) found that the closed nature of wards can restrict patients' freedom and emphasise the patient-nurse power imbalance. Moreover, compared to open wards, closed wards are more often the context for involuntary treatments. Because of the particular characteristics of the patient population and the ward's infrastructure, it is likely that nurses on closed wards perceive less opportunities to share power and responsibility with patients.

3.4.2. Factual questions and challenging questions (model II)

The receptivity of nurses to patients' factual and challenging questions is negatively associated with nurses' willingness to accept a new role. This surprising finding must be considered carefully. The descriptive statistics showed that the vast majority of nurses (> 89%) perceive themselves willing and able to deal with either factual, challenging, or notifying questions. For most items of the 'challenging questions' and 'notifying questions' components, a multivariate logistic regression model was not even applied, because the number of negative answers (non-events) was too low relative to the number of predictor variables. This restricted the possibility to obtain valid parameter estimates. Considering the positive responses on the challenging and notifying questions, it remains unclear whether nurses feel positive about patients' questions, because it provides them opportunities to

engage in collaborative risk management and facilitate patient participation, or because these questions enable them to avoid risks and keep control.

Nurses reported being least receptive to the patients' challenging question: 'Have you washed/disinfected your hands?'. This might provide some confirmation of the assumption based on the studies of van den Brink-Muinen et al. (2006) and Davis et al. (2011) that nurses perceive themselves less receptive to patients' challenging questions compared to patients' factual questions. Simultaneously, setting-specific aspects might partly explain why nurses perceive themselves least receptive to the patients' question: 'Have you washed/disinfected your hands?'. Despite the high relevance of infection spreading in this context, mental healthcare systems often lack specific personnel, resources, and measures to perform and monitor infection prevention. Moreover, because hand hygiene guidelines are usually tailored to general healthcare systems, those are often less suitable for mental healthcare systems (Fukuta & Muder 2013; Ott & French 2009). Therefore, when their hand hygiene behaviour is questioned, nurses might feel insufficiently equipped to respond and act upon this question.

3.4.3. Limitations

When interpreting the findings, it should be considered that the study was conducted in Flanders (Belgium), a region where the establishment of community mental healthcare is in its infancy (Lorant et al. 2016). Despite a significant decrease of psychiatric beds in the past decade, Belgium has still one of the highest numbers of psychiatric beds per 100.000 inhabitants in the world (Chow & Priebe 2016; World Health Organization 2008). Countries with a longer tradition of deinstitutionalisation might have more supportive societal and cultural norms regarding the inclusion and participation of individuals with mental health problems, which could reflect the perceptions of patients and healthcare workers regarding patient participation (Chow & Priebe 2016).

Another limitation was that the current study only considered nurses' perspective of patient participation. Acknowledging that the process of power and responsibility sharing is reciprocal, positive scores on nurse-related factors do not necessarily mean that patients can engage in a collaborative way with nurses. Patient-related factors, such as patients' willingness, preferences, and perceived competence to participate, must also be considered when evaluating patient participation (Broer et al. 2014; Davis et al. 2011).

In addition, the possibility of non-response bias should be considered. This bias could have occurred if the nurses who chose to participate had more favourable views towards patient participation, or differed on demographic characteristics, compared to nurses who did not participate (Polit & Beck 2012). For example, the ethnic and cultural background of the

nurses and the patients they interact with were not identified, although these characteristics can influence patient participation in patient safety (Johnstone & Kanitsaki 2009; Longtin et al. 2010). It should not simply be assumed that all nurses and patients are able to communicate proficiently in the region's mainstream language (Dutch), are able and willing to check and challenge patient safety issues, and attribute similar cultural meanings to patient participation in patient safety (Johnstone & Kanitsaki 2009).

Another potential limitation was that the validity of the self-reported answers could be subject to social desirability bias. The challenging and notifying questions, in particular, which raise awareness of potential adverse events (e.g. spread of infections) or harm (e.g. suicide and self-harm) can be prone to socially-sensitive responses (King & Bruner 2000). Therefore, the positive responses can be a reflection of the tendency of nurses to present a favourable image of themselves, rather than a reflection of their actual behaviour in practice (van de Mortel 2008). In addition, the fact that almost all scores show a positive 'skew' might suggest that the applied instrument does not fully capture the true variability in the participants' perceptions. This would then require more efforts to determine the sensitivity of the PaCT-PSY (Malfait et al. 2017). More specifically, repeated measures are needed to determine how well the PaCT-PSY discriminates between individual categories of participants (cross-sectional discrimination) and assesses changes over time (longitudinal discrimination) (Polit and Beck 2012). This is important because a lack of sensitivity impedes the instrument's potential to detect changes in the ward or hospital culture, especially given that cultural change represents a multi-faceted and complex endeavour in psychiatric hospitals (Espinosa et al. 2015).

The high percentage of positive responses on the 'challenging questions' and 'notifying questions' variables limited the opportunities of the study. Most of the excluded items were related to patient safety-specific issues and conditions, such as medication, aggression, suicide, and self-harm. Because this specificity is largely absent in the 'acceptance of a new role' outcome variable, the study conclusions remain restricted to general statements about patient safety, and relevant but less prominent patient safety issues and practices in mental health (e.g. hand hygiene). Future studies evaluating collaborative approaches towards risk assessment and safety management must consider patient safety-specific conditions, such as self-harm, emotional harm, and suicidal ideation and behaviour. This is because such conditions can mediate the nature of nurses' engagement with patients, including the extent to which nurses share responsibility (Manuel & Crowe 2014). Within this understanding, evidence points to a tendency of psychiatric nurses to adopt a defensive, risk-avoidant attitude towards assessing and discussing risks of suicide with patients. Adopting such a risk-avoidant attitude might severely restrict the opportunities of nurses and patients to

identify potential harm, and to establish nurse-patient relationships characterised by trust and collaboration (Cutcliffe et al. 2006; Lees et al. 2014).

3.5. Conclusion

The acceptance of a role, wherein nurses share power and responsibility with patients concerning patient safety, is positively associated with being male, older, employed on an open ward, and the perception of personal competence and support to facilitate patient participation. To support nurses in fulfilling their role in patient participation, it is fundamental to provide basic and continuing education specific towards facilitating patient participation. Furthermore, managers and supervisors within psychiatric settings must offer support to nurses, and provide them with the necessary resources to facilitate patient participation in patient safety. Special attention is needed for young nurses and nurses on closed psychiatric wards, because these particular groups report being more reluctant to accept a new role. More research is needed to explore the willingness and ability of nurses to engage in collaborative safety management with patients who have specific conditions, such as suicidal ideation and emotional harm.

3.6. Relevance for clinical practice

The findings in the present study indicate that managers and supervisors (e.g. head nurses) occupy a facilitating position in patient participation. They can act as a role model, provide support to nurses, and encourage a culture of collaboration on the ward. Managers and supervisors should emphasise that patient participation is a priority in the organisation, and provide educational and working conditions that enable nurses to engage in patient participation. Therefore, they must promote the principles of patient participation and be responsive for perceived barriers of nurses to facilitate patient participation, including a lack of training, low staffing levels, and work overload (Hickey & Kipping 1998; Vaismoradi et al. 2015). Special attention is needed for young nurses and nurses on closed wards, because these groups tend to be more reluctant to accept a new role, wherein they share power and responsibility with patients in patient safety. Based on Benner's (1982) model, the provision of specific basic and continuing education can be viewed as an effective strategy to enhance the competencies (e.g. communication and reflection) of nurses to engage in collaborative safety management with patients. Particularly in closed wards with an inherent restrictive nature (van der Merwe et al. 2009), psychiatric nurses should be supported to become aware of, and facilitate, opportunities for patient participation and to reflect on the indiscriminate use of coercive practices. Contemporary models and approaches, such as the Safewards model

(Bowers 2014) and positive risk-taking (Morgan 2004), provide valuable insights to stimulate this reflection and to inform collaborative nurse-patient interactions in managing risk and safety. Future research should apply cross-cultural designs to compare patient participation in patient safety while accounting for contemporary international evolutions, such as the growing cultural diversity in healthcare and the varying levels of deinstitutionalisation.

References

Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal*, 16, 11-23. doi.org/10.1037/h0095655

Bandura, A. (1971). *Social Learning Theory*. New York City, NY: General Learning Press.

Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavioral change. *Psychological Review*, 84, 191-215. doi.org/0.1037//0033-295x.84.2.191

Benner, P. (1982). From novice to expert. *American Journal of Nursing*, 82, 402-407.

Birch, S., Cole, S., Hunt, K., Edwards, B. & Reaney, E. (2011). Self-harm and the positive risk taking approach. Can being able to think about the possibility of harm reduce the frequency of actual harm? *Journal of Mental Health*, 20, 293-303. doi.org/10.3109/09638237.2011.570809

Bowers, L. (2014). Safewards: A new model of conflict and containment on psychiatric wards. *Journal of Psychiatric and Mental Health Nursing*, 21, 499-508. doi.org/10.1111/jpm.12129

van den Brink-Muinen, A., van Dulmen, S. M., de Haes, H. C., Visser, A. P., Schellevis, F. G. & Bensing, J. M. (2006). Has patients' involvement in the decision-making process changed over time? *Health Expectations*, 9, 333-342. doi.org/10.1111/j.1369-7625.2006.00413.x

Broer, T., Nieboer, A. P. & Bal, R. (2014). Mutual powerlessness in client participation practices in mental health care. *Health Expectations*, 17, 208-219. doi.org/10.1111/j.1369-7625.2011.00748.x

Chow, W. S. & Priebe, S. (2016). How has the extent of institutional mental healthcare changed in Western Europe? Analysis of data since 1990. *British Medical Journal Open*, 6, e010188. doi.org/10.1136/bmjopen-2015-010188

Coulter, A. (1999). Paternalism or partnership? Patients have grown up-and there's no going back. *British Medical Journal*, 319, 719-720. doi.org/10.1136/bmj.319.7212.719

Cutcliffe, J. R., Stevenson, C., Jackson, S. & Smith, P. (2006). A modified grounded theory study of how psychiatric nurses work with suicidal people. *International Journal of Nursing Studies*, 43, 791-802. doi.org/10.1016/j.ijnurstu.2005.09.001

Davis, R. E., Sevdalis, N. & Vincent, C. A. (2011). Patient involvement in patient safety: How willing are patients to participate? *BMJ Quality & Safety*, 20, 108-114. doi.org/10.1136/bmjqs.2010.041871

Espinosa, L., Harris, B., Frank, J., Armstrong-Muth, J., Brous, E., Moran, J., & Giorgi-Cipriano, J. (2015). Milieu Improvement in Psychiatry Using Evidence-Based Practices: The Long and Winding Road of Culture Change. *Archives of Psychiatric Nursing,* 29, 202-207. doi.org/10.1016/j.apnu.2014.08.004

Farkas, M., Gagne, C., Anthony, W. & Chamberlin, J. (2005). Implementing recovery oriented evidence based programs: Identifying the critical dimensions. *Community* Mental Health Journal, 41, 141-158. doi.org/10.1007/s10597-005-2649-6

Fukuta, Y. & Muder, R. (2013). Infections in psychiatric facilities, with an emphasis on outbreaks. *Infection Control and Hospital Epidemiology*, 34, 80-88. doi.org/10.1086/668774

Heck, R. H., Scott, L. T. & Lynn, N. T. (2014). *Multilevel and Longitudinal Modeling With IBM SPSS*. New York City, NY: Routledge.

Hickey, G. & Kipping, C. (1998). Exploring the concept of user involvement in mental health through a participation continuum. *Journal of Clinical Nursing*, 7, 83-88. doi.org/10.1046/j.1365-2702.1998.00122.x

Higgins, A., Doyle, L., Downes, C. et al. (2015). There is more to risk and safety planning than dramatic risks: Mental health nurses' risk assessment and safety-management practice. *International Journal of Mental Health Nursing*, 25, 159-170. doi.org/10.1111/inm.12180

Hox, J. (2002). *Multilevel Analysis: Techniques and Applications*. New York, NY: Taylor & Francis.

James, K., Stewart, D. & Bowers, L. (2012). Self-harm and attempted suicide within inpatient psychiatric services: A review of the literature. *International Journal of Mental Health Nursing*, 21, 301-309. doi.org./0.1111/j.1447-0349.2011.00794.x

Johnstone, M. J. & Kanitsaki, O. (2009). Engaging patients as safety partners: Some considerations for ensuring a culturally and linguistically appropriate approach. *Health* Policy, 90, 1-7. doi.org/10.1016/j.healthpol.2008.08.007

Jonker, E. J., Goossens, P. J., Steenhuis, I. H. & Oud, N. E. (2008). Patient aggression in clinical psychiatry: Perceptions of mental health nurses. *Journal of Psychiatric and Mental Health Nursing*, 15, 492-499. doi.org.10.1111/j.1365-2850.2008.01261.x

Kanerva, A., Lammintakanen, J. & Kivinen, T. (2013). Patient safety in psychiatric inpatient care: A literature review. *Journal of Psychiatric and Mental Health Nursing*, 20, 541-548. doi.org/10.1111/j.1365-2850.2012.01949.x

Kanerva, A., Lammintakanen, J. & Kivinen, T. (2014). Nursing staff's perceptions of patient safety in psychiatric inpatient care. *Perspectives in Psychiatric Care*, 52, 25-31. doi.org/10.1111/ppc.12098

King, M. F. & Bruner, G. C. (2000). Social desirability bias: A neglected aspect of validity testing. *Psychology and Marketing*, 17, 79-103. doi.org/10.1002/(SICI)1520-6793(200002)17:2<79::AID-MAR2>3.0.CO;2-0

Leamy, M., Bird, V., Le Boutillier, C., Williams, J. & Slade, M. (2011). Conceptual framework for personal recovery in mental health: Systematic review and narrative synthesis. *The British Journal of Psychiatry*, 199, 445-452. doi.org/10.1192/bjp.bp.110.083733

Lees, D., Procter, N. & Fassett, D. (2014). Therapeutic engagement between consumers in suicidal crisis and mental health nurses. *International Journal of Mental Health Nursing*, 23, 306-315. doi.org/10.1111/inm.12061

Longtin, Y., Sax, H., Leape, L., Sheridan, S., Donaldson, L. & Pittet, D. (2010). Patient participation: Current knowledge and applicabiliy to patient safety. *Mayo Clinical Proceedings*, 85, 53-62. doi.org/10.4065/mcp.2009.0248

Lorant, V., Grard, A., Van Audenhove, C., Helmer, E., Vanderhaegen, J. & Nicaise, P. (2016). Assessment of the priority target group of mental health service networks within a nation-wide reform of adult psychiatry in Belgium. *BMC Health Services Research*, 16, 187. doi.org/10.1186/s12913-016-1434-2

Malfait, S., Eeckloo, K., Van Daele, J. & Van Hecke, A. (2016). The Patient Participation Culture Tool for healthcare workers (PaCT-HCW) on general hospital wards: A development and psychometric validation study. *International Journal of Nursing Studies*, 61, 187-197. doi.org/10.1016/j.ijnurstu.2016.05.015

Malfait, S., Vandewalle, J., Eeckloo, K., Colman, R. & Van Hecke, A. (2017). The Development and validation of the patient participation culture tool for inpatient psychiatric wards (PaCT-PSY). *Archives of Psychiatric Nursing*, 31, 463-469. doi.org/10.1016/j.apnu.2017.06.010

Manuel, J. & Crowe, M. (2014). Clinical responsibility, accountability, and risk aversion in mental health nursing: A descriptive, qualitative study. *International Journal of Mental Health Nursing*, 23, 336-343. doi.org/10.1111/inm.12063

van der Merwe, M., Bowers, L., Jones, J., Simpson, A. & Haglund, K. (2009). Locked doors in acute inpatient psychiatry: A literature review. *Journal of Psychiatric and Mental Health Nursing*, 16, 293-299. doi.org/10.1111/j.1365-2850.2008.01378.x

Morgan, S. (2004). Positive risk-taking: An idea whose time has come. *Health Care Risk Report*, 10, 18-19.

van de Mortel, T. (2008). Faking it: Social desirability response bias in self-report research. *Australian Journal of Advanced Nursing*, 25, 40-48.

Muskett, C. (2014). Trauma-informed care in inpatient mental health settings: A review of the literature. *International Journal of Mental Health Nursing*, 23, 51-59. doi.org/10.1111/inm.12012

Ott, M. & French, R. (2009). Hand hygiene compliance among health care staff and student nurses in a mental health setting. *Issues in Mental Health Nursing*, 30, 702-704.

Peplau, H. E. (1997). Peplau's Theory of interpersonal relations. *Nursing Science Quarterly*, 10, 162-167. doi.org/10.1177/089431849701000407

Phillips, N., Street, M. & Haesler, E. (2015). A systematic review of reliable and valid tools for the measurement of patient participation in healthcare. *BMJ Quality & Safety*, 25, 110-117. doi.org/10.1136/bmjqs-2015-004357

Polit, D. F. & Beck, C. T. (2012). *Nursing Research: Generating and Assessing Evidence for Nursing Practice*, 9th edn. Philadelphia, PA: Wolters Kluwer Health.

Sahlsten, M. J. M., Larsson, I. E., Sjöström, B. & Plos, K. A. (2008). An analysis of the concept of patient participation. *Nursing Forum*, 43, 2-11. doi.org/10.1111/j.1744-6198.2008.00090.x

Shattell, M. M., Starr, S. S. & Thomas, S. P. (2007). 'Take my hand, help me out': Mental health service recipients' experience of the therapeutic relationship. *International Journal of Mental Health Nursing*, 16, 274-284. doi.org/10.1111/j.1447-0349.2007.00477.x

Snyder, H. & Engstrom, J. (2016). The antecedents, forms and consequences of patient involvement: A narrative review of the literature. *International Journal of Nursing Studies*, 53, 351-378. doi.org/10.1016/j.ijnurstu.2015.09.008

Stickley, T. & Felton, A. (2006). Promoting recovery through therapeutic risk taking. *Mental Health Practice*, 9, 26-30. doi.org/10.7748/mhp2006.05.9.8.26.c1910

Storm, M. & Edwards, A. (2013). Models of user involvement in the mental health context: Intentions and implementation challenges. *Psychiatric Quarterly*, 84, 313-327. doi.org/10.1007/s11126-012-9247-x

Stringer, B., Van Meijel, B., De Vree, W. & Van der Bijl, J. (2008). User involvement in mental health care: The role of nurses. A literature review. *Journal of Psychiatric and Mental Health Nursing*, 15, 678-683. doi.org/10.1111/j.1365-2850.2008.01285.x

Tambuyzer, E., Pieters, G. & Van Audenhove, C. (2014). Patient involvement in mental health care: One size does not fit all. *Health Expectations*, 17, 138-150. doi.org/10.1111/j.1369-7625.2011.00743.x

Vaismoradi, M., Jordan, S. & Kangasniemi, M. (2015). Patient participation in patient safety and nursing input - a systematic review. *Journal of Clinical Nursing*, 24, 627-639. doi.org/10.1111/jocn.12664

Verhaeghe, S., Duprez, V., Beeckman, D., Leys, J., Van Meijel, B. & Van Hecke, A. (2014). Mental Health Nurses' attitudes and perceived self-efficacy toward inpatient aggression: A cross-sectional study of associations with nurse-related characteristics. *Perspectives in Psychiatric Care*, 52, 12-24. doi.org/10.1111/ppc.12097

Vincent, C. A. & Coulter, A. (2002). Patient safety: What about the patient? *Quality and Safety in Health Care*, 11, 76-80. doi.org/10.1136/qhc.11.1.76

World Health Organization (2008). Policies and practices for mental health in Europe - meeting the challenges. Retrieved from: www.euro.who.int/__data/assets/pdf_file/0006/96450/E91732.pdf

World Health Organization (2013). Exploring patient participation in reducing health-care-related safety risks. Retrieved from: www.euro.who.int/__data/assets/pdf_file/0010/185779/e96814.pdf

Chapter 4. ‘Promoting and preserving safety and a life-oriented perspective’: A qualitative study of nurses’ interactions with patients who experience suicidal ideation

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Abstract

Suicide prevention is an imperative for psychiatric hospitals, where nurses have a crucial role in and make essential contributions to suicide prevention and promoting the recovery of patients experiencing suicidal ideation. The present qualitative grounded theory study aimed to uncover and understand the actions and aims of nurses in psychiatric hospitals during their interactions with patients experiencing suicidal ideation. Interviews were conducted with 26 nurses employed on 12 wards in four psychiatric hospitals. The data analysis was inspired by the Qualitative Analysis Guide of Leuven. The findings show that nurses’ actions and aims in their interactions with patients experiencing suicidal ideation are captured in the core element ‘promoting and preserving safety and a life-oriented perspective’. This core element represents the three interconnected elements ‘managing the risk of suicide’, ‘guiding patients away from suicidal ideation’, and ‘searching for balance in the minefield’. The enhanced understanding of nurses’ actions and aims can inform concrete strategies for nursing practice and education. These strategies should aim to challenge overly controlling and directing nursing approaches and support nurses’ capacity and ability to connect and collaborate with patients experiencing suicidal ideation.

4.1. Introduction

Suicide is a leading cause of death worldwide, accounting for at least 800,000 deaths each year (WHO 2018). The global lifetime prevalence is estimated to be 2.7% for suicide attempts and 9.2% for suicidal ideation, which refers to thinking about, considering, or planning suicide (Nock et al. 2008). Given suicide's profound impact at the personal, economic, and community levels, many countries and regions have developed national or regional suicide prevention plans containing several prevention strategies and actions (Zalsman et al. 2016).

Suicide prevention is an imperative for primary care and general hospitals (Hawton et al. 2015; Raue et al. 2014) and especially for psychiatric hospitals, given the association of suicide with mental health problems (Cavanagh et al. 2003) and the high suicide risk during psychiatric inpatient admission (Madsen et al. 2012;Walsh et al. 2015). Regarding psychiatric hospitals, the literature suggests the crucial role of nurses in multidisciplinary teams in preventing suicide and promoting patients' recovery from suicidal ideation (Cutcliffe & Stevenson 2008; Sellin et al. 2017). Reflecting this focus, the term 'nurses' is used throughout the present article to refer to nurses working in psychiatric hospitals. In addition, the formulation 'patients experiencing suicidal ideation' is used to acknowledge the hospital context while recognising and validating patients' individuality and the range of suicidal thoughts and feelings they can experience.

4.1.1. Background

Their position proximate to patients has made nurses a particular target of suicide prevention policies encompassing the use of risk assessment tools, involvement in formal observations, removal of harmful items, and restraint and seclusion of patients (Bowers et al. 2011; Kontio et al. 2012; Manuel et al. 2018). In addition, their proximity to patients makes nurses ideally placed to develop a therapeutic engagement with patients experiencing suicidal ideation that is underpinned by an interpersonal relationship, trust, acceptance and tolerance, and listening and understanding (Cutcliffe & Barker 2002; Lees et al. 2014). Nurses' capacity and ability to develop therapeutic engagement with patients experiencing suicidal ideation provide a vehicle to inspire hope in patients, understand the nature of their needs and problems, address their loss of control and distress, validate them as human beings, and help them move from a death-oriented position to a life-oriented position (Cutcliffe & Stevenson 2008; Lees et al. 2014; Talseth et al. 1999). Studies worldwide highlight that nurses' interactions with patients experiencing suicidal ideation often lack therapeutic engagement and are even devoid of the basics of care, such as acknowledging patients as

individuals and treating them with respect and empathy (Cutcliffe et al. 2015; Lees et al. 2014; Slemon et al. 2017). Several authors argue that the fundaments of nursing are under pressure, partly due to increasing requirements for nurses to conform to and uphold standardised and defensive practices for suicide prevention (e.g. formal observations, physical restraint, and seclusion) and growing demands for professional and public accountability with regard to ensuring patient safety inside and outside the ward (Hagen et al. 2017a; Higgins et al. 2016; Manuel & Crowe 2014). This context largely dictates the actions and aims of nurses in practice. As an example, Manuel et al. (2018) uncovered conflicts between policy recommendations to increase the use and restrictive level of protocolbased interventions to ensure patient safety and the views of clinicians, including nurses, that such recommendations undermine their intentions to develop therapeutic engagement with patients. While such findings reflect the challenge for research and practice of integrating clinical knowledge into the evidence base of suicide prevention (O'Connor & Portzky 2018), they also reflect that nurses' perspectives are often overlooked and that there is no clear articulation of what nurses do and what contribution they (can) make (Browne et al. 2012; Santangelo et al. 2018).

4.1.2. Aim

The aim of the study was to uncover and understand the actions and aims of nurses in psychiatric hospitals during their interactions with patients experiencing suicidal ideation. This focus reflects the need to consider nursing care for patients with suicidal ideation beyond actions and to understand the processes that underpin the nurses' actions.

4.2. Methods

4.2.1. Design

A qualitative grounded theory study with systematic and constant comparison analyses was conducted. This approach was indicated as the most appropriate given the aim to uncover basic elements in human interactions (nurse-patient) and to understand 'how' and 'why' people (nurses) act in certain ways (Foley & Timonen 2015; Glaser & Strauss 1967). The data collection and data analysis interacted in a cyclical process to support the progressive identification and integration of concepts and relations between concepts (Glaser 2002; Hallberg 2006).

4.2.2. Participants

Nurses were recruited on 12 wards of four psychiatric hospitals geographically distributed across Flanders (the Dutch-speaking part of Belgium). The head nurses on the wards acted as contact persons. They invited potential participants and facilitated the contact between the interviewer and the participants. The head nurses were fully informed about the study through an informed consent sheet and face-to-face interaction. In this process, the researchers had particular attention for explaining the aim of the study and clarifying the inclusion criteria. Nurses could be included if they were assigned to adult patients with suicidal ideation in the past year in a nursing model (e.g. primary or team nursing model). The interested nurses were contacted through the e-mail address provided by the head nurses.

4.2.3. Data collection

The first authour conducted individual semi-structured interviews with 26 nurses. He used an interview guide with open-ended questions, including the opening question 'What is it like for you to interact with patients who experience suicidal ideation?' The interviews were conducted in the hospitals, lasted between 61 and 120 min (mean 78), and were audio-recorded and transcribed. The interviewer was a PhD candidate with three years of prior experience as a nurse in a psychiatric hospital. He used reflexivity to facilitate active acknowledgement and explicit recognition of how his position as a researcher and his experience as a nurse affect the data collection. The other researchers supervised his contributions to the study based upon their diverse backgrounds (e.g. different fields of nursing, mental healthcare, and qualitative research). This diversity supported the possibility to monitor assumptions or biases based on substantive, methodological, or personal background of the researcher(s) (Creswell & Miller 2000; Foley & Timonen 2015).

In accordance with grounded theory (Glaser & Strauss 1967), data were collected at different geographical locations and new data were collected based on the emerging insights obtained from the constant comparison analysis. As an example, the preliminary analyses of the first interviews showed a predominant focus of nurses on formal and defensive actions aimed at ensuring patients' safety. This focus seemed to be high relative to the attention of these nurses for relational elements in their interactions with patients (e.g. collaborating). Nuanced discussions of these preliminary insights within the research team highlighted the need for efforts to broaden and deepen the understanding of the various elements in nurse–patient interactions. One of these efforts was that head nurses were asked whether they could also

invite nurses who attach more importance to relational elements in their interactions with patients experiencing suicidal ideation.

4.2.4. Ethical considerations

The study was approved by the Ethical Committee of the Ghent University Hospital and the local Ethical Committees of the hospitals (B670201630531). The participants were fully informed about the goal of the study, the nature of involvement, the voluntariness of participation, and the confidential treatment and anonymity of the data. This information was provided through an informed consent sheet and face-to-face interaction. All participants provided written and verbal informed consent prior to participation.

4.2.5. Data analysis

Systematic and constant comparison analyses were prioritised to support the progressive identification and integration of concepts and relations between concepts (Glaser 2002; Hallberg 2006). The Qualitative Analysis Guide of Leuven (QUAGOL) was considered particularly useful to support these evolving processes of analysis within a grounded theory approach (Dierckx de Casterle et al. 2012). The first authour repeatedly read the transcripts and listened to the audio recordings. In line with the QUAGOL, he wrote memos and developed a narrative report and a conceptual scheme of each interview to identify preliminary concepts while developing a holistic understanding of the context wherein the concepts acquire their meaning (Dierckx de Casterle et al. 2012). The last authour read all the transcripts and added memos. The first and last authour engaged in open discussions about the emerging insights to elaborate the concepts and the relations between concepts. Three other researchers read some of the transcripts, made their own memos, and checked and verified the emerging conceptual understandings. Alongside this attention for investigator triangulation, reflexivity was prioritised and discussed in order for the researchers to remain open to varied interpretations and to monitor assumptions or biases (Creswell & Miller 2000; Foley & Timonen 2015). The recurrent open discussions inspired the constant comparison analysis and the purpose of compiling a list of meaningful concepts. Then, the first and last authour read the interviews again and used the QSR NVivo 10 software programme (QSR International, Burlington, MA, USA) to code the data. These efforts supported the process of shaping the essential analysis structure and describing the conceptual meanings and relations. Data saturation was confirmed based upon the cyclical

processes of gradually deepening the analysis and the recurring discussions within the research team (Dierckx de Casterle et al. 2012).

4.3. Findings

The interviewed nurses (n = 26) were employed on adult wards with an open or closed entrance divided according to psychotherapeutic focus (e.g. mentalisation-based treatment), age (e.g. ≥ 35 years), or psychiatric diagnoses (e.g. mood disorders). On average, the nurses were aged 36 years (range: 22-61) and had been employed for 12 years as a nurse (range: 1-39). They all had a degree in psychiatric nursing. While all the nurses had direct experiences of patients' suicide attempts, 18 nurses had at least one professional experience of a patient's suicide. The demographic data are summarised in Table 1.

TABLE 1: *Demographic data of the nurses*

	Age (years)					
	<25	25–34	35–44	45–54	≥55	*n* = 26
Gender						
Female	2	6	5	3	1	17
Male	1	5	1	1	1	9
Employment (years)						
<5	3	4	2			9
5–14		7	1	1		9
15–24			3	1		4
≥25				2	2	4
% FTE appointment						
100	3	9	3	2	1	18
75		2	3	2		7
50					1	1
Education level						
Undergraduate		3	3	3	1	10
Bachelor's	3	6	3	1	1	14
Master's		2				2
Ward type[†]						
Closed		4			1	5
Open	3	7	6	4	1	21
	3	11	6	4	2	

*Ward type: entrance of the ward is open or closed.

4.3.1. Promoting and preserving safety and a life-oriented perspective

'Promoting and preserving safety and a life-oriented perspective' reflects nurses' actions and aims in their interactions with patients who experience suicidal ideation. This core element represents the three interconnected elements 'managing the risk of suicide', 'guiding patients away from suicidal ideation', and 'searching for balance in the minefield'. Nurses emphasised other aspects depending on whether their interactions with patients experiencing suicidal ideation are guided more by controlling and directing patients or by connecting and collaborating with patients.

4.3.2. Managing the risk of suicide

Nurses consider it important to use suicide prevention protocols. They explained that these protocols provide guidance to assess suicide risk, assign a level of risk to patients, and carry out actions, such as removing suicide means, locking doors or enforcing seclusion, and performing formal observations by checking on patients, having standardised conversations with patients, or having patients sign an observation form. Some nurses use protocols primarily to ensure a secure environment. They conduct formal observations to check and control suicide risk, determine whether the assigned risk level to patients is sufficient, and intensify formal observations and protective measures accordingly.

> *"If risk level two is assigned to patients, then we have one standard conversation with them before noon and one conversation after noon. We assign the third level of risk to patients if their suicidality is more serious. Then we also observe them every half hour and document their whereabouts. Finally, we have level four, which refers to very serious suicidality. Most of the time this means that we seclude patients, with or without fixation."* (male, 25-34y, closed ward)

> *"In the past, we would check patients once every hour, but now, based on the protocol, we check patients every fifteen minutes if they express suicidal thoughts or when we are suspicious of emerging suicidal ideation."* (female, 35-44y, open ward)

Other nurses indicated that they are considerate towards using formal observations and protective measures. They emphasised that they only use these interventions in a way that

still allows patients to feel that a human is interacting with them, a human who treats them as a valid person. They reflected that their main intention is not to control patients but rather to initiate caring contact with patients and to be sensitive and responsive to their needs. These nurses stressed their commitment to being present with patients in a way that conveys compassion, eases their burden, and gives them courage. Nurses perceive that this contact is intense but worthwhile because it provides a foundation upon which to develop an emotional connection. They articulated that this connection facilitates patient-nurse contact, enables patients' communication of their suicidal ideation, and can serve as a secure base during suicidal crises.

> *"There is a suicide prevention protocol, and everyone follows it like a robot. I strongly believe you should perform interventions so that patients feel that someone is interacting with them as a person and not as a professional who has to check patients every 15 minutes because that is expected! I believe it is far more important to be present with patients, listen to them, and establish that connection, even if you go to them every 15 minutes." (male, 25-34y, closed ward)*

> *"I try to make a connection with patients by being present, recognising them and their story, and avoiding the reflex to initiate quick solutions. I belief that connecting is the most important thing, being human in contact with patients, showing your willingness to understand how difficult it is for them."* (female, ≥ 55y, open ward)

Nurses indicated that they make agreements with patients to manage suicide risk and potentially risky situations (e.g. ward leave). Some nurses' perspectives reflected that making agreements follows a controlling and directing discourse. These nurses indicated that they allow patients to negotiate procedural features in a way that limits the intrusive nature of the procedures and (thus) assures their application and protective value. Furthermore, these nurses use persuasive communication to exercise control both inside and outside the ward. For example, they may express the expectation that patients phone them during weekend leave or move from their room to the ward's dayroom so that they can better be observed. Some nurses indicated that such expectations can be part of a contract in which patients agree not to harm themselves.

> *"We had an agreement that he must call us on Saturday and Sunday morning to let us know what he is doing and how he feels. But he did not call us on Sunday*

morning! And then we waited for a while, and Sunday afternoon his brother found him dead at home." (female, 35-44y, open ward)

"Sometimes patients are able and prefer to come to our nursing station downstairs. And if that is feasible, then I say to them, 'Let us agree that you come downstairs every hour to sign the sheet of paper we have for you'." (female, < 25y, open ward)

For other nurses, making agreements is a collaborative endeavour of working through suicidal crises with patients. These nurses avoid imposing instant protection and instead engage in dialogue with patients that facilitates understanding of risks and potentially risky situations (e.g. taking a bath), the meaning that patients attach to risks and potentially risky situations, and what can be done to address risks. Nurses reflected that these dialogues are underpinned by mutuality in the form of connectedness, trust, enabling patients' choice, and including patients' views. Mutuality also means that nurses can suggest alternatives and express their concerns to patients when they perceive that patients' proposals (e.g. request for ward leave) might be more harmful than beneficial. Nurses perceive that their way of making agreements enables them to promote and preserve patients' personal responsibility and self-control. Moreover, they perceive that making agreements enables them to rely less on protective actions without interfering too little or leaving at-risk patients to themselves.

"I always consider whether I can make agreements with someone. Of course, agreements do not offer 100% certainty. I cannot read the patient's mind. But starting from my relationship with the patient, I can try to leave responsibility with them and explore how they can overcome difficult moments and what can help them in this. Then I believe you can rely on agreements just as well as on protective measures." (male, 45-54y, open ward)

"I believe that for patients and for me, you achieve far better results when you enter into dialogue instead of immediately saying, "We are going to lock your door!". Such intervention is so invasive, while they actually ask for help and want to find solutions together. And then I try to appeal to the relationship we have to make agreements and to ask in all honesty whether the agreements are feasible for them. If patients answer, "It will not be possible", then I have to propose something else. And if they say, "You can trust me!", then I know it is safe." (female, 35-44y, open ward)

Nurses' perspectives reflected that several conditions can trigger a pivot to a more controlling and directing approach. Nurses referred to their interactions with patients who they do not yet know very well, isolate themselves, lack engagement in their treatment, do not disclose suicidal ideation, and who seem to be disconnected from themselves, such as when dealing with psychosis or concrete suicide plans. Besides these elements, some nurses referred to a lack of time and staffing shortage as conditions under which they cannot—or no longer—make agreements with patients, must take control, and rely more on formal observations and protective actions to preserve safety. While nurses perceived that diverse conditions such as lack of time and patients' social isolation can trigger a pivot to a more controlling and directing approach, some nurses framed these conditions as an impetus to make a greater effort to establish caring contact and connection.

> *"I think it is important that we make agreements with patients. But when they are very psychotic... we have already seen that people can do dangerous things and then you cannot just watch and let it happen. In their psychosis they can feel threatened or live in their own world. This makes it difficult to make contact with them and make agreements."* (female, 25-34y, open ward)

> *"When I notice that patients isolate themselves, then for me this is an extra trigger to make contact and to try to establish a connection. In this way I can address their loneliness and focus on the healthy elements, instead of being merely fixated on suicide and everything about prevention. I honestly believe that this only induces more suicidality."* (female, 25-34y, open ward)

4.3.3. Guiding patients away from suicidal ideation

Nurses emphasised their actions and aims to guide patients away from suicidal ideation. These actions and aims reflect a perceived need of nurses to foster patients' sense of hopefulness and prevent hopelessness. This perceived need is underpinned by nurses' perception that patients experiencing suicidal ideation often seek social isolation, are passive and introverted, share repeated expressions of hopelessness, and have little or no perspective on life. Some nurses indicated that patients can be stuck in 'tunnel vision', and that this presents challenges to guide patients away from suicidal ideation.

> *"I believe I am responsible for the well-being of patients. To enable them to see a bit of light at the end of the tunnel or that something can be established that they*

can hold onto and that gives some new courage to continue with life." (male, < 25y, open ward)

"People have a whole history, carry a backpack with them, and very often they have got the door slammed in their face several times. I hope for them that one day it will turn out positive or that I can help to bring about a turnaround of their suicidality, but that is one of the most difficult things." (female, ≥ 55y, open ward)

Nurses find it important to create conditions for patients to (re)gain hope and be distracted from suicidal ideation. Some nurses are primarily concerned with explicit actions. They encourage physical activity by persuading patients to plan their day, follow therapies, or just do something (e.g. sports) to distract them. Furthermore, these nurses operationalise assessment information (e.g. protective factors) by using it to refer patients to therapists or therapies. They perceive that the extent to which they can foster hope in patients largely depends on environmental conditions, such as routines regarding ward leave and the presence of various therapists.

"I explain to patients that we know from experience that if you are preoccupied with suicidal thoughts you get stuck in tunnel vision. And then I ask patients to try something else, to put the death wish aside for a while and to focus on life. Then we discuss actions with them such as walking, listening to music, writing in a diary, calling a friend. We expect those actions from them and try to make them experience that, independent of their bad mood, those actions can prevent them from staying stuck in those negative thoughts." (female, 35-44y, open ward)

"I try to support patients in finding distraction, for instance by saying to creative people "go painting in your room" or to people who are sporty "go to the gym"… If they come more into the ward's dayroom, do sports, or follow therapy, their thoughts might still be present but will be less intense." (male, 25-34y, open ward)

Other nurses expressed that their commitment to establishing caring contact, connection, and collaboration with patients might instil a sense of hope in patients, even when the nurse is not present. These nurses try to create opportunities for patients to express hopeful experiences and perspectives and to gain a sense of meaningful activity. They stressed their commitment to doing things together with patients, listening attentively to the patients' stories, showing genuine interest, and expressing their belief in patients. Furthermore, these

nurses emphasised the significance of being attentive to ‘little things’ such as a daily greeting, drinking coffee together, using humour, and acknowledging positive signs and accomplishments.

> *“Listening and saying, “You are at an end”, “I see that you are tired of fighting”. But look, “I still see it for you!”, or “Tomorrow I will be back, tomorrow we will see each other again”. Saying such things really helps! I believe such little things mean a lot. Use their first name, say “good morning”, or acknowledge it when someone is laughing, wears make-up, ...”* (female, 45-54y, open ward)

> *“I find it important to listen to their life story in order to foster their hope. Do they have children who give them perspective? Did they have a better period in their life? [...] I believe it means a lot to just be together, to make human and warm contact, for instance, when having a coffee together. It must not always be the planned and expected moments, but rather spontaneously and ask what interests them. I believe all those little things can ensure that people have more trust in me and feel a connection. When they feel suicidal, that is something they can hold on to.”* (female, 25-34y, open ward)

Nurses also try to support patients in acquiring awareness and understanding their suicidal ideation. They emphasised the meaning of demonstrating concern for patients to raise the patients’ awareness of their suicidal ideation. In addition, some nurses engage in repeated conversations to support patients in identifying and organising their thoughts and feelings and making sense of their suicidal ideation. Nurses revealed that this is challenging when patients lack insight into their suicidal ideation or verbalise chaotic messages.

In addition, several nurses indicated that they use conversations with patients to explore warning signs and coping strategies, sometimes in consultation with family. Only a few of them operationalise this information in written safety plans. Some nurses use safety planning as part of a controlling and directing approach, in particular by imposing input for the safety plan based on professional assessments. Other nurses present themselves as a coach who coproduces the safety plan with the patient. In this way, they believe that safety planning enables shared and early recognition of emerging suicidal ideation and enhances the patients’ understanding of their suicidal ideation.

> *“When a patient is home and calls me in the evening with the message that it is not going well, then I take that safety plan out of my ring binder and look at it with them to see in what stage of crisis they are and what they can do. “I see that you*

can take a bath because this gives you a relaxed feeling." Then I encourage them to do this again, because they often say, "I have done everything on that list and it does not work". (female, 35-44y, open ward)

"In one-to-one conversations, I try to support the patient's insight into triggers and ways to address their suicidal thoughts. "How do you experience that?", "How do you deal with this?", "What are possible actions?". So I coach them in this process. And personally, I start with a safety plan, because I notice that people can communicate very chaotically and mix up the meaning of their thoughts with their feelings. So I help them to get their thoughts and feelings a bit ordered." (male, 35-44y, open ward)

Nurses try to avoid encouraging suicidal ideation. They indicated that they do not talk too frequently about suicidal ideation and do not 'dig too deep' into the patients' suicidal ideation history. They are cautious not to elicit emotionally loaded issues (e.g. trauma) to a point that patients' suicidal ideation is encouraged and they as nurses cannot offer a solution for the issues raised. Several nurses indicated that talking about traumatic experiences is neither a task nor a competency of them, or that they conform to team agreements that nurses must not engage in such conversations. Some nurses interrupt conversations when patients share repeated expressions of hopelessness or trauma and then offer quick solutions. Offering quick solutions involves directing patients to do something to distract themselves or referring them to a psychologist or psychiatrist for a therapeutic conversation or an evaluation of their medication. Other nurses instead make the autonomous and deliberate decision to engage in conversations in the patients' best interests. They indicated that they as nurses should create time and space to listen to, acknowledge, and understand what patients want to share with them, including trauma and hopelessness.

"If people talk about past traumas, then I believe that is better to refer them to the psychologist because they have learned how to respond to that. As a nurse, I feel less competent to do that and it might be that I make things worse by saying something inappropriate. Patients must know that they can go to the psychologist with their story." (female, 25-34y, closed ward)

"I believe it is more important for patients to be able to come up with a story than to whom they say it. I deliberately do not say, "I am just a nurse!", because I think we have a very important role. I notice that nurses are often the ones to whom patients tell the most stories and the quickest, even about traumas, because we

spend more time with them. So I always tell them that they can tell me everything that lives in them." (female, 45-54y, open ward)

4.3.4. Searching for balance in the minefield

Nurses' interactions with patients experiencing suicidal ideation can be viewed as a minefield in which nurses act with extreme caution, experience intense emotions, and struggle with conflicting actions and aims. Nurses' accounts revealed a conflict between providing sufficient safety and avoiding overprotection. Nurses perceived that protective actions such as seclusion are sometimes the only safe option. Moreover, some nurses indicated that a lack of protective measures on the ward limits their ability to prevent suicide and is sometimes the reason they refer high-risk patients to a ward that is more secure. However, nurses also perceive that protective measures do not guarantee that patients will not attempt or die by suicide. Furthermore, they perceive that protective measures can exacerbate patients' feelings of hopelessness, failure, and loss of dignity, and can provoke agitation and counter-reactions. Nurses experienced that patients sometimes conceal or lie about their suicidal ideation to avoid protective measures. Some nurses reflected that they should avoid overprotection by regularly evaluating whether the application and intensity of protective measures are (still) needed.

"She must have acted immediately after our supervision. Because precisely after 15 minutes we went back to her room ... You know, we watch over them, but patients also watch over us, so if they want to do it [suicide], they always find a way [...]. It will always be searching for a balance. If you want to be certain then you have to put patients naked in a seclusion room under camera surveillance. But is that human dignity? Then you take even more freedom and hope away from them." (female, 45-54y, open ward)

"I sometimes hear people saying, "I did not dare to open up about those suicidal thoughts because I was afraid of being locked up or being not allowed to leave on the weekend". (male, 25-34y, open ward)

Nurses' actions and aims to protect patients can be reinforced by intense emotions when interacting with patients experiencing suicidal ideation, including feelings of guilt about a previous suicide and fear of future suicides. Nurses also indicated that they can feel highly responsible for patients' behaviour, feel distrust towards high-risk patients, and feel insecure and powerless regarding their ability to maintain safety. These feelings can trigger nurses to

preserve or increase patients' assigned risk level, conduct formal observations (beyond the protocol), and restrain and seclude patients for their own comfort. Some nurses acknowledged a need for emotional debriefing to avoid becoming paralysed by intense emotions and preserve open and caring contact with patients. Furthermore, nurses referred to the pressure they feel to meet legal responsibilities, knowing that they can be held accountable if a patient dies by suicide. Nurses described strategies to protect themselves from blame, including conforming to and upholding protocols, documenting about their actions, and shifting the responsibility for decisions involving risk (e.g. ward leave) to colleagues (e.g. psychiatrist).

> *"If there are no safe alternatives, if that person really cannot function on the ward, then I do feel better with that person being in seclusion. That is maybe bad to say but it just makes me feel more secure that the person is safe from harm."* (female, < 25y, open ward)

> *"I try to follow the protocol as well as possible. So I go regularly to the patient, ask them questions, and complete my records. Because in case of a suicide, the police will look into these records and the protocol and then query nurses about their involvement. So I find it very important that they do not get the impression that I have been negligent. And also to hear, "You have done everything!". That feels good because if that happens you feel responsible."* (female, 25-34y, open ward)

In addition, nurses' perspectives reflected a conflict between upholding protection as a predominant aim and promoting and preserving patients' autonomy and self-determination. A number of nurses emphasised that their foremost responsibility is to protect patients, especially when they are at heightened risk of suicide. They believed that they are justified in taking control of patients and minimising suicide risk by putting patients under observation, administering psychotropic medication, taking suicide means into custody, and restraining and secluding patients. These actions are guided primarily by a controlling and directing approach in which nurses cautiously conform to and uphold ward protocols, sometimes regardless of the patients' perspective.

> *"If we evaluate that the suicide risk is too high, we look for seclusion and communicate, "We feel that you can no longer guarantee your own safety, we must take over from you, that is to protect you". I really try to persuade patients that they come with us voluntarily to the seclusion room, that they feel, "I am in a*

protected environment, protected from myself, that is necessary." (female, < 25y, open ward)

"If we indicate to patients that we are going to the seclusion room, then few patients say they'd "rather not". But even when they say they'd "rather not", we do it anyway, and then we emphasise, "Look, we want to protect you against your thoughts"." (male, ≥ 55y, closed ward)

Other nurses indicated that they avoid a 'protection mode', which they described as a position from which they exert constant vigilance and control over patients to prevent suicide. These nurses instead reason and act beyond protocols to create opportunities to attune themselves to the patients' perspective and preserve their autonomy, self-control, and personal responsibility. They criticised legal responsibilities and organisational expectations, claiming that these only underpin, value, and legitimise formal practices to prevent suicide rather than the meaningfulness of interactions such as being genuinely present with patients, addressing their needs, and inspiring hope.

"If someone says to me, "I want to go to my husband", then I will not say, "No, you have to stay here and sign the sheet of paper every hour!". I will listen carefully and negotiate with them, "What would you like to do with your husband?", "Are you going to feel satisfied afterwards?"." (female, 45-54y, open ward)

"Sometimes I spend more time reporting than being present with the person. That is a shame! I sometimes wonder what is most important, "What I write down or what I really do with that person?". Of course, I believe it is important that you write down things in case something happens, but I also believe that there are too many administrative tasks." (female, 35-44y, open ward)

Nurses also expressed uncertainty regarding the appropriateness of their attempts to foster patients' hope. They perceived that patients' suffering can be so intense that it makes no sense to try to inspire hope, which might even induce adverse effects. This conflict was central in the accounts of nurses focusing on explicit actions to foster patients' hope and prevent their hopelessness. Some of them expressed that their actions (e.g. encouraging physical activity) can evoke agitation or disappointment in patients when they do not match the patients' preferences or lack realism in terms of future prospects.

"Stimulating knitting, crochet and tinkering with someone who is totally not creative or competent in that will lead to frustration. So, I try to look at what interests they have and what those were in the past." (female, 35-44y, open ward)

"We try to find out what that person needs. If that person cannot think of anything but suicide, then I think there is no point in fostering hope. If I were in such a negative spiral, it would not have much meaning to me if someone said, 'Come on, life is beautiful!'." (female, 25-34y, open ward)

4.4. Discussion

Nurses' actions and aims in their interactions with patients who experience suicidal ideation are captured within the core element 'promoting and preserving safety and a life-oriented perspective'. This core element represents the three interconnected elements 'managing the risk of suicide', 'guiding patients away from suicidal ideation', and 'searching for balance in the minefield'.

The findings reflect that nurse-patient interactions are importantly underpinned by protocols that are focused on safety and suicide prevention. All nurses were involved in actions such as assigning risk levels, using observation procedures, and applying protective measures. These findings resonate with the literature emphasising the widespread and continuing use by nurses of formal observations, restraint, door-locking, and seclusion. Nurses perform these procedural actions despite evidence questioning their effectiveness in terms of suicide prevention and highlighting their predominant negative emotional and relational outcomes, including increased distress and social isolation, reduced autonomy, and (re)traumatisation (Bowers et al. 2011; Cox et al. 2010; Cusack et al. 2018; Huber et al. 2016; Kontio et al. 2012). The findings confirm some of these outcomes including the nurses' perception that protective measures can exacerbate patients' feelings of hopelessness and provoke counter-reactions (e.g. conceal suicidal ideation) (Cardell & Pitula 1999; Frueh et al. 2005).

Alongside uncovering 'what' actions nurses perform, the grounded theory approach was most appropriate to uncover the dynamics and meanings underlying these actions. While some nurses adhere more to a controlling and directing approach when performing actions (e.g. observations), others manage to underpin and reconcile their actions with caring contact, connection, and collaboration. This insight was also illustrated in the way nurses involve in making agreements and safety planning. The literature describes that safety planning is an evidence-based intervention for therapeutic risk management in (nursing)

practice and that making safety agreements is central to nurse–patient interactions (Higgins et al. 2016; Kontio et al. 2012; Stanley & Brown 2012).

The present study highlights that safety planning can be misapplied and is not a standard in nursing practice. Moreover, it was seen that nurses emphasise other aspects when making agreements with patients. Whereas a connecting and collaborating approach reflects efforts to make shared agreements and to co-construct the patients' safety plan in order to preserve autonomy and develop a shared responsibility for safety, the controlling and directing approach reflects that agreements and safety planning are underpinned by paternalistic and instrumental actions in order to protect patients from harm and to correct their hopelessness (Higgins et al. 2016; Slemon et al. 2017).

The findings offer indications that a connecting and collaborating approach has an inherent potential with regard to achieving safety and therapeutic goals. This insight was highlighted in the nurses' perceptions that efforts to connect and collaborate with patients experiencing suicidal ideation provide a foundation that serves as a secure base during suicidal crises and as a vehicle that fosters patients' hope and prevents their hopelessness. The literature confirms that nurses' efforts to connect and collaborate with patients can support patients in developing a sense of hope (Cutcliffe et al. 2006; Sun et al. 2006), efforts that are crucial given the theoretical association of hopelessness with suicidal ideation (Klonsky & May 2015). Furthermore, the literature suggests that a connection with professionals is crucial for patients' sense of safety and their recovery from suicidal crises, and is a factor that protects against suicide (Berg et al. 2017; Lakeman & FitzGerald 2008). Nurses should engage with patients experiencing suicidal ideation in a way that enables patients to communicate their suffering, gain insight and understanding about their suicidal ideation, and develop coping strategies (Cutcliffe et al. 2006; Lees et al. 2014; McLaughlin 1999; Talseth et al. 1999).

At the same time, the findings show that a large number of nurses adopt an overemphasis on procedural, controlling, and directing approaches. This overemphasis seems to preclude nurses from connecting and collaborating with patients experiencing suicidal ideation, and thereby from more fully realising their potential to achieve safety and therapeutic goals. For instance, the accounts of these nurses reflected minimal emphasis on relational and emotional elements of safety and on efforts to reason and act beyond protocols. However, these elements and efforts are crucial in creating opportunities to attune to the patients' perspective, promote their self-control and personal responsibility, and to best serve patients' recovery from mental health problems and suicidal ideation (Berg et al. 2017; Leamy et al. 2011).

The findings imply that revising policy documents (e.g. protocols) and strategies is warranted so that these do not (unintentionally) contribute to an overemphasis in nursing practice on directing and controlling approaches, and to an understatement of connecting and

collaborating approaches (Hagen et al. 2017a; Higgins et al. 2016). In this respect, the present study can inform policies that aim to reduce the use of restraint and seclusion in psychiatric hospitals and to replace formal observations with approaches that foster meaningful engagement (Cox et al. 2010).

The findings highlight the potential of nursing actions such as making agreements and safety planning, actions that can only be considered as 'therapeutic risk management strategies' when being shaped in collaborative interaction (Kontio et al. 2012; Stanley & Brown 2012). Furthermore, evidence suggests the potential of empathetic interactions, communication skills, and de-escalation techniques as means to prevent or minimise the need for restraint and seclusion (Cusack et al. 2018; Gerace & Muir-Cochrane 2019; Kontio et al. 2012). These insights reflect the importance of incorporating the rudiments of trauma-informed and recovery-oriented care in psychiatric hospitals, including attention for patients' self-determination and choice, emotional and physical safety, connection and hope, and mindful and collaborative interactions (Farkas 2007; Muskett 2014).

Hospital and ward cultures and structures must be considered because they influence nurses' actions and aims in their interactions with patients. The findings regarding nurses' controlling and directing approach of patients suggest that many nurses strictly adhere to a medical model of care. Then, the nurses' approach reflects professionally-led and risk-aversive strategies to keep patients and themselves safe. This primary orientation on self-protection and protecting patients appears to be reinforced in organisations where nurses experience a lack of time and staffing shortage as well as a fear of blame and litigation concerning possible adverse outcomes. In such organisations, nurses are often encouraged to meet institutional and professional needs at the expense of meeting the needs of patients. Another cultural aspect is the degree of autonomy that nurses have within multidisciplinary teams. According to Barker and Buchanan-Barker (2011), nurses might fill—or easily settle for—subordinate positions in teams, especially in those teams that uphold power structures and a medical model of care. The present findings suggest that certain team dynamics represent a restricted nursing role. For example, some nurses referred to team agreements that they as nurses should not engage with patients in conversations about hopelessness or traumatic experiences. Such agreements might partly explain why nurses had a limited therapeutic perspective in their interactions with patients. Rather than assisting patients in developing self-understanding and coping strategies, nurses were often more concerned with performing procedures, for instance, to 'correct' a patient's hopelessness. Thus, an overemphasis on procedural practices can prompt nurses to approach patients in instrumental ways and this can restrict nurses' attention for approaching patients based on the unique personal processes they go through, including their suicidal- and recovery process.

The cultural aspects considered above represent a need for further ‘emancipation’ of nursing as a discipline in its own right with an integral and recovery-oriented approach (Barker and Buchanan-Barker 2011, Santangelo et al. 2018). This requires organisational structures and managerial cultures that foster a more autonomous and appreciated nursing role and contribution, and promote person-centred and collaborative forms of care and treatment. Special attention should be paid to leadership as a critical component of fostering cultures that promote trauma-informed and recovery-oriented care, patient participation, and seclusion and restraint reduction initiatives (Isobel & Edwards 2017; Kontio et al. 2012; Vandewalle et al. 2018). Hospital leaders should create an environment in which there is less emphasis on defensive and self-protective interventions and more on recovery-oriented interventions, such as providing time and space for patients to really express themselves and creating opportunities for therapeutic risk management (Higgins et al. 2016; Sellin et al. 2017). Considering this, the implementation of nurse specialists might play a crucial role in ensuring the development and integrity of a person-centred and collaborative care culture (Hanrahan et al. 2012). For example, nurse specialists can coach nurses to realise a meaningful integration between their interpersonal engagement of patients and a skilled involvement in suicide risk management practices (e.g. safety planning). Furthermore, the findings reflect the need to provide opportunities for debriefing and inter- and supervision as venues for nurses to express intense emotions and to reflect upon their interactions with patients experiencing suicidal ideation (Hagen et al. 2017b). Regarding the nurses’ fear of blame and litigation, Slemon et al. (2017) highlight the importance to review critical incidents (such as suicide) not to blame nurses, but to nurture trust in their professional judgements, and provide support and learning opportunities for everyone involved.

4.5. Conclusion

The study in the context of psychiatric hospitals enhances the conceptual understanding of nurses’ actions and aims in their interactions with patients experiencing suicidal ideation. These actions and aims are captured in the core element ‘promoting and preserving patients’ safety and a life-oriented perspective’. The enhanced understanding of nurses’ actions and aims can inform concrete strategies for nursing practice and education. These strategies should aim to challenge overly controlling and directing nursing approaches and support nurses’ capacity and ability to connect and collaborate with patients experiencing suicidal ideation.

References

Allison, S., Bastiampillai, T., Licinio, J., Fuller, D. A., Bidargaddi, N. & Sharfstein, S. S. (2017). When should governments increase the supply of psychiatric beds? *Molecular Psychiatry*, 23, 796-800. doi.org/10.1038/mp.2017.139

Barker, P. & Buchanan-Barker, P. (2011). Myth of mental health nursing and the challenge of recovery. *International Journal of Mental Health Nursing*, 20, 337-344. doi.org/10.1111/j.1447-0349.2010.00734.x

Berg, S. H., Rørtveit, K. & Aase, K. (2017). Suicidal patients' experiences regarding their safety during psychiatric inpatient care: A systematic review of qualitative studies. *BMC Health Services Research*, 17, 73. doi.org/10.1186/s12913-017-2023-8

Bowers, L., Dack, C., Gul, N., Thomas, B. & James, K. (2011). Learning from prevented suicide in psychiatric inpatient care: An analysis of data from the National Patient Safety Agency. *International Journal of Nursing Studies*, 48, 1459-1465. doi.org/10.1016/j.ijnurstu.2011.05.008

Browne, G., Cashin, A. & Graham, I. (2012). The therapeutic relationship and Mental Health Nursing: It is time to articulate what we do! *Journal of Psychiatric and Mental Health Nursing*, 19, 839-843. doi.org/10.1111/j.1365-2850.2012.01944.x

Cardell, R. & Pitula, C. R. (1999). Suicidal inpatients' perceptions of therapeutic and nontherapeutic aspects of constant observation. *Psychiatric Services*, 50, 1066-1070. doi.org/10.1176/ps.50.8.1066

Cavanagh, J. T., Carson, A. J., Sharpe, M. & Lawrie, S. M. (2003). Psychological autopsy studies of suicide: A systematic review. *Psychological Medicine*, 33, 395-405. doi.org/10.1017/s0033291702006943

Cox, A., Hayter, M. & Ruane, J. (2010). Alternative approaches to 'enhanced observations' in acute inpatient mental health care: A review of the literature. *Journal of Psychiatric and Mental Health Nursing*, 17, 162-171. doi.org/10.1111/j.1365-2850.2009.01507.x

Creswell, J. W. & Miller, D. L. (2000). Determining Validity in Qualitative Inquiry. *Theory Into Practice*, 39, 124-130. doi.org/10.1207/s15430421tip3903_2

Cusack, P., Cusack, F. P., McAndrew, S., McKeown, M. & Duxbury, J. (2018). An integrative review exploring the physical and psychological harm inherent in using restraint in mental health inpatient settings. *International Journal of Mental Health Nursing*, 27, 1162-1176. doi.org/10.1111/inm.12432

Cutcliffe, J. R. & Barker, P. (2002). Considering the care of the suicidal client and the case for 'engagement and inspiring hope' or 'observations'. *Journal of Psychiatric and Mental Health Nursing*, 9, 611-621. doi.org/10.1046/j.1365-2850.2002.00515.x

Cutcliffe, J. R. & Stevenson, C. (2008). Feeling our way in the dark: The psychiatric nursing care of suicidal people – A literature review. *International Journal of Nursing Studies*, 45, 942-953. doi.org/10.1016/j.ijnurstu.2007.02.002

Cutcliffe, J. R., Stevenson, C., Jackson, S. & Smith, P. (2006). A modified grounded theory study of how psychiatric nurses work with suicidal people. *International Journal of Nursing Studies*, 43, 791-802. doi.org/10.1016/j.ijnurstu.2005.09.001

Cutcliffe, J. R., Santos, J. C., Kozel, B., Taylor, P. & Lees, D. (2015). Raiders of the Lost Art: A review of published evaluations of inpatient mental health care experiences emanating from the United Kingdom, Portugal, Canada, Switzerland, Germany and Australia. *International Journal of Mental Health Nursing*, 24, 375-385. doi.org/10.1111/inm.12159

Dierckx de Casterlé, B., Gastmans, C., Bryon, E. & Denier, Y. (2012). QUAGOL: A guide for qualitative data analysis. *International Journal of Nursing Studies*, 49, 360-371. doi.org/10.1016/j.ijnurstu.2011.09.012

Farkas, M. (2007). The vision of recovery today: What it is and what it means for services. *World Psychiatry*, 6, 68-74.

Foley, G. & Timonen, V. (2015). Using grounded theory method to capture and analyze health care experiences. *Health Services Research*, 50, 1195-1210. doi.org/10.1111/1475-6773.12275

Frueh, B. C., Knapp, R. G., Cusack, K. J. et al. (2005). Special Section on Seclusion and Restraint: Patients' reports of traumatic or harmful experiences within the psychiatric setting. *Psychiatric Services*, 56, 1123-1133. doi.org/10.1176/appi.ps.56.9.1123

Gerace, A. & Muir-Cochrane, E. (2019). Perceptions of nurses working with psychiatric consumers regarding the elimination of seclusion and restraint in psychiatric inpatient settings and emergency departments: An Australian survey. *International Journal of Mental Health Nursin*g, 28, 209-225. doi.org/10.1111/inm.12522

Glaser, B. (2002). Conceptualization: On theory and theorizing using grounded theory. *International Journal of Qualitative Methods*, 1, 1-31. doi.org/10.1177/160940690200100203

Glaser, B. G. & Strauss, A. L. (1967). *The Discovery of Grounded Research: Strategies for Qualitative Research*. Chicago, IL: Aldine Publishing Company.

Hagen, J., Hjelmeland, H. & Knizek, B. L. (2017a). Relational principles in the care of suicidal inpatients: Experiences of therapists and mental health nurses. *Issues in Mental Health Nursing*, 38, 99-106. doi.org/10.1080/01612840.2016.1246631

Hagen, J., Knizek, B. L. & Hjelmeland, H. (2017b). Mental health nurses' experiences of caring for suicidal patients in psychiatric wards: An emotional endeavor. *Archives of Psychiatric Nursing*, 31, 31-37. doi.org/10.1016/j.apnu.2016.07.018

Hallberg, L. R.-M. (2009). The 'core category' of grounded theory: Making constant comparisons. *International Journal of Qualitative Studies on Health and Well-Being*, 1, 141-148. doi.org/10.1080/17482620600858399

Hanrahan, N. P., Delaney, K. R., & Stuart, G. W. (2012). Blueprint for development of the advanced practice psychiatric nurse workforce. *Nursing Outlook, 60*, 91-104. doi.org/10.1016/j.outlook.2011.04.007

Hawton, K., Bergen, H., Cooper, J. et al. (2015). Suicide following self-harm: Findings from the Multicentre Study of self-harm in England, 2000-2012. *Journal of Affective Disorders*, 175, 147-151. doi.org/10.1016/j.jad.2014.12.062

Higgins, A., Doyle, L., Downes, C. et al. (2016). There is more to risk and safety planning than dramatic risks: Mental health nurses' risk assessment and safety management practice. *International Journal of Mental Health Nursing*, 25, 159-170. doi.org/10.1111/inm.12180

Huber, C. G., Schneeberger, A. R., Kowalinski, E. et al. (2016). Suicide risk and absconding in psychiatric hospitals with and without open door policies: A 15 year, observational study. *The Lancet Psychiatry*, 3, 842-849. doi.org/10.1016/S2215-0366(16)30168-7

Isobel, S. & Edwards, C. (2017). Using trauma informed care as a nursing model of care in an acute inpatient mental health unit: A practice development process. *International Journal of Mental Health Nursing*, 26, 88-94. doi.org/10.1111/inm.12236

Klonsky, E. D. & May, A. M. (2015). The three-step theory (3ST): A new theory of suicide rooted in the "ideation-to-action" framework. *International Journal of Cognitive Therapy*, 8, 114-129. doi.org/10.1521/ijct.2015.8.2.114

Kontio, R., Joffe, G., Putkonen, H. et al. (2012). Seclusion and restraint in psychiatry: Patients' experiences and practical suggestions on how to improve practices and use alternatives. *Perspectives in Psychiatric Care*, 48, 16-24. doi.org/10.1111/j.1744-6163.2010.00301.x

Lakeman, R. & FitzGerald, M. (2008). How people live with or get over being suicidal: A review of qualitative studies. *Journal of Advanced Nursing*, 64, 114-126. doi.org/10.1111/j.1365-2648.2008.04773.x

Leamy, M., Bird, V., Le Boutillier, C., Williams, J. & Slade, M. (2011). Conceptual framework for personal recovery in mental health: Systematic review and narrative synthesis. *The British Journal of Psychiatry*, 199, 445-452. doi.org/10.1192/bjp.bp.110.083733

Lees, D., Procter, N. & Fassett, D. (2014). Therapeutic engagement between consumers in suicidal crisis and mental health nurses. *International Journal of Mental Health Nursing*, 23, 306-315. doi.org/10.1111/inm.12061

Madsen, T., Agerbo, E., Mortensen, P. B. & Nordentoft, M. (2012). Predictors of psychiatric inpatient suicide: A national prospective register-based study. *The Journal of Clinical Psychiatry*, 73, 144-151. doi.org/10.4088/JCP.10m06473

Manuel, J. & Crowe, M. (2014). Clinical responsibility, accountability, and risk aversion in mental health nursing: A descriptive, qualitative study. *International Journal of Mental Health Nursing*, 23, 336-343. doi.org/10.1111/inm.12063

Manuel, J., Crowe, M., Inder, M. & Henaghan, M. (2018). Suicide prevention in mental health services: A qualitative analysis of coroners' reports. *International Journal of Mental Health Nursing*, 27, 642-651. doi.org/10.1111/inm.12349

McAllister, S., Robert, G., Tsianakas, V. & McCrae, N. (2019). Conceptualising nurse-patient therapeutic engagement on acute mental health wards: An integrative review. *International Journal of Nursing Studies*, 93, 106-118. doi.org/10.1016/j.ijnurstu.2019.02.013

McLaughlin, C. (1999). An exploration of psychiatric nurses' and patients' opinions regarding in-patient care for suicidal patients. *Journal of Advanced Nursing*, 29, 1042-1051. doi.org/10.1046/j.1365-2648.1999.01000.x

Morrissey, J. & Higgins, A. (2019). "Attenuating anxieties": A grounded theory study of mental health nurses' responses to clients with suicidal behaviour. *Journal of Clinical Nursing*, 28, 947-958. doi.org/10.1111/jocn.14717

Muskett, C. (2014). Trauma-informed care in inpatient mental health settings: A review of the literature. *International Journal of Mental Health Nursing*, 23, 51-59. doi.org/ 10.1111/inm.12012

Nock, M. K., Borges, G., Bromet, E. J., Cha, C. B., Kessler, R. C. & Lee, S. (2008). Suicide and suicidal behavior. *Epidemiologic Reviews*, 30, 133-154. doi.org/10.1093/epirev/mxn002

O'Connor, R. C. & Portzky, G. (2018). Looking to the future: A synthesis of new developments and challenges in suicide research and prevention. *Frontiers in Psychology*, 9, Article 2139. doi.org/10.3389/fpsyg.2018.02139

Raue, P. J., Ghesquiere, A. R. & Bruce, M. L. (2014). Suicide risk in primary care: Identification and management in older adults. *Current Psychiatry Reports*, 16, 466. doi.org/10.1007/s11920-014-0466-8

Santangelo, P., Procter, N. & Fassett, D. (2018). Mental health nursing: Daring to be different, special and leading recovery-focused care? *International Journal of Mental Health Nursing*, 27, 258-266. doi.org/10.1111/inm.12316

Sellin, L., Asp, M., Wallsten, T. & Wiklund Gustin, L. (2017). Reconnecting with oneself while struggling between life and death: the phenomenon of recovery as experienced by persons at risk of suicide. *International Journal of Mental Health Nursing*, 26, 200-207. doi.org/10.1111/inm.12249

Slemon, A., Jenkins, E. & Bungay, V. (2017). Safety in psychiatric inpatient care: The impact of risk management culture on mental health nursing practice. *Nursing Inquiry*, 24, e12199. doi.org/10.1111/nin.12199

Stanley, B. & Brown, G. K. (2012). Safety planning intervention: A brief intervention to mitigate suicide risk. *Cognitive and Behavioral Practice*, 19, 256-264. doi.org/10.1016/j.cbpra.2011.01.001

Sun, F.-K., Long, A., Boore, J. & Tsao, L.-I. (2006). A theory for the nursing care of patients at risk of suicide. *Journal of Advanced Nursing*, 53, 680-690. doi.org/10.1111/j.1365-2648.2006.03774.x

Talseth, A. G., Lindseth, A., Jacobsson, L. & Norberg, A. (1999). The meaning of suicidal psychiatric in-patients' experiences of being cared for by mental health nurses. *Journal of Advanced Nursing*, 29, 1034-1041. doi.org/10.1046/j.1365-2648.1999.00990.x

Vandewalle, J., Malfait, S., Eeckloo, K. et al. (2018). Patient safety on psychiatric wards: A cross-sectional, multilevel study of factors influencing nurses' willingness to share power and responsibility with patients. *International Journal of Mental Health Nursing*, 27, 877-890. doi.org/10.1111/inm.12376

Walsh, G., Sara, G., Ryan, C. J. & Large, M. (2015). Meta-analysis of suicide rates among psychiatric in-patients. *Acta Psychiatrica Scandinavica*, 131, 174-184. doi.org/10.1111/acps.12383

World Health Organization (2018). Suicide rate estimates, age-standardized estimates by WHO region. Retrieved from: apps.who.int/gho/data/view.main. MHSUICIDEASDRREGv?xml:lang=en [Accessed 16 May 2019]

Zalsman, G., Hawton, K., Wasserman, D. et al. (2016). Suicide prevention strategies revisited: 10-year systematic review. *The Lancet Psychiatry*, 3, 646-659. doi.org/10.1016/S2215-0366(16)30030-X

Chapter 5. Making contact with patients who experience suicidal ideation: A qualitative study of nurses' perspectives

Based on:
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Contact and communication with patients experiencing suicidal ideation: A qualitative study of nurses' perspectives.
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Abstract

Aim: To uncover and understand the core elements of how nurses in psychiatric hospitals make contact with patients experiencing suicidal ideation.

Design: A qualitative study based on the principles of grounded theory was performed.

Methods: Nineteen nurses on wards of four psychiatric hospitals were interviewed between May 2017 – February 2018. The Qualitative Analysis Guide of Leuven was used to facilitate the constant comparison of data.

Findings: Nurses make contact with patients experiencing suicidal ideation by "creating conditions for open and genuine communication" while maintaining a focus on "developing an accurate and meaningful picture of patients". These interconnected core elements represent nurses' attention to relational processes like building trust as well as their predominant focus on assessing suicide risk. Nurses put other emphases in their contacts with patients depending on whether their approach is guided more by checking and controlling suicide risk or by acknowledging and connecting (with) the person.

Conclusion: The study enhances the conceptual understanding of how nurses on psychiatric wards can involve in compassionate and considerate contact and communication with patients experiencing suicidal ideation. These findings can be used to underpin the nurses' role in and contribution to suicide prevention.

Impact: The core elements "creating conditions for open and genuine communication" while maintaining a focus on "developing an accurate and meaningful picture of patients" can inform policies for nursing practice and education that aim to preserve and improve the capacity of nurses to involve in compassionate and considerate contact and communication with patients experiencing suicidal ideation.

5.1. Introduction

Suicide is a worldwide public health problem. Each year, close to 800.000 individuals die by suicide and approximately 20 million individuals attempt suicide (World Health Organization, 2018). International comparisons estimate the global lifetime prevalence to be 2.7% for suicide attempts and 9.2% for suicidal ideation, which refers to thinking about, considering, or planning suicide (Nock et al. 2008). Suicide is a particular risk in psychiatric inpatient settings (Qin & Nordentoft 2005), which have an estimated suicide rate of one suicide per 676 admissions (Walsh et al. 2015). Theoretical insights indicate that suicidal ideation is often underpinned by loneliness, social isolation, and interpersonal trauma. These insights emphasise that the sensitive development of interpersonal relationships is of crucial importance for patients who experience suicidal ideation (O'Connor & Kirtly 2018; Van Orden et al. 2010). More specifically, studies highlight that the involvement of professionals in timely, ongoing, and supportive contact with individuals experiencing suicidal ideation is a fundamental component of suicide prevention (Fleischmann et al. 2008; Inagaki et al. 2015; Luoma et al. 2002). Nurses on psychiatric wards are well suited to this type of contact given their close proximity to patients and their daily interactions with them.

Background

Qualitative studies indicate that nurses can initiate and develop warm, regular and care-based human-to-human contact with patients experiencing suicidal ideation, thus providing a foundation on which to establish nurse-patient relationships with therapeutic potential (Cutcliffe et al. 2006; Lees et al. 2014; Talseth et al. 1999). A body of knowledge has emerged regarding the potential impact of the interpersonal relationship on the recovery of patients experiencing suicidal ideation. The interpersonal relationship can be a vehicle that enables patients to resolve suicidal crises, re-connect with humanity, and move from a death-oriented position to a life-oriented position (Cutcliffe et al. 2006; Lakeman & FitzGerald 2008; Sellin et al. 2017).

Studies report overlapping interpersonal processes that enable patients' recovery and underpin nurses' therapeutic potential, including talking, listening and understanding; developing engagement; building trust; inspiring hope; re-building a positive sense of self; and developing coping strategies (Cutcliffe et al. 2006; Hagen et al. 2017; Lees et al. 2014; Samuelsson et al. 2000; Sun & Long 2013; Talseth et al. 1999). However, evidence suggests that nurses on psychiatric wards spend only a small amount of their time listening to and talking with patients, thus questioning the meaning and therapeutic potential of nurse-patient contacts (McAndrew et al. 2014). Sharac et al.'s (2010) review indicates that nurses in

psychiatric wards spend at best 50% of their time in contact with patients. Moreover, of this time, nurses spend no more than 4 to 20% in delivering individual or group therapy.

Studies in both general and psychiatric hospitals point to diverse elements that preclude nurses from being involved in meaningful contact with patients experiencing suicidal ideation, including holding negative attitudes towards patients, having limited time, and experiencing a lack of training, supervision and emotional support (Bolster et al. 2015; Hagen et al. 2017; Lees et al. 2014; McLaughlin 1999; Rebair & Hulatt 2017). In addition, it is argued that nurses are increasingly involved in protocol-based practices for suicide prevention. These practices are often defensive and do not value or obstruct nurses' efforts to provide relational-emotional care for patients experiencing suicidal ideation (Hagen et al. 2017; Horsfall & Cleary 2000; Manuel et al. 2018).

The aforementioned insights reflect and reinforce concerns that nurse-patient contacts might become increasingly truncated, thus doing little or nothing to support the development of therapeutic nurse-patient relationships (Cutcliffe & McKenna 2018). As a result, such contacts may limit nurses' potential to contribute to suicide prevention and to support patients' recovery (Hagen, Hjelmeland et al., 2017; Lees et al. 2014). These concerns have led to a call for ongoing and renewed attention to the fundamentals of nursing care and to its conceptual understanding in psychiatric wards as a complex and demanding environment (Cleary et al. 2012; Gunasekara et al. 2014). The authours of this study suggest that these fundamentals can be understood by uncovering how nurses make contact with hospitalised patients experiencing suicidal ideation. The formulation "patients experiencing suicidal ideation" is used consistently to acknowledge the hospital context while recognising and validating patients' individuality and the range of suicidal thoughts and feelings they can experience.

5.2. The study

5.2.1. Aim

The aim of the study was to uncover and understand the core elements of how nurses on psychiatric wards make contact with patients experiencing suicidal ideation.

5.2.2. Design

Qualitative research enables the understanding of issues around suicidality (Hjelmeland & Knizek 2010). This study used a qualitative approach inspired by the principles of grounded

theory (Glaser 2002). Data collection and analysis interacted iteratively to uncover and understand the concepts and basic processes that reflect and underpin how nurses make contact with patients experiencing suicidal ideation.

5.2.3. Participants

Nurses were recruited on wards in four psychiatric hospitals where adults experiencing suicidal ideation are regularly admitted. The hospitals were spread across Flanders; the Dutch-speaking part of Belgium. The first authour contacted head nurses who approached potential participants. Interested nurses were e-mailed to schedule an interview. All nurses had to have experience caring for patients experiencing suicidal ideation in the last year. Nineteen nurses were recruited. They were employed on adult wards with a closed entrance or on wards with an open entrance divided according to age group (e.g. 18-35 years), psychotherapeutic focus (e.g. mentalisation-based) or psychiatric condition (e.g. mood disorders). The participants were aged between 22-61 years (mean 37.5) and had worked between 4 months and 39 years as a nurse (mean 13.7). All participants had a degree in psychiatric nursing. Demographic data of the participants are summarised in Table 1.

Table 1. Demographic data of the participants

	Length of employment (years)				
	<5	5-14	15-24	≥25	**n = 19**
Gender					
Female	2	5	3	2	**12**
Male	2	2	2	1	**7**
Age (years)					
<25	1				**1**
25-34	2	4			**6**
35-44	1	2	3		**6**
45-54		1	2	2	**5**
≥55				1	**1**
Education level					
Undergraduate		4	3	1	**8**
Bachelor	3	3	2	2	**10**
Master	1				**1**
% FTE appointment					
100%	4	2	3	2	**11**
75%		5	2	1	**8**
Ward types*					
Closed	2	2		1	**5**
Open	2	5	5	2	**14**
	4	**7**	**5**	**3**	

* Ward types: entrance of the ward is open or closed

5.2.4. Data collection

A male PhD candidate (first authour) with 3 years of prior experience as a nurse in psychiatric hospitals conducted individual semi-structured interviews with 19 nurses. An interview guide comprising open questions was used. Interviews were initiated with the question: “How do you interact with patients who experience suicidal ideation?”. The interviews lasted on average 80 min (range: 66-120) and were conducted in the hospitals between May 2017 and February 2018. All interviews were audio-recorded and transcribed verbatim.

Reflecting the evolving nature of grounded theory studies, the emerging concepts from the constant comparison of data guided the data collection (Glaser 2002). Data-informed sampling decisions were made to broaden, deepen and (dis)confirm the insights that were emerging from the preliminary analyses. As an example, the researchers noticed that the first seven nurses were involved in contacts with patients that were largely underpinned by formal protocol-based practices such as the surveillance of patients through intermittent observations. Following discussions with the research team, the first authour asked the head nurses to recruit nurses who attach more importance to interpersonal elements in their contacts with patients experiencing suicidal ideation.

5.2.5. Ethical considerations

The ethics committees of the participating settings approved this study (B670201630531). The first authour informed the participants about the goal of the study, the voluntary character of their participation and the anonymity and confidential treatment of the data. All participants provided written and verbal informed consent.

5.2.6. Data analysis

The Qualitative Analysis Guide of Leuven (QUAGOL) was used (Dierckx de Casterlé, Gastmans, Bryon & Denier 2012). This comprehensive guide supported the iterative processes of gradually deepening the analysis and facilitated the constant comparison of data. The first authour listened to the audio recordings and read the transcripts repeatedly. Another researcher with advanced qualitative research experience read all transcripts. Both researchers made memos. For each interview, the first authour developed a narrative report and a conceptual scheme to identify preliminary concepts while maintaining a holistic understanding of the participant's experiences.

The preliminary concepts and memos were discussed and crosschecked between the researchers to elaborate concepts and relations between concepts. To develop meaningful insights, three additional discussions were organised with two researchers who read some of the transcripts. By systematically comparing text fragments within and between interviews, a list of contextually and analytically meaningful concepts was drawn up. These concepts were linked with interview fragments using the QSR NVivo 10 software programme. The concepts were then grouped, described and tested empirically by reading all interviews again. Data collection and analysis continued until data saturation of the essential structure was established (Glaser, 2002).

5.2.7. Rigour

The criteria of Lincoln and Guba (1985) were applied to establish the trustworthiness of the study. To enhance the credibility of the findings, investigator triangulation was established by involving six researchers (Morse 2015). Heterogeneity of participant characteristics (e.g. length of employment) and experiences were taken into account and described to support (consideration of) the transferability of the findings. In addition, dependability was enhanced through a decision trail consisting of transparent reporting of the decision making throughout the study (Koch 2006). To promote confirmability, the first author reflected systematically on his prior experiences as a nurse and shared and discussed a transcript of these reflections with the last authour. This was done to support the active acknowledgement and the explicit recognition of how his position might have an impact on the data collection and interpretation (Berger 2015).

5.3. Findings

The analysis indicated two interconnected core elements. Nurses make contact with patients experiencing suicidal ideation in such a way that they “create conditions for open and genuine communication” while maintaining a focus on “developing an accurate and meaningful picture of patients”. Nurses put other emphases in their contacts with patients depending on whether their approach is guided more by checking and controlling suicide risk or by acknowledging and connecting (with) the person.

5.3.1. Creating conditions for open and genuine communication

Nurses' accounts reflected a need to create conditions for open and genuine communication as an enabler to get to know patients and to develop an accurate and meaningful picture of suicidal ideation.

Creating avenues to patients who experience suicidal ideation

Nurses perceived that a large number of patients who experience suicidal ideation do not easily take the first step to make contact with them and are difficult to reach because of their social and emotional isolation. Nurses discussed several elements that reflect and underpin their efforts to enable continuity of contact as a means of getting to know patients and of developing an accurate and meaningful picture of their suicidal state. Nurses stressed the importance of an ongoing active involvement characterised by initiating regular contact on formal and informal moments; being present, accessible, approachable; and reaching out to patients. For the same reason, they emphasised that they are transparent about their availability on the ward and invite and encourage patients to make contact with them as well as with other professionals on the ward.

> *"If they cannot come to me, then I go regularly to patients myself. Just to be there with them. Sometimes it helps people when you sit down a moment with them and they know 'someone is here, someone I can hold on to."* (female, 38y, open ward)

> *"We always try to tell patients that they should come and speak to us when they have a difficult moment. And we reach out to their room during intermittent observations. On these moments we can ask: 'How are you?' and maybe observe that she or he appears distressed today".* (female, 22y, open ward)

Nurses emphasised that they have to initiate conversations about suicidal ideation. Some nurses ask about and name suicidal ideation explicitly in their first and recurring contacts. They do this because this behaviour is expected from them as part of the protocol they work with and because they perceive that a direct approach provides straightforward information or brings relief to patients that suicidal ideation is not a taboo subject. Other nurses rather initiate conversations about suicidal ideation indirectly by asking about the patient's mood, exploring signs that they observe, expressing their concern for patients, or using creative methods (e.g. drawings). Indirect approaches are associated with nurses' efforts to align with patients' communication preferences and abilities and with nurses' perception that indirect approaches feel more comfortable for themselves and their patients.

"I am surely going to say to a person: 'You have suicidal thoughts, how must I interpret this?' 'Do you have any plans?', 'Have you written any farewell letters?' These are things that I discuss straightaway with people." (male, 43y, open ward)

"I ask patients how they feel about it when I talk to them about suicidality and how they prefer to have these interactions. Because you can bring in something into these conversations but that is not a general theory about wound care. Discussing suicidality is very personal." (female, 26y, open ward)

Nurses' accounts reflected how their contacts with patients are importantly underpinned by their duties and responsibilities to assess and document suicide risk and to perform formalised procedures, including assessment and intermittent observations. Differences were noticed in the way nurses perform procedures as well as the meaning they attach to elements such as "being present", "encouraging patients" and "reaching out". A large number of nurses on open and closed wards were primarily concerned with gathering focused information about patients that can be used to control potential suicide risk. These nurses use procedures instrumentally (e.g. surveillance of patients) and initiate contact with an instrumental function, for instance by encouraging patients to move from their rooms to the dayroom so that they can better observe them.

"If observations are intensified because of suicide risk, then we have to be very alert with the nursing team and check and question the patient regularly. [...] For me it is very important to perform this very punctually. That is my responsibility. So when patients are on an observation level of every half hour, then I will certainly go every half hour to them and not a minute later!" (female, 36y, open ward)

Other nurses on open and closed wards are more involved in creating avenues to patients in ways that acknowledge the patient as a person. These nurses emphasised the value of conveying openness, listening attentively, expressing genuine interest, and being involved in apparent "little things" such as daily greetings and using humour. According to the nurses, these ways of making contact enable them to establish an emotional connection with patients. Nurses believe that when such a connection can be formed, this supports patients in discussing their thoughts and feelings and provides them with a sense of security they can hold onto, even when they are not present with the nurse. Nurses indicated that they try to confirm this connection by expressing to patients that they stay in touch with them and advocating for their interests in multidisciplinary team meetings.

> *"When I express my concern, I think patients feel the connection we have. That you bring in something personal rather than merely inventorying the things you see or hear. I believe then you really do make contact from human to human and that this can be something positive for individuals, that it can help them a step further in communicating their thoughts and feelings".* (female, 50y, open ward)

Nurses that intent to acknowledge and connect (with) the patient as a person also perform procedures, such as assessments and observations. However, in contrast to the more instrumental approach of nurses that focus on checking and controlling suicide risk, these nurses try to use procedures in a way that allows them to be genuinely present with patients, listen to patients and explore and address the needs of patients at the moment. At the same time, these nurses expressed more concern and criticism regarding the organisational requirements to assess, observe and document suicide risk formally and constantly. They perceived that these formal requirements may impede their intention to acknowledge and connect (with) the patient as a person, either because these requirements induce a formal nurse-patient contact or because these consume time that they could otherwise spend on being meaningfully present with patients.

> *"During an intermittent observation, I entered the room and that person was sitting in huddled position on the floor against the wall. And then I sat down next to her and said: 'Know, if you want to say something or if I can do something, I am here.'"* (female, 38y, open ward)

> *"I have always questioned the practice of scoring suicide risk. Do you score just to have the figures? Well okay, I prefer to be present with patients and to listen to them rather than just filling out a score sheet".* (male, 32y, closed ward)

Creating a safe atmosphere to talk about suicidality

Nurses perceived that patients often do not disclose suicidal ideation because they feel unsafe or unready to do so and that this involves a major challenge to develop an accurate and meaningful picture of the patients' suicidal ideation. Nurses reported challenges communicating with patients who feel ashamed of their suicidal ideation, have been rejected previously when disclosing suicidal ideation, experience extreme distress or hopelessness, and verbalise suicidal ideation in a chaotic way. In addition, nurses encountered patients who distrusted them because of exacerbations of mental health problems (e.g. psychosis) or

because of negative preconceptions about what might happen to them when they disclose suicidal ideation.

> *"People lie in their bed, refuse to eat and refuse to talk. You try to make contact and build up some trust but this is very difficult in the beginning. And of course you cannot force them to disclose their suicidal thoughts".* (male, 29y, closed ward)

Nurses acknowledged that suicidal ideation is an emotionally loaded subject. They emphasised that they have to "dare to discuss" suicidal ideation with patients. To enable patients' communication of suicidal ideation, nurses noted that it is fundamental to establish a relationship with patients and to develop a trusting bond. For the same reason, they believed that it is important to respect the emotions of patients, reassure patients that they can disclose suicidal ideation and present themselves as reliable professionals.

> *"We must have a certain relationship to discuss suicidality. It is true that we ask about suicidal thoughts and plans at admission, but I wonder whether people are honest at that moment. I think it must be difficult to talk about this when you meet someone for the first time".* (male, 45y, open ward)

Nurses struggle to perform their duties to assess and document suicide risk while simultaneously maintaining a safe atmosphere where to talk about suicidal ideation. Especially in the accounts of nurses who use assessment and observation procedures intensively and instrumentally, it became clear that counter-reactions can emerge when patients experience procedures as "being controlled and restricted" rather than as "being cared for". Nurses perceived that the formal application of clinical procedures (e.g. assessment) could trigger patient agitation, initiate efforts to conceal or deny suicidal ideation to avoid control and undermine patients' sense of trust in the nurse. Nurses perceived this as problematic because it limits their opportunities to obtain an accurate idea of suicidal ideation and, as a result, downgrades their potential contribution to suicide prevention.

> *"I sometimes hear people saying 'we did not dare to talk openly about those thoughts because we were afraid of being locked up or being not allowed to leave on the weekend'".* (female, 33y, closed ward)

Nurses indicated that they tried to remediate the intrusive character of procedures and patients' associated feelings of being controlled and restricted. Especially the nurses with

more years of working experience stressed the importance of taking assessment as part of an open conversation, informing about and discussing the application of procedures with patients (e.g. time of observations), and explaining to patients how procedures contribute to good and safe care. While some nurses merely stress these issues to preserve the functional course of formalised procedures (e.g. avoid counter-reactions), other nurses do this as part of genuine efforts to include and align patients' point of view with regard to their care and treatment and to explore and address their needs.

> *"People can be very reluctant about restriction and sometimes cannot see this as a form of care, for instance when being in a room with a locked door. So the way you explain this to patients is very important and that you discuss what they want and do not want and whether other things can be done to make them feel safe?"* (female, 39y, open ward)

5.3.2. Developing an accurate and meaningful picture of patients

Nurses perceive that patients' open and genuine communication about suicidal ideation provides a foundation on which to develop an accurate and meaningful picture of them. In particular, nurses focus on getting to know patients and getting an idea of suicidal ideation, risk factors (e.g. history of suicide attempts) and protective factors (e.g. family support). Nurses' accounts showed that they try to maintain their focus by being alert for suicidal cues, communicating with patients, observing patients, using intuition, taking assessment and using screening tools, collaborating and consulting in the multidisciplinary team and, to a lesser extent, using family impressions. Nurses hold their focus during everyday contact, especially during hospital intakes, planned conversations (e.g. weekly) and before perceived risky situations such as weekend leave. In addition, some nurses stressed the need for recurring assessment to capture fluctuations in suicidal ideation, to capture changes in risk and protective factors and to refine their picture of patients based on patients' gradual disclosure of suicidal ideation when a trusting bond is developing.

> *"I always try to get an idea of how it is for them to have these thoughts and how concrete these are. Do they have these thoughts once a day or continuously? I actually try to develop the clearest possible picture of it."* (female, 26y, open ward)

Nurses are alert for patients' (non-)verbal expressions that might be indicative of suicidal ideation, such as self-harm and social isolation. When nurses suspect suicidal ideation, they

try to characterise its seriousness by checking with colleagues and asking patients about the presence of concrete suicide plans. Nurses indicated that they are forced to observe warning signs when patients do not disclose suicidal ideation. Moreover, they expressed increased alertness for suicide risk in patients who seem to isolate themselves or seem to be disconnected from themselves, for instance when hearing voices that drive suicidal ideation. Several nurses said that their alertness had been triggered by patients who attempted suicide or died by suicide and yet in these patients, they could not or could only barely observe warning signs. According to the nurses, there are patients who "wear a mask" to hide suicidal ideation as well as "determined patients" who do not reveal their suicidal plans to preserve the possibility of suicide as a last resort.

> *"I certainly write down: 'okay this is someone with suicide plans but does not want to talk about it, that is something we have to keep an eye on."* (female, 22y, open ward)

> *"In the patient group they [patients who wear a mask] are the ones with the most stories and humour and take the lead to do sports; but when you see them individually, you notice how hopeless and desperate they are".* (female, 45y, open ward)

Nurses said that they can intuitively feel emerging hopelessness and suicidal ideation in patients without observing concrete warning signs. They indicated that their intuitive senses are supported by getting to know patients, being able to relate to patients, and gaining work experience. In addition, some nurses acknowledged that their own emotional responses, including "feeling fear of a suicide attempt", can provide cues to emerging suicidal ideation. These nurses emphasised the need for self-awareness, reflection and emotional debriefing so that their emotions do not disturb their assessment, for instance when triggering them to assess suicide risk as higher than what is actually present and, as a result, to excessively check and control patients.

> *"As a psychiatric nurse, you work a lot with your intuitive senses. And these senses become more accurate over the years you work as a nurse. In the beginning when I worked, I did not use my senses so much and I did not feel things as well as I feel them now."* (female, 46y, open ward)

> *"Sometimes as a nurse you can do too much out of the fearful feeling: 'We cannot lose another patient!' And then you act too restrictive, which can trigger*

counter-reactions of patients and that is not a good way of working." (female, 35y, open ward)

Nurses' focus on suicide risk assessment is importantly underpinned by duties and responsibilities to prevent suicide. Some nurses on open and closed wards use a checking approach with a primary focus on gathering and documenting information to guide formulations regarding the level of suicide risk. They maintain this focus by posing standardised questions (e.g. "Do you have suicidal thoughts?", "Do you have suicidal plans?"), listening to hear what they must hear, surveilling patients through observations and by labelling and categorising suicide risk and the sincerity of suicidal expressions (e.g. "genuine death wish" vs. "bids for attention"). The checking approach is also concerned with making up an inventory of protective factors and with explicit efforts to elicit hopeful elements (e.g. using checklists). In this way, the checking approach provides a vehicle for nurses to select and intensify interventions to control patients' suicide risk and to correct their hopelessness. Overall, while the checking approach seemed to be more regularly used by the nurses with less years of working experience, it was also seen in nurses with more years of working experience.

"We ask straightaway: 'Do you have suicidal thoughts?, Have you made suicide attempts?'. These questions are incorporated in our checklist and we are obliged to register in our electronic record. And then the suicide prevention protocol is initiated. So automatically we become more alert for suicide risk and are more involved with suicide prevention." (male, 61y, closed ward)

"We are expected to carry out standard suicide-conversations which only aim to check: 'How suicidal is that patient at that moment?' And then I look for their verbal and non-verbal communication and warning signs and I constantly report about this." (male, 25y, closed ward)

"I work with a 'Pleasurable Activities List' with 139 activities such as knitting or crocheting. And this can support people in getting new ideas, especially when they are alone for a long time, are inactive, have no ideas about what they can do." (female, 36y, open ward)

For nurses who are more involved in acknowledging and connecting with the person, developing an accurate and meaningful picture is not merely concerned with gathering and documenting information about suicide risk. It is concerned with trying to enter patients' life

world by conveying openness, expressing genuine interest, listening non-judgementally to the patient's story and exploring and understanding the triggers and meanings of suicidal expressions. Both female and male nurses also expressed that they are involved in sensitive listening and probing to facilitate the expression of 'sparkles of hope'. They emphasised the meaningful nature of being involved in conversations with patients about daily experiences, (earlier) interests and hobbies and future prospects, as well as inviting patients to do things together, such as walking or drinking a coffee. Overall, while an approach that is guided more by acknowledging and connecting seemed to be more regularly used by the nurses with more years of working experience, it was also seen in nurses with less years of working experience.

> *"The suffering always comes first! It is true that it is sometimes said that suicidal expressions are a bid for attention or so… Perhaps in a certain way… but especially because they do not know how to respond in a constructive way. So I always take these expressions very seriously."* (female, 46y, open ward)

> *"I always try to listen for sparkles of hope in a conversation such as things they like or used to like, hobbies, things they are very passionate about, or people who are important to them."* (male, 32y, closed ward)

5.4. Discussion

The interconnected core elements "creating conditions for open and genuine communication" while focusing on "developing an accurate and meaningful picture of patients" represent nurses' crucial and advantaged position to contribute to suicide prevention in a multidisciplinary context. Based on their close proximity to patients, nurse try to enable patients' communication about suicidal ideation through an active involvement in creating avenues for communication and creating a safe atmosphere. This communication gives the nurses an essential perspective from which to assess and document suicidal ideation and to identify risk and protective factors. Overall, these insights shed new light on the evidence indicating that recognising and discussing suicide may reduce, rather than increase patients' suicidal ideation and therefore is a critical component of suicide prevention (Dazzi et al. 2014).

The insight emerged that nurses' involvement in suicide risk assessment is essentially underpinned by nurse-patient contact and communication. Nurses' capacity to develop an accurate and meaningful picture of patients is supported by elements such as listening and talking to patients; being alert; using intuitive senses; respecting the emotions of patients;

and developing a trusting bond. In addition, nurses emphasised barriers to suicide risk assessment, including their perception that patients may find it difficult to talk about suicidal ideation or even conceal or deny suicidal ideation. Studies indicate that these phenomena are associated with patients' feelings of hopelessness and shame, experiences of rejection when disclosing suicidal ideation and decisions not to let anyone intervene (Fulginiti et al. 2016; Isometsä 2001; Samuelsson et al. 2000). Furthermore, the present findings suggest that patients sometimes conceal or deny suicidal ideation during assessments to avoid perceived restrictive and controlling interventions, such as standardised observations (Richards et al. 2019). Overall, these insights strengthen the need for nurses to involve in an approach to suicide risk assessment that is underpinned by compassionate and considerate contact and communication with patients rather than solely reliant on risk assessment tools that are limited in their ability to predict suicidal ideation (Bolton et al. 2015).

The findings highlight that a large number of nurses are guided predominantly by a checking and controlling approach. These nurses seem to be more concerned with fulfilling observing and reporting functions than with involving in compassionate and considerate contact and communication with patients (Cutcliffe & Barker 2002; Hagen et al. 2017; Horsfall & Cleary 2000). Nurses' involvement in a checking and controlling approach is likely to be inspired and reinforced by suicide prevention guidelines, suggesting that nurses must be involved in observation policies and patient checks and must use protocols that enable direct and specific questioning about suicidal ideation (Bowers et al. 2000; Manuel et al. 2018). At the same time, the findings show that some nurses on open and closed wards seem to have the interpersonal qualities and skills to move beyond checking and controlling suicide risk and instead make efforts to acknowledge and connect with the patient as a person, even during standardised assessments and observations. These nurses adopt a focus that transcends a reductionistic focus on static risk and protective factors and seems to open doors to develop a more holistic picture of patients by being attentive to their needs and hopes and trying to understand the nature of their suicidal expressions (Higgins et al. 2016; Wand 2012).

Integrating the findings with literature on patient perspectives, it seems that nurses' ability and capacity to acknowledge and connect (with) the patient as a person is vital to develop effective interpersonal practice. More specifically, patients express the need of having opportunities to connect and build trust with compassionate and competent professionals, having time and space to express and explore personal experiences as well as (previously withheld) suicidal thoughts and feelings, and gaining the insight and understanding to address personal difficulties (Berg et al. 2017; Lakeman & FitzGerald 2008; Lees et al. 2014; Sellin et al. 2017; Sun et al. 2006). The findings from a nurse perspective support the literature indicating that these needs of patients are unlikely to be met by nurses' involvement

in an overly checking and controlling approach (Cutcliffe et al. 2006; Hagen, Hjelmeland et al., 2017; Lees et al. 2014).

The findings offer indications of nurse characteristics that potentially mediate nurses' contribution to effective interpersonal practice in the context of contact and communication with patients experiencing suicidal ideation. In line with the literature, these characteristics include the nurses' ability to manage personal emotions (e.g. fear), the nurses' interpersonal qualities and skills (e.g. being non-judgemental), the nurses' capacity for self-awareness and reflection, and the nurses' working experience (Cleary et al. 2012; Hagen, Knizek et al. 2017; Lees et al. 2014). With the aim of supporting effective interpersonal practice, the authours recommend to conduct quantitative studies that enable large-scale exploration of the characteristics (e.g. working experience, hospital and ward culture, ward type) that may influence nurses' involvement in and approaches to contact and communication with patients experiencing suicidal ideation.

The findings must be interpreted within the understanding that nursing education and guidelines often overlook relational aspects of care (Cutcliffe & McKenna 2018; Horsfall & Cleary 2000). Moreover, literature points to the increasing number of standardised curricula with emphasis on generic preparation nurse education programmes. Concerns are expressed that nursing curricula have a decreased focus on preparing nurses for the mental health field, emphasise technical aspects of practice (e.g. assessment) rather than the interpersonal elements and might result in an erosion or diminution of interpersonal and communicative skills in nursing practice (Cutcliffe & McKenna 2018; Happell & McAllister 2014).

Therefore, the findings can inform nursing education and guidelines that aim to improve the ability and capacity of nurses to acknowledge and connect (with) the person as a meaningful approach in itself and as a foundation for using protocols, talking and listening to patients experiencing suicidal ideation and for really getting to know patients as a person (Gunasekara et al. 2014). The attention for increasing interpersonal qualities and skills is crucial for nurses across healthcare settings and especially for nurses who maintain distant relationships with patients experiencing suicidal ideation, do not know how to assess and evaluate suicidal ideation and avoid communication about suicidal ideation (Bolster et al. 2015; Rebair & Hulatt 2017; Talseth et al. 1997).

Training and feedback initiatives in hospitals that aid the application of the findings and related evidence can assist nurses in establishing meaningful contact with patients who experience suicidal ideation. Such initiatives transcend a focus on procedural practices and aim to foster nurses' interpersonal and communicative skills and qualities—and their confidence—to discuss suicide and assess suicide risk as part of an interpersonal approach. Training and feedback initiatives can also raise nurses' attention for the interconnectedness

between ‘creating conditions for open and genuine communication’ and ‘developing an accurate and meaningful picture of patients’. This particular attention might open doors for encouraging clinical reasoning skills in nurses to assess and evaluate suicidal ideation within an approach that is underpinned by interpersonal processes, such as listening, building trust, and getting to know patients as persons.

Policymakers and hospital leaders should aim to create environments where nurses can be involved in multifaceted and interpersonal approaches to suicide risk assessment (Bolton et al. 2015; Higgins et al. 2016; Wand 2012) and forming nurse-patient relationships with preventive and therapeutic potential (Cutcliffe et al. 2006; Lees et al. 2014; Peplau 1997; Sun et al. 2006). Therefore, nurses should not be prompted to involve themselves in impersonal observing functions and ineffective checklist style approaches (Cutcliffe & Barker 2002; Hagen et al., 2017). Instead, nurses must be empowered to use evidence-based frameworks, such as The Collaborative Assessment and Management of Suicidality, that promote nurses’ interpersonal engagement with patients and their understanding of the nature of suicidal expressions (Jobes 2012). Finally, the findings emphasise a need to provide nurses with opportunities and resources (e.g. debriefings) to manage their own emotions and to develop self-awareness and reflection. Such opportunities and resources can support nurses to avoid or remediate an excessive checking and controlling approach and instead to develop an approach that is guided more by acknowledging and connecting with the patient as a person.

Limitations

Although the findings can be related to evidence obtained from the perspective of patients experiencing suicidal ideation, the integration of nurses’ and patients’ perspectives would have generated a fuller understanding of the research question. In addition, the data collection might be subject to a lack of method triangulation (Morse 2015). Besides using semi-structured interviews, participant observations might have strengthened the understanding of the core elements, for instance by providing more insight into the non-verbal and contextual elements of nurse-patient contact (Mulhall 2003).

Furthermore, potential cross-cultural differences must be taken into account when considering nurses’ involvement in and approaches to contact and communication with patients experiencing suicidal ideation (Hjelmeland 2011). Whereas the perceptions of nurses in the study context (Belgium) are clearly influenced by the development of suicide prevention policies and hospital procedures in Western societies, this is likely to be different in African and Asian countries, where suicide prevention strategies are hardly developed (World Health Organization 2014). In addition, studies across continents uncovered elements

of the sociocultural context (e.g. religious beliefs, stigma, criminalisation of suicide) that can influence the individuals' lived experiences of suicidal ideation, the (student) nurses' attitudes towards suicide and suicide attempts and the (student) nurses' engagement in recognising and discussing suicide (Flood et al. 2018; Osafo et al. 2018; Vedana et al. 2018).

Overall, the authours assert that their rigourous research process generated meaningful data and valid interpretations and that the findings can be similarly experienced by nurses in other psychiatric hospitals. In particular, the insights about the nurses' involvement in recognising and discussing suicidal ideation (e.g. "daring to discuss suicidal ideation") and how this involvement provides an essential perspective from which to assess and document suicide risk can meaningfully inform nursing practice.

5.5. Conclusion

The study enhances the conceptual understanding of how nurses on psychiatric wards enable patients' communication of suicidal ideation and how this is related to their role in and contribution to suicide risk assessment. While some nurses adopt an overemphasis on instrumental principles and formal practices to check and control suicide risk, other nurses involve more in acknowledging and connecting with the patient as a person. The findings can be used to inform policies for nursing practice and education that aim to preserve and improve the capacity of nurses to talk and listen to patients experiencing suicidal ideation; to develop multifaceted and interpersonal approaches to suicide risk assessment; and to develop and use nurse-patient relationships with preventive and therapeutic potential.

References

Berg, S. H., Rørtveit, K. & Aase, K. (2017). Suicidal patients' experiences regarding their safety during psychiatric in-patient care: A systematic review of qualitative studies. *BMC Health Services Research*, 17, 73. doi.org/10.1186/s12913-017-2023-8

Berger, R. (2015). Now I see it, now I don't: Researcher's position and reflexivity in qualitative research. *Qualitative Research, 15,* 219-234. doi.org/10.1177/14687 94112 468475

Bolster, C., Holliday, C., Oneal, G. & Shaw, M. (2015). Suicide assessment and nurses: What does the evidence show? *The Online Journal of Issues in Nursing*, 20, 2. doi.org/10.3912/OJIN.Vol20 No01M an02

Bolton, J. M., Gunnell, D. & Turecki, G. (2015). Suicide risk assessment and intervention in people with mental illness. *British Medical Journal, 351,* h4978. doi.org/10.1136/bmj.h4978

Bowers, L., Gournay, K. & Duffy, D. (2000). Suicide and self-harm in inpatient psychiatric units: A national survey of observation policies. *Journal of Advanced Nursing*, 32, 437-444. doi.org/10.1046/j.1365-2648.2000.01510.x

Cleary, M., Hunt, G. E., Horsfall, J. & Deacon, M. (2012). Nurse-patient interaction in acute adult inpatient mental health units: A review and synthesis of qualitative studies. *Issues in Mental Health Nursing*, 33, 66-79. doi.org/10.3109/01612 840.2011.622428

Cutcliffe, J. R., & Barker, P. (2002). Considering the care of the suicidal client and the case for 'engagement and inspiring hope' or 'observations'. *Journal of Psychiatric and Mental Health Nursing*, *9*, 611-621. doi.org/10.1046/j.1365-2850.2002.00515.x

Cutcliffe, J. R. & McKenna, H. (2018). Psychiatric/mental health nursing in the 21st century: It's 'déjà vu' all over again!. *International Journal of Nursing Studies*, 81, A3-A5. doi.org/10.1016/j.ijnurstu.2018.03.004

Cutcliffe, J. R., Stevenson, C., Jackson, S. & Smith, P. (2006). A modified grounded theory study of how psychiatric nurses work with suicidal people. *International Journal of Nursing Studies*, 43, 791-802. doi.org/10.1016/j.ijnur stu.2005.09.001

Dazzi, T., Gribble, R., Wessely, S. & Fear, N. T. (2014). Does asking about suicide and related behaviours induce suicidal ideation? What is the evidence? *Psychological Medicine*, 44, 3361-3363. doi.org/10.1017/S0033 29171 4001299

Dierckx de Casterlé, B., Gastmans, C., Bryon, E. & Denier, Y. (2012). QUAGOL: A guide for qualitative data analysis. *International Journal of Nursing Studies*, 49, 360-371. doi.org/10.1016/j.ijnurstu.2011.09.012

Fleischmann, A., Bertolote, J. M., Wasserman, D. et al. (2008). Effectiveness of brief intervention and contact for suicide attempters: A randomized controlled trial in five countries. *Bulletin of the World Health Organization*, *86*, 703-709. doi.org/10.2471/BLT.07.046995

Flood, C., Yilmaz, M., Phillips, L. et al. (2018). Nursing students' attitudes to suicide and suicidal persons: A cross-national and cultural comparison between Turkey and the United Kingdom. *Journal of Psychiatric and Mental Health Nursing*, 25, 369-379. doi.org/10.1111/jpm.12461

Fulginiti, A., Pahwa, R., Frey, L. M., Rice, E. & Brekke, J. S. (2016). What factors influence the decision to share suicidal thoughts? A multilevel social network analysis of disclosure among individuals with serious mental illness. *Suicide and Life-Threatening Behavior*, 46, 398-412. doi.org/10.1111/sltb.12224

Glaser, B. (2002). Conceptualization: On theory and theorizing using grounded theory. *International Journal of Qualitative Methods*, 1, 1-31. doi.org/10.1177/16094 06902 00100203

Gunasekara, I., Pentland, T., Rodgers, T. & Patterson, S. (2014). What makes an excellent mental health nurse? A pragmatic inquiry initiated and conducted by people with lived experience of service use. *International Journal of Mental Health Nursing*, 23, 101-109. doi.org/10.1111/inm.12027

Hagen, J., Hjelmeland, H. & Knizek, B. L. (2017). Relational principles in the care of suicidal inpatients: Experiences of therapists and mental health nurses. *Issues in Mental Health Nursing*, 38, 99-106. doi.org/10.1080/01612 840.2016.1246631

Hagen, J., Knizek, B. L. & Hjelmeland, H. (2017). Mental health nurses' experiences of caring for suicidal patients in psychiatric wards: An emotional endeavor. *Archives of Psychiatric Nursing*, 31, 31-37. doi.org/10.1016/j.apnu.2016.07.018

Happell, B. & McAllister, M. (2014). The views of heads of schools of nursing about mental health nursing content in undergraduate programs. *Issues in Mental Health Nursing*, 35, 330-336. doi.org/10.3109/01612 840.2013.863413

Higgins, A., Doyle, L., Downes, C. et al. (2016). There is more to risk and safety planning than dramatic risks: Mental health nurses' risk assessment and safety-management practice. *International Journal of Mental Health Nursing*, 25, 159-170. doi.org/10.1111/inm.12180

Hjelmeland, H. (2011). Cultural context is crucial in suicide research and prevention. *Crisis*, 32, 61-64. doi.org/10.1027/0227-5910/a00009

Hjelmeland, H. & Knizek, B. L. (2010). Why we need qualitative research in suicidology. *Suicide and Life-Threatening Behavior*, 40, 74-80. doi.org/10.1521/suli.2010.40.1.74

Horsfall, J., & Cleary, M. (2000). Discourse analysis of an 'observation levels' nursing policy. *Journal of Advanced Nursing*, 32, 1291-1297. doi.org/10.1046/j.1365-2648.2000.01601.x

Inagaki, M., Kawashima, Y., Kawanishi, C. et al. (2015). Interventions to prevent repeat suicidal behavior in patients admitted into an emergency department for a suicide attempt: A meta analysis. *Journal of Affective Disorders*, 175, 66-78. doi.org/10.1016/j.jad.2014.12.048

Isometsä, E. T. (2001). Psychological autopsy studies – a review. *European Psychiatry*, 16, 379-385. doi.org/10.1016/S0924-9338(01)00594-6

Jobes, D. A. (2012). The Collaborative Assessment and Management of Suicidality (CAMS): An evolving evidence-based clinical approach to suicidal risk. *Suicide and Life-Threatening Behavior*, 42, 640-653. doi.org/10.1111/j.1943-278X.2012.00119.x

Koch, T. (2006). Establishing rigour in qualitative research: The decision trail. *Journal of Advanced Nursing*, 53, 91-100. doi.org/10.1111/j.1365-2648.2006.03681.x

Lakeman, R. & FitzGerald, M. (2008). How people live with or get over being suicidal: A review of qualitative studies. *Journal of Advanced Nursing*, 64, 114-126. doi.org/10.1111/j.1365-2648.2008.04773.x

Lees, D., Procter, N. & Fassett, D. (2014). Therapeutic engagement between consumers in suicidal crisis and mental health nurses. *International Journal of Mental Health Nursing*, 23, 306-315. doi.org/10.1111/inm.12061

Lincoln, Y. S. & Guba, E. G. (1985). *Naturalistic inquiry*. Newbury Park, CA: Sage Publications.

Luoma, J. B., Martin, C. E. & Pearson, J. L. (2002). Contact with mental health and primary care providers before suicide: A review of the evidence. *The American Journal of Psychiatry*, 159, 909-916. doi.org/10.1176/appi.ajp.159.6.909

Manuel, J., Crowe, M., Inder, M. & Henaghan, M. (2018). Suicide prevention in mental health services: A qualitative analysis of coroners' reports. *International Journal of Mental Health Nursing*, 27, 642-651. doi.org/10.1111/inm.12349

McAndrew, S., Chambers, M., Nolan, F., Thomas, B. & Watts, P. (2014). Measuring the evidence: Reviewing the literature of the measurement of therapeutic engagement in acute mental health inpatient wards. *International Journal of Mental Health Nursing*, 23, 212-220. doi.org/10.1111/inm.12044

McLaughlin, C. (1999). An exploration of psychiatric nurses' and patients' opinions regarding in-patient care for suicidal patients. *Journal of Advanced Nursing*, 29, 1042-1051. doi.org/10.1046/j.1365-2648.1999.01000.x

Morse, J. M. (2015). Critical analysis of strategies for determining rigor in qualitative inquiry. *Qualitative Health Research*, 25, 1212-1222. doi.org/10.1177/10497 32315 588501

Mulhall, A. (2003). In the field: Notes on observation in qualitative research. *Journal of Advanced Nursing*, 41, 306-313. doi.org/10.1046/j.1365-2648.2003.02514.x

Nock, M. K., Borges, G., Bromet, E. J., Cha, C. B., Kessler, R. C. & Lee, S. (2008). Suicide and suicidal behavior. *Epidemiologic Reviews*, 30, 133-154. doi.org/10.1093/epirev/mxn002

O'Connor, R. C. & Kirtley, O. J. (2018). The integrated motivational–volitional model of suicidal behaviour. *Philosophical Transactions of the Royal Society of London. Series B, Biological Sciences*, 373, 20170268. doi.org/10.1098/rstb.2017.0268

Osafo, J., Akotia, C. S., Boakye, K. E. & Dickson, E. (2018). Between moral infraction and existential crisis: Exploring physicians and nurses' attitudes to suicide and the suicidal patient in Ghana. *International Journal of Nursing Studies*, 85, 118-125. doi.org/10.1016/j.ijnur stu.2018.05.017

Peplau, H. E. (1997). Peplau's theory of interpersonal relations. *Nursing Science Quarterly*, 10, 162-167. doi.org/10.1177/089431849701000407

Qin, P., & Nordentoft, M. (2005). Suicide risk in relation to psychiatric hospitalization: Evidence based on longitudinal registers. *Archives of General Psychiatry*, 62, 427-432. doi.org/10.1001/archpsyc.62.4.427

Rebair, A. & Hulatt, I. (2017). Identifying nurses' needs in relation to suicide awareness and prevention. *Nursing Standard*, 31, 44-51. doi.org/10.7748/ns.2017.e10321

Richards, J. E., Whiteside, U., Ludman, E. J. et al. (2019). Understanding why patients may not report suicidal ideation at a health care visit prior to a suicide attempt: A qualitative study. *Psychiatric Services*, 70, 40-45. doi.org/10.1176/appi.ps.20180 0342

Samuelsson, M., Wiklander, M., Asberg, M. & Saveman, B. I. (2000). Psychiatric care as seen by the attempted suicide patient. *Journal of Advanced Nursing*, 32, 635-643. doi.org/10.1046/j.1365-2648.2000.01522.x

Sellin, L., Asp, M., Wallsten, T. & Wiklund Gustin, L. (2017). Reconnecting with oneself while struggling between life and death: The phenomenon of recovery as experienced by persons at risk of suicide. *International Journal of Mental Health Nursing*, 26, 200-207. doi.org/10.1111/inm.12249

Sharac, J., McCrone, P., Sabes-Figuera, R., Csipke, E., Wood, A. & Wykes, T. (2010). Nurse and patient activities and interaction on psychiatric inpatients wards: A literature review. *International Journal of Nursing Studies*, 47, 909-917. doi.org/10.1016/j.ijnurstu.2010.03.012

Sun, F.-K. & Long, A. (2013). A suicidal recovery theory to guide individuals on their healing and recovering process following a suicide attempt. *Journal of Advanced Nursing*, 69, 2030-2040. doi.org/10.1111/jan.12070

Sun, F.-K., Long, A., Boore, J. & Tsao, L. (2006). A theory for the nursing care of patients at risk of suicide. *Journal of Advanced Nursing*, 53, 680-690. doi.org/10.1111/j.1365-2648.2006.03774.x

Talseth, A. G., Lindseth, A., Jacobsson, L. & Norberg, A. (1997). Nurses' narrations about suicidal psychiatric in-patients. *Nordic Journal of Psychiatry*, 51, 359-364. doi.org/10.3109/08039 48970 9090730

Talseth, A. G., Lindseth, A., Jacobsson, L. & Norberg, A. (1999). The meaning of suicidal psychiatric in-patients' experiences of being cared for by mental health nurses. *Journal of Advanced Nursing*, 29, 1034-1041. doi.org/10.1046/j.1365-2648.1999.00990.x

Van Orden, K. A., Witte, T. K., Cukrowicz, K. C., Braithwaite, S., Selby, E. A. & Joiner, T. E. (2010). The interpersonal theory of suicide. *Psychological Review*, 117, 575-600. doi.org/10.1037/a0018697

Vedana, K. G. G., Pereira, C. C. M., dos Santos, J. C. et al. (2018). The meaning of suicidal behaviour from the perspective of senior nursing undergraduate students. *International Journal of Mental Health Nursing*, 27, 1149-1161. doi.org/10.1111/inm.12431

Walsh, G., Sara, G., Ryan, C. J. & Large, M. (2015). Meta-analysis of suicide rates among psychiatric in-patients. *Acta Psychiatrica Scandinavica*, 131, 174-184. doi.org/10.1111/acps.12383

Wand, T. (2012). Investigating the evidence for the effectiveness of risk assessment in mental health care. *Issues in Mental Health Nursing*, 33, 2-7. doi.org/10.3109/01612840.2011.616984

World Health Organization. (2014). *Preventing suicide. A global imperative*. Geneva, Switzerland: WHO Press. Retrieved from: apps.who.int/iris/bitstream/handle/10665/131056/9789241564779_eng.pdf

World Health Organization. (2018). *Suicide rate estimates, age-standardized estimates by WHO region*. Retrieved from: https://apps.who.int/gho/data/view.main.MHSUI CIDEA SDRRE Gv?xml:lang=en

Chapter 6. The perspectives of adults with suicidal ideation and behaviour regarding their interactions with nurses in mental health and emergency services: a systematic review

Based on:
Vandewalle, J., Van Bos, L., Goossens, P., Beeckman, D., Van Hecke, A., Deproost, E., Verhaeghe, S. (2020).
The perspectives of adults with suicidal ideation and behaviour regarding their interactions with nurses in mental health and emergency services: a systematic review.
International Journal of Nursing Studies. doi.org/10.1016/j.ijnurstu.2020.103692

Abstract

Background: In contemporary healthcare, both community and inpatient mental health and emergency services are important help-seeking avenues for persons with suicidal ideation and behaviour. Regarding nursing practice in these services, there is a strong focus on assessing and managing suicide risk. Within this clinical context, the perspectives of persons with suicidal ideation and behaviour are often overlooked.

Objective: To synthesise the literature examining the perceptions and experiences of persons with suicidal ideation and behaviour regarding their interactions with nurses.

Design: Review of qualitative and quantitative studies within a data-based convergent synthesis design.

Data sources: A systematic search of electronic databases (until January 2020) in PubMed, Web of Science, Embase, and PsycARTICLES. Additional articles were identified through hand searching reference lists. Review methods: The methodological quality was assessed using the Critical Appraisal Skills Programme for qualitative studies and the QualSyst tool for quantitative studies. Thematic analysis was used to identify the key themes and subthemes.

Results: In total, 26 studies were selected for analysis. Most studies were qualitative and focused on inpatient mental health services. The studies reflected a spectrum of positive and negative perceptions and experiences of persons with suicidal ideation and behaviour regarding their interactions with nurses. Three key themes were identified: being cared for and acknowledged as a unique individual, giving voice to myself in an atmosphere of connectedness, and encountering a nurturing space to address my suicidality.

Conclusions: This systematic review provides insights that can be used to encourage nurses to contribute to suicide prevention and treatment of suicidal ideation as part of an approach in which they care for, connect, and collaborate with people experiencing suicidal ideation and behaviour as unique individuals.

What is already known about the topic?

- In contemporary healthcare, both community and inpatient mental health and emergency services are important help-seeking avenues for persons with suicidal ideation and behaviour.
- Multidisciplinary guidelines in suicide prevention influence nursing practice. The content and depth of these guidelines often fall short in addressing the perspective of persons with suicidal ideation and behaviour and in illuminating aspects of meaningful interaction beyond the enumeration of key actions for suicide prevention.

What this paper adds

- Persons with suicidal ideation and behaviour want to interact with nurses who care for and acknowledge them as a unique individual; nurses who meet their basic needs, connect with them, and accept and understand what they are going through.
- Nurses can enable persons to give voice to themselves and their suicidality, and thereby create a nurturing space in which they can learn to cope with their suicidality, and (re)establish close ties with other people, services, and life itself.

6.1. Introduction

Each year, approximately 800.000 individuals end their life by suicide (WHO 2018). While this is a considerably high number, suicidal ideation and behaviour are far more common. Cross-national studies report an estimated one-year prevalence of 0.4% for suicide attempts, 2% for suicidal ideation, and a lifetime prevalence of 3% for suicide attempts and 9% for suicidal ideation (Borges et al. 2010; Nock et al. 2008). Suicide, and suicidal ideation and behaviour reflect immense, long-lasting burdens for those affected and closely involved, including family, friends, and healthcare professionals (Hagen et al. 2017; Miklin et al. 2019, Shneidman 1993; Takahashi et al. 2011).

In contemporary healthcare, both community and inpatient mental health and emergency services are essential help-seeking avenues for persons with suicidal ideation and behaviour (Miller et al. 2017; Stene-Larsen & Reneflot 2019). Regarding multidisciplinary professionals working in these contexts, suicide prevention guidelines stress the importance of assessing suicidal intent, risk and protective factors, use risk management strategies (e.g. restrict access to means), provide psychopharmacological and psychotherapeutic treatments, and use safety planning (Bernert et al. 2014). Within multidisciplinary teams, nurses are a focus in suicide prevention guidelines given their crucial role in detecting suicidality and applying preventive and therapeutic interventions (Bolster et al. 2015; Hagen et al. 2017).

Suicide prevention guidelines have their limitations. They often provide nurses with little content and critical depth about how to interact with persons with suicidal ideation and behaviour, including how to initiate contact, discuss suicide, and how to collaborate (Bernert et al. 2014). Moreover, suicide prevention guidelines often focus on the actions expected from nurses rather than reflecting on the perspective of persons with suicidal ideation and behaviour regarding aspects they find most critical when interacting with nurses. Thus, it raises concerns about a lack of an integrative perspective in nursing practice between the nurses' contribution to suicide prevention and their traditional orientation of interacting meaningfully with persons and attending to their human experiences, needs, and responses (Hagen et al. 2017; Peplau 1989).

In particular, studies suggest that nurses are involved in safety planning with few intentions to collaborate with persons with suicidal ideation and behaviour; observe persons without engaging with them; or perform suicide risk assessments as a mere act to gather information, rather than as an opportunity to connect with persons with suicidal ideation and behaviour (Gamarra et al. 2015; Lees et al. 2014; Vandewalle et al. 2019). Such insights are crucial, given that an inadequate basis of meaningful interaction not only limits the effectiveness and therapeutic potential of interventions, but may even increase suicide risk by compounding persons' experiences of loss of control, objectification (Lees et al. 2014), burdensomeness, and exacerbating their unmet needs for human connection (Cutcliffe et al. 2006; Van Orden et al. 2010).

The authors identified three recent literature reviews to explore the perspective of persons with suicidal ideation and behaviour, including a qualitative meta-synthesis (Berglund et al. 2016), a systematic review of qualitative studies (Berg et al. 2017), and a critical interpretive synthesis (Talseth & Gilje 2018). These reviews had no specific focus on the persons' interaction with nurses but instead focused on the nature of their suicidality, and their experiences of safety and recovery (Berg et al. 2017; Berglund et al. 2016; Talseth & Gilje 2018). Moreover, these reviews *a priori* excluded quantitative studies, studies in non-English languages, or studies in emergency and community services. The latter is a limitation in contemporary healthcare, where emergency services are often the first point of access for persons with suicidal ideation and behaviour; and where there is an increasing offer of community services, particularly in response to high-risk periods for suicide, such as service transition and discharge (Chung et al. 2017; Miller et al. 2017).

Considering the current evidence and the limitations of suicide prevention guidelines, it is crucial, and in fact, a scientific responsibility to illuminate the perspectives of persons with suicidal ideation and behaviour and understand what elements they perceive most critical in their interactions with nurses.

Objective

This systematic review aims to synthesise the literature examining the perceptions and experiences of persons with suicidal ideation and behaviour regarding their interactions with nurses across mental health and emergency services. This synthesis is needed to provide insights for service provision evaluation, re-centre nursing practice on the fundamentals of interaction, and help nurses meet the needs of persons with suicidal ideation and behaviour.

6.2. Method

6.2.1. Design

This systematic review applied a data-based convergent synthesis design. This method allows analysis of quantitative and qualitative evidence using the same synthesis method (Hong et al. 2017). The method suitable for this purpose was thematic analysis (Braun & Clarke 2006; Dixon-Woods et al. 2005). Synthesis of quantitative and qualitative evidence was considered necessary to include studies that correspond with the evolution toward measuring aspects of nurse-patient interaction, such as ‘care’ and ‘therapeutic engagement’ (McAndrew et al. 2014; Sitzman & Watson 2019). The PRISMA statement was used to enhance a systematic approach of conducting and reporting this review (Moher et al. 2009).

6.2.2. Search strategy

The electronic databases PubMed, Web of Science, Embase, and PsycARTICLES were searched for all studies published until January 2020. Key words were identified through expert consultation and an explorative literature review. The key words were related to the phenomenon of interest (interaction with nurses): communication, interaction AND nurses, nursing staff; the population (persons with suicidal ideation and behaviour): suicide, attempted suicide, suicidal ideation AND patients, service users; the context (inpatient or community mental health and emergency services): mental health services, community mental health services, emergency hospital services. The search filter entered in PubMed has been provided in Addendum 3.

6.2.3. Study selection

The first and second author independently screened all articles for inclusion. They applied the following inclusion criteria: (1) articles written in English, Dutch, French, or German, (2) focus on persons admitted to, or discharged from, inpatient or community mental health and emergency services, (3) focus on the perspectives of persons with suicidal ideation and behaviour regarding their interactions with nurses.

In addition, the following exclusion criteria were applied: (1) non-empirical research studies and literature reviews, (2) studies focusing on conditions other than suicidal ideation and behaviour (e.g. aggression), (3) studies focusing exclusively on other disciplines than nurses, (4) studies in general hospital wards (e.g. oncology), (5) studies where the main proportion of the sample was aged under 18 or over 65. The latter criterion accounted for potential differences in perspectives and needs across age groups.

For instance, concepts such as autonomy, power, and responsibility sharing can play a different role in nurses' interactions with adults opposed to children, youth, and older adults (Longtin et al. 2010). In addition, particular adversities encountered by youth, such as bullying, abuse, and identity struggles often require specific educative, school-based, and family interventions (Bilsen 2018; Steele et al. 2018). Older adults might experience physical illness and bereavement, and their suicidal behaviour is generally more lethal. Addressing medical comorbidities, preserving independence, and lethal means counselling then become even more crucial (Stanley et al. 2016; Steele et al. 2018). Furthermore, there was debate about the inclusiveness of 'suicidal ideation and behaviour'. Acknowledging the lack of uniform nomenclature, the authors limited the inclusion to studies that specifically mentioned the presence of suicidal ideation and behaviour in their sample (Goodfellow et al. 2018).

A total of 2646 articles were identified. Duplicates (n = 539) were identified using EndNote software and Rayyan, a web application to enable the systematic process of screening and collaborative decision-making (Ouzzani et al. 2016). As outlined in Figure 1, the titles and abstracts of the remaining articles (n = 2107) were screened and the full text of 360 articles were reviewed. The interrater agreement was calculated for title and abstract screening (96%) and full text screening (94%). Disagreements were discussed until consensus was reached. The reference lists of literature reviews were hand searched. The final selection included 26 articles.

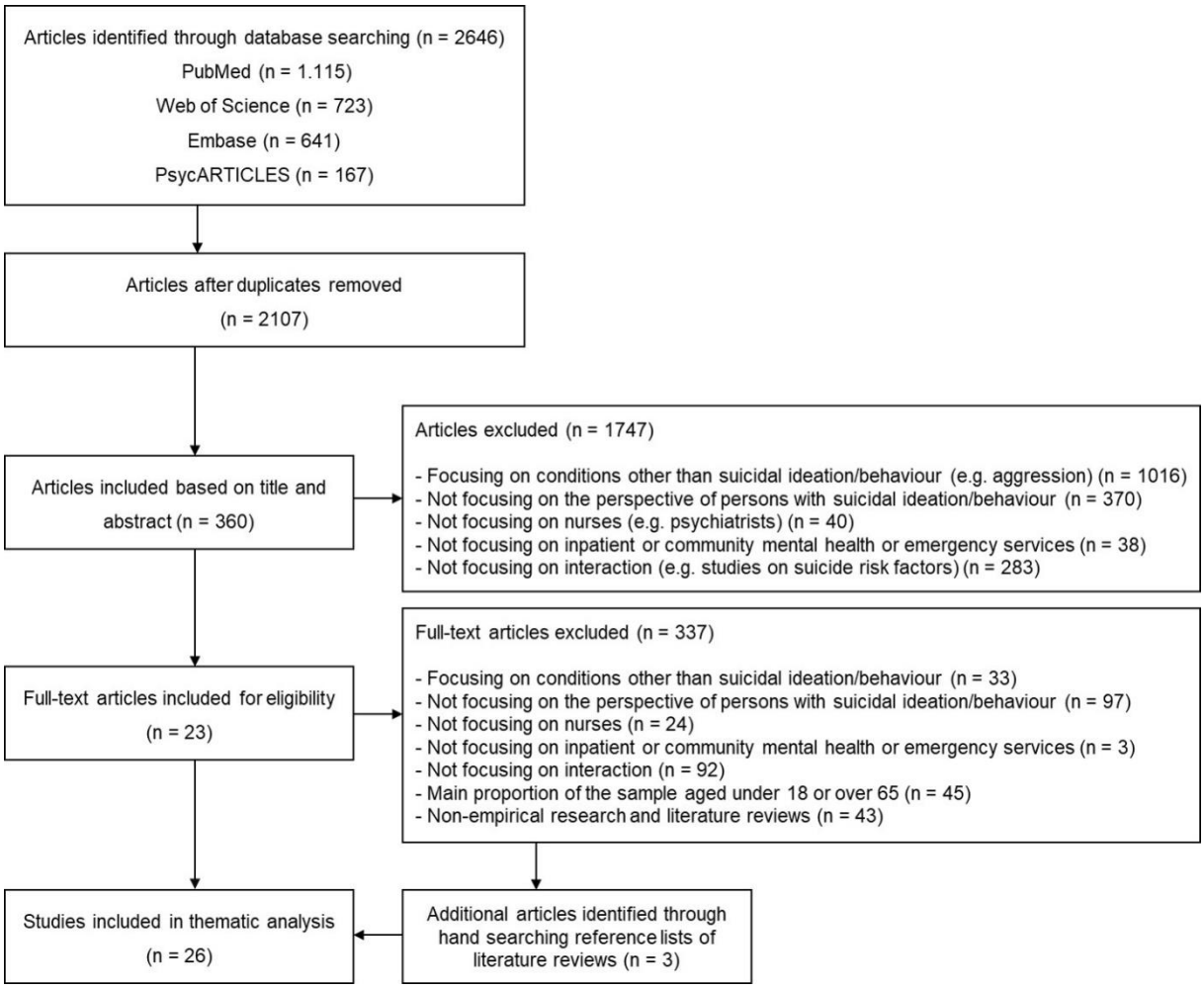

Figure 1. PRISMA flow diagram

6.2.4. Quality assessment

The methodological quality of the studies was assessed independently by two reviewers. While the first author assessed all studies, the second author assessed a random sample of 25% of the studies, including one quantitative study (n=4) and six qualitative studies (n = 22). The interrater agreement was calculated.

The qualitative studies were assessed using the 'Critical Appraisal Skills Programme' (CASP) for qualitative research (Critical Appraisal Skills Programme 2019). The quantitative studies reflected a variety of study designs. Therefore, the QualSyst tool, a validated generic checklist, was used (Kmet et al. 2004).

6.2.5. Data-extraction and analysis

The study characteristics were extracted and inserted into Table 1, which contains information about the publication date, main purpose, setting, study type and design, and sample. The main characteristics of each study and the text fragments under the heading ‘results’ were extracted into a Word document. In studies with a scope beyond the research question, only the relevant data were extracted. The Word document provided the foundation to initiate the systematic steps of thematic analysis as outlined by Braun and Clarke (2006). The first and second author read the full articles multiple times to gain familiarity with the data. The first author initiated line-by-line coding by inserting the Word document into the QSR NVivo 12 software program (QSR International). The second author independently assigned codes to 25% of the extracted data. This selection was considered representative of the complete selection in terms of study setting and design. Following the applied convergent synthesis design, the numeric quantitative data were transformed into words for thematic analysis (Hong et al. 2017).

The authors discussed and compared their codes within and between the studies, enabling them to consider the diverse meanings of the dataset and identify relations between codes. The codes were then grouped into themes and subthemes that were subsequently checked against the content of the dataset to ensure that the analysis adequately represented the perspective of persons with suicidal ideation and behaviour. Moreover, regular meetings were organised with three other authors who reviewed the study characteristics and themes. These processes of triangulation among researchers with diverse backgrounds and areas of expertise (e.g. nursing, mental healthcare, research methodology) assisted monitoring of the authors’ prior understanding as a source of understanding instead of bias, respect the authenticity of the participants’ perspectives, and to produce fully worked-out themes (Morse 2015).

Table 1. Characteristics of the studies

Author(s), (year)	Main purpose	Setting (country)	Study type Design Data collection methods	Sample of persons with suicidal ideation and behaviour Characteristics
Cardell and Pitula (1999)	Explore the patients' experiences of constant observation to determine any therapeutic benefits beyond the intended protective benefit.	Wards of three inpatient mental health facilities. (USA).	Qualitative research; Grounded theory analysis; In-depth interviews.	n=20; Non-random sample Age: 32 years (mean) Gender: female (n=13); male (n=7)
Carrigan (1994)	Investigate and highlight psychosocial needs perceived by individuals who survived a suicide attempt through self-poisoning.	One hospital; Inpatient emergency services. (Northern Ireland).	Qualitative research; Exploratory, descriptive design; Focused interviews.	n=6; Convenience sample Age: unreported Gender: female (n=3); male (n=3)
Cutcliffe et al. (2006)	Determine if and how mental health nurses provide meaningful caring response(s) towards suicidal people.	Two large urban areas; Inpatient and community mental health services. (UK).	Qualitative research; Modified grounded theory design; Semi-structured interviews.	n=20; Theoretical sample Age: >18 years Gender: unreported
Dekker et al. (2017)	Assess the acceptance of a nurse-led follow-up intervention 'guidance to care' following attempted suicide. Improve the continuity of care.	One emergency ward. (Netherlands)	Quantitative research; Cross-sectional design; Structured interviews.	n=257 Age: <25 years - >45 years (range); 39 years (mean); Gender: female (n=164); male n=93)
Dunleavey (1992)	Assess parasuicidal patients' response to the received nursing care.	One emergency ward. (UK).	Qualitative research; Content analysis; Interviews.	n=17 Age: >16 years Gender: unreported

Fletcher (1999)	Explore the perceptions of staff and patients regarding constant observation of suicidal patients.	One large urban area - acute mental health hospital. (UK).	Qualitative research; Ethnographic design; Semi-structured interviews.	n=6; Convenience sample Age: unreported Gender: female (n=4); male (n=2)
Ghio et al. (2011)	Gain insight into the individual experiences of patients who attempt suicide and the attitude towards the assistance they receive.	One university hospital; acute mental health wards. (Italy).	Qualitative research; Focus groups.	n=17; Convenience sample Age: 45.6 years (mean) Gender: female (n=10); male (n=7)
Guthrie et al. (2001)	Determine the effects of a nurse-led brief psychological intervention for patients after deliberate self-poisoning compared with usual treatment.	One university hospital; emergency department. (UK).	Quantitative research; Randomized Controlled Trial; Assessment and self-report scales.	n=119; Random stratified sample Age: 18-65 years (range); 31.2 years (mean) Gender: female (n=66); male (n=53)
Hagen et al. (2018)	Explore (former) suicidal inpatients experience regarding treatment and care in psychiatric wards following the implementation of the National guidelines for prevention of suicide.	Acute mental health wards and community services. (Norway).	Qualitative research; Interpretative phenomenological analysis; In-depth interviews;	n=5; Criterion-convenience sample Age: 33-54 years (range) Gender: female (n=4); male (n=1)
Holm and Severinsson (2011)	Explore how a recovery process facilitated changes in suicidal behaviour in a sample of women with borderline personality disorder.	Acute mental health wards and community services. (Norway).	Qualitative research; Exploratory design; Narrative conversations.	n=13; Purposive sample Age: 25-53 years (range); 39 years (mean) Gender: female (n=13)
Jones et al. (2000)	Gain understanding of psychiatric inpatients' experience of being closely observed by mental health nurses.	One mental health hospital providing inpatient and community services. (UK).	Quantitative research; Structured interviews; Repertory grid technique and factor analysis.	n=8; Convenience sample Age: 31-59 years (range) Gender: female (n=3); male (n=5)
Jordan et al. (2012)	Gain insight from the perspective of young men about the context of their suicidal behaviour. Use this contextual perspective as a basis for thinking about service delivery and clinical care.	Inpatient and community mental health services. (Northern Ireland).	Qualitative research; Grounded theory; In-depth interviews.	n=36; Purposive sample Age: 18-34 years (range) Gender: male (n=36)

Lees et al. (2014)	Explore experiences and needs that adult mental health-care consumers had of suicidal crisis.	Inpatient mental health wards and community services. (Australia).	Qualitative research; In-depth, semi-structured interviews.	n=9; Age: 41 years (mean) Gender: female (n=6); male (n=3)
McLaughlin (1999)	Explore psychiatric nurses' and patients' opinions regarding the care provided to patients experiencing suicidality.	One mental health hospital; inpatient wards. (Northern Ireland).	Qualitative research; Semi-structured interviews.	n=17; Age: 20-60 years (range) Gender: female (n=10); male (n=7)
Pitula and Cardell (1996)	Explore the perspectives of inpatients with suicidality on the experience of constant observation.	Two inpatient mental health wards. (USA).	Qualitative research; Exploratory design; Interviews.	n=14; Convenience sample Age: 21-47 years (range) Gender: female (n=8); male (n=6)
Samuelsson et al. (2000)	Describe the perception of patients who attempted suicide of receiving specialised inpatient psychiatric care.	One inpatient mental health ward. (Sweden).	Qualitative research; Content analysis; Interviews.	n=18; Convenience sample Age: 18-53 years (range) Gender: female (n=6); male (n=12)
Sein Anand et al. (2005)	Evaluate the social support given by nurses to patients following a suicidal attempt	One emergency ward. (Poland).	Quantitative research; Questionnaire design	n=40; Age: 14-53 years (range); 31.4 years (mean). Gender: female (n=32); male (n=8)
Sellin et al. (2017)	Describe the phenomenon of recovery in a context of nursing care as experienced by persons at risk of suicide.	One mental health hospital; inpatient wards. (Sweden).	Qualitative research; Phenomenological design; Phenomenon-oriented interviews.	n=14; Age: 20-70 years (range) Gender: female (n=11); male (n=3)
Sellin et al. (2019)	Explore and evaluate how the 'Recovery Oriented Care Approach' was experienced by a patient who experiences suicidality in a context of close relatives and nurses.	One inpatient mental health ward. (Sweden).	Qualitative research; Single-case study; Interview.	n=1; Age: middle-aged Gender: male (n=1)

Sun et al. (2006)	Present a nursing care theory developed to guide the care given to people with suicidal ideas and those with a previous suicide attempt.	Three mental health hospitals. (Taiwan).	Qualitative research; Grounded theory design; Observation and interviews.	n=15; Theoretical sample Age: 16-47 years (range) Gender: female (n=9); male (n=6)
Talseth et al. (2003)	Describe a process of consolation revealed by two suicidal patients' experiences in the light of a model of consolation.	One inpatient mental health ward. (Norway).	Qualitative research; Phenomenological hermeneutic design; Narrative interviews.	n=2; Convenience sample Age: middle-aged Gender: unreported
Talseth et al. (1999)	Illuminate the meaning of experiences of being cared for by mental health nurses from the perspective of patients experiencing suicidality.	One mental health hospital; five inpatient wards. (Norway).	Qualitative research; Phenomenological design; Interviews.	n=21; Convenience sample Age: 25-63 years (range) Gender: female (n=12); male (n=9)
Taylor (2019)	Explore system Entrapment, the basic psycho-social problem that emerged from analysis of women's help-seeking for suicidality after intimate partner violence.	Inpatient and community mental health services. (Canada).	Qualitative research; Grounded theory design; In-depth interviews and group dialogues.	n=32; Theoretical sample Age: 19-68 years (range) Gender: female (n=32)
Tofthagen et al. (2017)	Explore, describe and understand former patients' experiences of recovery from self-harm.	Two mental health hospitals. (Norway).	Qualitative research; Phenomenological hermeneutic design; Interviews.	n=8 (history of attempted suicide); Age: 36 years (mean) Gender: female (n=7); male (n=1)
Vatne and Naden (2018)	Develop knowledge on what alleviates the suicidal suffering after having survived a suicide attempt.	Two emergency mental health wards and one community mental health service. (Norway).	Qualitative research; Explorative hermeneutic design; In-depth interviews.	n=10; Age: 21-52 years (range) Gender: female (n=4); male (n=6)
Wiklander et al. (2003)	Highlight aspects of care that were reported as associated with the shame reaction following a suicide attempt.	One inpatient mental health ward. (Sweden).	Qualitative research; Content analysis; Semi-structured interviews.	n=13; Convenience sample Age: 22-53 years (range) Gender: female (n=5); male (n=8)

6.3. Results

6.3.1. Study characteristics

This systematic review includes 26 articles, written in English, and published between 1992 and 2019. Twenty-two qualitative and four quantitative studies were identified. Studies were conducted in Norway (n = 6), the UK (n = 5), Sweden (n = 4), Northern Ireland (n = 3), the USA (n = 2), Australia (n = 1), Canada (n = 1), Italy (n = 1), Poland (n = 1), Taiwan (n = 1), and the Netherlands (n = 1). The studies focused on the perspectives of persons with suicidal ideation and behaviour regarding their interactions with nurses in inpatient mental health services (n = 13), a combination of inpatient and community mental health services (n = 8), and inpatient emergency services (n = 5). Several studies included mixed samples (e.g. patients and nurses) or reported persons' perspectives regarding multiple professionals (e.g. nurses and psychiatrists). In several studies, general descriptions were used to refer to the population, including 'suicidal people' and 'suicidality'. Other studies included details about participants' suicidal ideation and behaviour, for example: suicidal thoughts, ideas, and feelings; suicidal plans and impulses; and attempted suicide, for instance by self-poisoning or overdose. Additionally, several studies included participants who reported both suicidal ideation and behaviour as part of a suicidal (recovery) process. The sample size of persons with suicidal ideation and behaviour ranged from 1 to 257. The majority were female (n = 422) as opposed to men (n = 277). Their age ranged between 14 and 68 years.

The scores of the methodological quality appraisal are provided in Tables 2 and 3. Decisions for all assessed items were discussed and revealed interrater agreement of > 90%. No studies were excluded based on methodological quality. An average of 25% of the items for qualitative studies was evaluated positively (range 0-70%). The evaluation revealed a lack of justification for the applied sampling procedures and data collection methods (e.g. interview guide). Several articles lacked adequate discussion of principles relating to the rigorousness of the analysis and the credibility of the findings (e.g. triangulation and transferability). Moreover, most researchers shared no reflexive accounts about their relationship with the participants, which raises concerns about reflexivity. The quantitative studies received an overall quality score of at least 70%, except for the cross-sectional, descriptive study of Sein Anand et al. (2005). Only the randomised controlled trial (RCT) of Guthrie et al. (2001) could be scored on the items regarding randomisation and blinding. Overall, the quality appraisal revealed potential sources of bias, including the use of non-valid measures, small sample sizes, and a lack of control for confounding variables.

Table 2. Quality assessment of the qualitative studies

Reference	Items									
	Was there a clear statement of the aims of the research?	Is a qualitative methodology appropriate?	Was the research design appropriate to address the aims of the research?	Was the recruitment strategy appropriate to the aims of the research?	Where the data collected in a way that addressed the research issue?	Has the relationship between researcher and participants been adequately considered?	Have ethical issues been taken into consideration ?	Was the data analysis sufficiently rigorous?	Is there a clear statement of findings?	How valuable is the research?
Cardell and Pitula 1999	yes	yes	no	no	no	no	no	no	yes	yes
Carrigan 1994	yes	yes	yes	no	no	yes	yes	no	no	yes
Cutcliffe et al. 2006	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes
Dunleavy 1992	yes	yes	no	no	no	no	no	no	no	yes
Fletcher 1999	yes	yes	no	no	no	no	no	no	yes	yes
Ghio et al. 2011	yes	yes	yes	yes	yes	no	yes	yes	yes	yes
Hagen et al. 2018	yes	yes	yes	yes	yes	no	yes	yes	yes	yes
Holm and Severinsson 2011	yes	yes	yes	no	no	yes	yes	yes	yes	yes
Jordan et al. 2012	yes	yes	yes	yes	yes	no	yes	yes	yes	yes
Lees et al. 2014	yes	yes	yes	yes	no	no	yes	no	no	yes
McLaughlin 1999	yes	yes	no	yes	yes	no	yes	no	yes	yes
Pitula and Cardell 1996	yes	yes	no	no	yes	no	no	no	no	yes
Samuelsson et al. 2000	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes
Sellin et al. 2017	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes
Sellin et al. 2019	yes	yes	yes	yes	yes	no	yes	yes	yes	yes
Sun et al. 2006	yes	yes	yes	no	yes	no	yes	no	yes	yes
Talseth et al. 1999	Yes	yes	yes	no	yes	no	no	yes	yes	yes
Talseth et al. 2003	Yes	yes	yes	no	yes	no	no	yes	yes	yes
Taylor 2019	Yes	yes	yes	yes	yes	yes	yes	yes	yes	yes
Tofthagen et al. 2017	Yes	yes	yes	yes	no	no	yes	yes	yes	yes
Vatne and Naden 2018	Yes	yes	yes	yes	yes	yes	yes	yes	yes	yes
Wiklander et al. 2003	Yes	yes	yes	yes	yes	yes	yes	yes	no	yes

Table 3. Quality assessment of the quantitative studies

		Dekker et al. 2017	Guthrie et al. 2001	Jones et al. 2000	Sein Anand et al. 2005
Criteria					
1	Question/ objective sufficiently described?	2	2	2	1
2	Study design evident and appropriate?	1	2	1	2
3	Method of subject/ comparison group selection or source of information/ input variables described and appropriate?	2	2	2	0
4	Subject characteristics sufficiently described?	2	2	2	1
5	If interventional and random allocation was possible, was it described?	N/A	2	N/A	N/A
6	If interventional and blinding of investigators was possible, was it reported?	N/A	2	N/A	N/A
7	If interventional and blinding of subjects was possible, was it reported?	N/A	2	N/A	N/A
8	Outcome and exposure measure(s) well defined and robust to measurement/ misclassification bias? Means of assessment reported?	1	2	1	1
9	Sample size appropriate?	1	1	0	0
10	Analytic methods described/ justified and appropriate?	2	1	2	0
11	Some estimate of variance is reported for the main results?	2	2	1	N/A
12	Controlled for confounding?	2	1	1	N/A
13	Results reported in sufficient detail?	1	1	2	1
14	Conclusions supported by the results?	2	1	2	1
Total score		**18/22**	**23/28**	**16/22**	**7/18**

6.3.2. Themes and subthemes

The findings are synthesised into three themes and seven subthemes. The synthesis reflects a spectrum of positive and negative perceptions and experiences of persons with suicidal ideation and behaviour regarding their interactions with nurses across inpatient and community mental health and emergency services. The themes and subthemes are presented in Table 4 and described in detail below.

Table 4. Themes and subthemes reflecting the perspective of persons with suicidal ideation and behaviour regarding their interactions with nurses

Themes and subthemes
Being cared for and acknowledged as a unique individual
○ Care for my basic needs
○ Please accept and try to understand what I'm going through
○ Don't judge me, but connect with me as the person I am
Giving voice to myself in an atmosphere of connectedness
○ Feel enabled or disabled to communicate about my suicidal ideation or behaviour
○ Don't leave me powerless, make room for interpersonal engagement
Encountering a nurturing space to address my suicidality
○ Help me to cope with and make sense of myself and my suicidality
○ Support me to (re)establish close ties with other people, services, and life itself

Being cared for and acknowledged as a unique individual

The first theme reflects the value that persons with suicidal ideation and behaviour attach to nurses who care for their basic needs, accept and try to understand what they are going through, and try to connect with them as the person they are.

Care for my basic needs

Persons with suicidal ideation and behaviour expressed their need for nurses who are available, approachable, and reach out to them (Ghio et al. 2011; McLaughlin 1999, Samuelson et al. 2000; Sein Anand et al. 2005). While they perceived nurses as approachable when they spend time with them, conveyed openness (e.g. calm voice), and were 'friendly' and 'kind', they perceived nurses as distant when they stayed in the nursing station or were too busy with other tasks (Cardell & Pitula 1999; Lees et al. 2014; Sun et al. 2006; Talseth et al. 1999; Wiklander et al. 2003). Positive experiences included nurses who focused their presence on them, such as doing activities or communicate warm and comforting attention by having a chat or bringing a cup of tea. Negative experiences included accounts of nurses who 'just left them in bed'; seldom, or only formally, contacted them ('it's dinner time'); or having to contact nurses themselves. These experiences added to their feeling of isolation and confirmed their perception that nobody cares about them (Cutcliffe et

al. 2006; Dunleavey 1992; Fletcher 1999; McLaughlin 1999; Talseth et al. 1999; Vatne & Naden 2018).

In addition, it was appreciated when nurses attended to basic needs for personal hygiene, food, sleep and rest, fresh air, and physical activity; especially at times when they felt despair and apathy or neglected their own needs (e.g. periods without proper eating) (Hagen et al. 2018; Sein Anand et al. 2005; Sellin et al. 2017; Sun et al. 2006; Talseth et al. 1999). Conversely, several persons experienced that nurses overlooked their basic needs. They referred to nurses who disrespected their sleeping habits or need for rest, dismissed their request to go outside, or prevented them from showering or taking a bath at will. Moreover, following their suicide attempt, they perceived nurses providing little support in activities of daily living, such as washing, dressing, and eating (Cardell & Pitula 1999; Lees et al. 2014; Sein Anand et al. 2005; Talseth et al. 1999). Others had positive experiences with nurses providing support and encouragement to attend to their own basic needs. This made them feel more stabilised and secure, cultivated feelings of self-worth, and enabled them to find a vital rhythm in life (Dunleavey 1992; Hagen et al. 2018; Sellin et al. 2017; Talseth et al. 1999; Tofthagen et al. 2017).

Please accept and try to understand what I'm going through

Persons with suicidal ideation and behaviour expressed their need to be accepted and understood in what they are going through. They indicated that a sense of acceptance and understanding was communicated by nurses who were willing and able to listen to their story and responded to it with empathy and compassion (Carrigan 1994; Cutcliffe et al. 2006; McLaughlin 1999; Sellin et al. 2017; Sun et al. 2006; Tofthagen et al. 2017). They valued nurses who expressed genuine concern and recognised their emotional distress and disturbing thoughts. This sensitive involvement enabled them to ask for help and begin expressing their thoughts and feelings (Hagen et al. 2018; McLaughlin 1999; Samuelson et al. 2000; Talseth et al. 1999; Vatne and Naden 2018).

Others reported that nurses did not take their perspective of suffering into account. They felt that nurses did not take them seriously; they did not listen to their story, did not respond to them, or broke off conversations (Carrigan 1994; Cardell & Pitula 1999; Dunleavey 1992; Fletcher 1999; Hagen et al. 2018; Talseth et al. 2003). Moreover, some experienced that nurses dismissed or minimised their feelings. They perceived that nurses imposed their values on them or provided superficial reassurance (e.g. 'be an optimist'). Following these experiences, they lost trust in the nurse, withdrew in silence, and dealt with their pain alone (Hagen et al. 2018; Lees et al. 2014; Sellin et al. 2017; Talseth et al. 2003; Taylor 2019).

Experiencing nurses' psychical and emotional closeness allowed them—while often struggling to stay alive—to feel less anxious, more secure in moments of loneliness, and safe

from their suicidal impulses (Cardell & Pitula 1999; Fletcher 1999; Hagen et al. 2018; Jones et al. 2000; McLaughlin 1999). Moreover, the nurses did not give up on them; instead, they conveyed a sense of belief and unconditional positive regard toward them and their recovery. This positive support relieved their daily suffering, gave them the courage to 'hold on', and inspired hope that their condition might improve. In contrast, some felt that nurses confirmed their hopelessness with messages such as, 'there is no recipe for getting well' (Cutcliffe et al. 2006; Hagen et al. 2018; Jordan et al. 2012; Sellin et al. 2019; Talseth et al. 1999).

Don't judge me, but connect with me as the person I am

Persons with suicidal ideation and behaviour expressed various elements which made them feel that nurses acknowledged them as the person they are. They referred to nurses who showed everyday attentiveness (e.g. greeting them), treated them with respect, and approached them in a non-judgmental way (Cardell & Pitula 1999; Fletcher 1999; Hagen et al. 2018; Lees et al. 2014; Sellin et al. 2017). They found it particularly valuable to interact with a genuine person who tried to connect with them; nurses who conveyed a sense of genuine interest and concern, listened without prejudice, and referred to future connective encounters (Cutcliffe et al. 2006; Hagen et al. 2018; Lees et al. 2014; McLaughlin 1999; Sellin et al. 2019; Talseth et al. 1999).

However, others expressed that nurses appeared detached or uninterested, seldom praised them, and gave no intention to get to know or connect with them. Some even considered self-harm so the nurses would finally notice them (Cardell & Pitula 1999; Dunleavey 1992; Sein Anand et al. 2005; Talseth et al. 2003). In addition, some nurses condemned their suicidality through expressions of anger and blame or approached them with an emphasis on medical diagnosis and treatment of symptoms. In response, they perceived that nurses were judging them as 'crazy' or 'another suicide attempt', and that they overlooked the concerns that mattered to them (Holm & Severinsson 2011; Lees et al. 2014; Talseth et al. 1999; Taylor 2019; Wiklander et al. 2003).

Also, there was reference to nurses who only interacted with them as part of formal procedures, such as to control the 'object' they were responsible for. Moreover, some nurses prevented toilet visits when being in an isolation room, invaded their privacy during formal observations, or communicated distrust by searching their belongings. These impersonal and judgemental attitudes of nurses added to their feelings of shame and burdensomeness and eroded their sense of being a dignified and capable person (Cardell & Pitula 1999; Hagen et al. 2018; Holm and Severinsson 2011; Samuelson et al. 2000; Tofthagen et al. 2017).

Giving voice to myself in an atmosphere of connectedness

The second theme pertains to persons' perspectives on feeling enabled or disabled to communicate about their suicidal ideation or behaviour and their interactions with nurses that facilitated or impeded interpersonal engagement.

Feel enabled or disabled to communicate about my suicidal ideation or behaviour

Persons with suicidal ideation and behaviour expressed feelings of being supported or discouraged to talk about suicide because of conditions pertaining to themselves, their live world, and their interactions with nurses. Barriers to discussing suicide include anticipated stigma and perceived judgement, shame and embarrassment (e.g. after a suicide attempt), fear to re-experience strong emotions, inability to put words to their suicidal ideation and behaviour, and difficulties to trust people or to talk confidentially with 'just anyone' (Dunleavey 1992; Cutcliffe et al. 2006; Fletcher 1999; Lees et al. 2014; Sellin et al. 2017).

Within these broader experiences, some interactions with nurses made them feel disabled to communicate about suicide. They shared experiences where nurses did not talk with them about suicide, thereby, eliminating opportunities to speak about their suicidal ideation or behaviour. Additionally, some nurses appeared to avoid the topic or indicated that talking about suicide would increase their suicidal ideation. Others expressed that the judgmental responses of some nurses intensified their challenges to discuss suicide, including shame and lack of trust (Carrigan 1994; Cutcliffe et al. 2006; Fletcher 1999; Hagen et al. 2018; Lees et al. 2014; Taylor 2019; Wiklander et al. 2003).

Conversely, they expressed their need and appreciation for nurses who conveyed openness by a relaxed body language and initiating conversations concerning suicide. Foremost, persons with suicidal ideation and behaviour referred to the connectedness they experience with nurses, which reflected a sense of security and trust that enabled them to freely discuss their suicidal thoughts, feelings, and experiences they previously internalised (Cutcliffe et al. 2006; Hagen et al. 2018; Lees et al. 2014; Talseth et al. 1999). In addition, several persons pointed to the additional trust and security they experienced by talking about and reflecting on their suicidal ideation and behaviour with nurses whom they perceived as experienced, competent in listening and talking, and able to tolerate their feelings (Carrigan 1994; Cutcliffe et al. 2006; McLaughlin 1999; Samuelsson et al. 2000). Feeling enabled to discuss their suicidal ideation and behaviour provided a sense of relief and allowed for experiences of reduced suffering and isolation (Cutcliffe et al. 2006; Lees et al. 2014; Sellin et al. 2017; Talseth et al. 1999; Taylor 2019).

Don't leave me powerless, make room for interpersonal engagement

Persons with suicidal ideation and behaviour reflected on the interpersonal engagement or the 'companionship' and 'communicative togetherness' they could develop with nurses (Hagen et al. 2018; Sellin et al. 2019). They expressed that they could begin to engage with nurses when they experienced a sense of connectedness, of being seen, and taken into account (Holm and Severinsson 2011; Jordan et al. 2012; Lees et al. 2014; Sellin et al. 2017). They referred to the information they got from nurses about medical issues (e.g. medicine), the ward environment, and whom they could contact when needed. This gave them a sense of control over their environment. Conversely, they reported feelings of being overwhelmed and frustrated when nurses did not inform them about clinical procedures, such as formal observations, and more specifically, about their intrusive attributes (Cardell & Pitula 1999; Jones et al. 2000; Lees et al. 2014).

They valued it when nurses invited them for dialogue, and when they were open to their opinions, offered treatment options, and enabled choice about aspects of daily living (Hagen et al. 2018; McLaughlin 1999; Sein Anand et al. 2005; Talseth et al. 2003). However, they often thought of themselves as being in 'a system' where it was not evident to have voice and choice (Lees et al. 2014; Sellin et al. 2017; Taylor 2019). Nurse interactions where they felt powerless included nurses' verbal expressions or their body language. They perceived that some nurses controlled aspects of daily living; they dismissed requests to go jogging, emphasised that they cannot walk around unsupervised, or controlled them when 'just sitting outside' (Fletcher 1999; Holm & Severinsson 2011; Lees et al. 2014; McLaughlin 1999, Wiklander et al. 2003).

They regularly expressed that nurses observed them, restricted their freedom, physically restrained them, or locked them in an isolation room (Cardell & Pitula 1999; Lees et al. 2014; Sun et al. 2006; Taylor 2019). While they mostly expressed negative experiences with these rules and routines, such as loss of autonomy, their experiences were often mediated by the presence or absence of an interpersonal engagement. For instance, while they expressed feelings of safety and security when nurses engage personally with them during observations, they expressed that observations in the absence of engagement were an impersonal experience of 'being watched', which contributed to their feelings of anxiety, isolation, and objectification. In response, some persons tried to hasten the termination of observations by lying about their degree of suicidal ideation or behaviour (Cardell & Pitula 1999; Fletcher 1999; Jones et al. 2000; Lees et al. 2014; Pitula & Cardell 1996; Sun et al. 2006).

Encountering a nurturing space to address my suicidality

The third theme reflects persons' experiences of nurses who helped them cope with and make sense of themselves and their suicidal ideation and behaviour, including those who supported them to (re)establish close ties with other people, services, and life itself.

Help me to cope with and make sense of myself and my suicidality

Persons with suicidal ideation and behaviour experienced that nurses made efforts to reduce their suffering and distract their mind away from suicidal ideation, for instance, by administering medication or by initiating social conversations and activities (Cardell & Pitula 1999; Fletcher et al. 1999; Tofthagen et al. 2017). While they regularly stressed the value of these initiatives, they also emphasised that it provided temporary relief and did not help them understand and change their suicidal ideation or behaviour. Moreover, they perceived that some nurses did nothing more than suggesting sedatives, initiating social chats to 'keep their mind occupied', or communicate quick advice (Hagen et al. 2018; Holm & Severinsson 2011; McLaughlin 1999; Taylor 2019).

They often wanted more enduring and constructive assistance from nurses. They reflected on the nurturing space they experienced when nurses talked with and questioned them in a way that stimulated discussion about their feelings and to reflect on their coping strategies and attitudes toward suicide. These conversations, when accompanied by emotional support, provided space to explore their difficulties, to fail and learn (e.g. when trying to reduce self-harm), and to gradually develop alternative ways of coping (Cutcliffe et al. 2006; Fletcher 1999; Lees et al. 2014; McLaughlin 1999; Sellin et al. 2019; Tofthagen et al. 2017). Regarding these processes of development and change, persons with suicidal ideation and behaviour also reported positive effects after receiving nurse-led psychodynamic therapy following hospitalisation. At six-month follow-up, they had reduced scores of suicidal ideation and they self-reported a reduction in self-harm (Guthrie et al. 2001).

The data also reflected that, at times of experiencing hopelessness, persons with suicidal ideation and behaviour may live with constricting beliefs about themselves and their lifeworld, such as 'I'm worthless'; 'nobody cares about me'; or 'I'll be stigmatised' (Cutcliffe et al. 2006; Dunleavey 1992; Jordan et al. 2012; Taylor 2019). Against this background, interactions with nurses could either provide mirror experiences that perpetuated persons' constricting beliefs or contrary experiences that challenged these beliefs. While nurses perpetuated their constricting beliefs (e.g. being worthless) with non-caring and judgemental attitudes, these beliefs were challenged by nurses who demonstrated care and concern, listened without prejudice, and conveyed acceptance and understanding (Cutcliffe et al. 2006; Fletcher 1999; Samuelsson et al. 2000; Sellin et al. 2017; Talseth et al. 1999). Further, when recognising

their constricting beliefs together with nurses, they could begin to replace these beliefs with more realistic and positive views about themselves and their lifeworld (Cutcliffe et al. 2006; Jordan et al. 2012).

Support me to (re)establish close ties with other people, services, and life itself.

Persons with suicidal ideation and behaviour expressed that (re)establishing close ties is crucial to their recovery and helped counter loneliness, which was a contributing factor to their suicidality. Conversely, several persons highlighted their feelings of isolation and a lack of support from their relatives (Carrigan et al. 1994; Dekker et al. 2017; Sellin et al. 2019; Sun et al. 2006; Taylor 2019). In this context, the data suggest nurses can provide support to (re)establish close ties with other people. Nurses could stimulate these ties by talking with persons about their relatives, providing appropriate information to their relatives, and involving their relatives in safety planning. More subtly, the data suggested that the opportunities persons with suicidal ideation and behaviour experienced to give voice to themselves and to build trust and connect with another person (the nurse) enabled them to approach other people with their experiences of feeling suicidal (Cutcliffe et al. 2006; Ghio et al. 2011; Hagen et al. 2018; Sein Anand et al. 2005; Sellin et al. 2017). They also expressed that nurses helped them to acquire affiliations with social networks (e.g. meeting centres, peer groups) where they could find comfort, support, and hope (Jordan et al. 2012; Hagen et al. 2018; Taylor 2019). Moreover, they indicated that nurses facilitated their access to a range of activities and educational programs, which helped them to regain a sense of competence and meaningful activity, and to attribute new purpose and meaning in life (Cardell & Pitula 1999; Jordan et al. 2012; Sellin et al. 2019; Sun et al. 2006; Tofthagen et al. 2017).

Furthermore, they experienced that nurses supported them to (re)establish close ties with healthcare services. While some contemplated leaving the service in response to degrading attitudes of nurses, others stressed that their connectedness with nurses made them stay in contact with the service. Likewise, they pointed to the security they felt at discharge when nurses indicated they could contact the ward whenever needed (Jordan et al. 2012; Samuelsson et al. 2000; Wiklander et al. 2003). Finally, they expressed the value of follow-up visits by community nurses after hospitalisation who could offer ongoing support or encourage them to engage in post-discharge services (Dekker et al. 2017; Ghio et al. 2011).

6.4. Discussion

This systematic review enhances the understanding of the perspectives of persons with suicidal ideation and behaviour regarding their interactions with nurses within mental health and emergency services. The thematic analysis revealed themes and subthemes with high contemporary relevance, which stress the importance for nurses to reflect on how they present themselves to persons with suicidal ideation and behaviour and meet their multiple needs.

Starting from the basics of interaction, persons with suicidal ideation and behaviour often expressed that nurses had limited contact with them, were difficult to access, or interacted with them in non-caring and impersonal ways. This was exemplified in their perceptions of nurses who were distant, and who judged and approached them as a diagnosis or 'another suicide attempt'. The significance of these findings is underscored by the insight that, when persons with suicidal ideation and behaviour encountered judgemental, non-caring attitudes of nurses, they experienced increased withdrawal, became silent, and reluctant to seek help. These corresponding behaviours reflect their sensitivity to nurses' attitudes. Considering literature about suicide-related factors, this may be partly due to cognitive rigidity in persons with suicidal ideation and behaviour, including a tendency to misconstrue experiences in a negative way (Beck et al. 1990) and perceive themselves as a burden (Van Orden et al. 2010).

Reflecting more positive perspectives, the findings suggest that persons with suicidal ideation and behaviour can gain a sense of being cared for and acknowledged as unique individuals by nurses. In particular, the value of nurses who listen, demonstrate empathy and compassion, communicate acceptance and understanding, and provide support for physical care needs was emphasised. The sense of being cared for and acknowledged is pivotal for persons with suicidal ideation and behaviour. Consistent with The Interpersonal Theory of Suicide (Van Orden et al. 2010), this can challenge their perceptions of being a burden or that 'nobody cares about them' as well as enable their sense of human connection. In turn, experiencing connectedness enables them to feel safe and hopeful, ask the nurses' help, and talk about their suicidality. Moreover, nurses must consider the value of connectedness within a greater social and care context. Indeed, persons with suicidal ideation and behaviour expressed concrete and subtle ways nurses can help them to (re)establish close ties with other people, healthcare services, and life itself.

In close interaction with connectedness, the findings highlight the need for nurses to collaborate with persons with suicidal ideation and behaviour, including sharing information, offering choice, building dialogue, and supporting change and development. Regarding

support for change and development, the persons referred to the nurturing space provided by sensitive nurses who stimulated them to talk and reflect on how they feel and cope with their suicidal ideation and behaviour. While nurses appear to provide less delineated therapeutic treatments than psychiatrists or psychologists, they provide more direct care and address everyday risks (Hagen et al. 2017). Their engagement can be therapeutic, particularly through enabling a person's sense of being cared for, security, being understood, and providing opportunities to give voice to themselves and their suicidality. However, reflecting Peplau's theoretical understanding (1989), persons with suicidal ideation and behaviour often experienced a 'quick effort' of nurses giving advice, to reassure, and focus on distraction, rather than to investigate their difficulties and discuss their inner experiences. Moreover, they often felt controlled and left powerless by nurses and their indiscriminate use of suicide prevention procedures.

Overall, the findings show considerable variation in the interactions between nurses and persons with suicidal ideation and behaviour. This raises questions about the factors that underpin this variation. Nursing research highlights that attitudes, communication skills, empathy, emotional regulation, and reflection can mediate the potential of nurses to connect and engage with persons with suicidal ideation and behaviour (Hagen et al. 2017; Lees et al. 2014). In addition, the findings suggest that persons with suicidal ideation and behaviour may have characteristics that challenge their interaction with nurses, including a lack of trust in other people and a limited ability to talk about their suicidality. Furthermore, Lees et al. (2014) indicate that ambivalence and intent to die, and psychiatric diagnoses (e.g. personality disorder) might present challenges for both persons with suicidal ideation and behaviour and nurses to engage and connect.

In addition, service-related factors including lack of time and staffing shortages may influence interaction. This was evident given that persons with suicidal ideation and behaviour often reported that nurses were 'busy'. However, the findings also suggest that nurses may distance themselves and may not spend their available time on meaningful interaction. Factors that limit the potential for meaningful interaction might be particularly apparent in emergency wards, characterised by short-term admissions and pressing clinical demands, including 'screening' multiple patients and instant decision-making regarding risk management (Heyland et al. 2018). Moreover, the included studies suggest (e.g. Dekker et al. 2017) that emergency wards appear more likely to report suicide attempts. In this context, persons perceived that nurses might address their physical needs (e.g. food insufficiency), but simultaneously demonstrate little interpersonal engagement in listening to and understanding their experiences (e.g. 'they just left me in bed'). This accords with evidence indicating that emergency nurses can have negative attitudes toward suicidality and that

patients perceive more stigma with emergency professionals opposed to mental health professionals (Frey et al. 2016; Heyland et al. 2018).

Related to the above factors, the findings suggest a mediating role of the dominant model of care. Some nurses appear to follow a recovery-oriented model of care, as seen in persons' perceptions of nurses who invited them for dialogue, engaged with them as a person, and attended to their needs for emotional care and connection (Cutcliffe & Stevenson 2008). Other nurses appear to follow the dominant medical-custodial model of care in which persons are approached by their physical symptoms and suicide risk, which need to be managed and controlled (Lees et al. 2014).

6.4.1. Methodological considerations

The authors attempted to ensure a transparent design and a systematic and collaborative review and analysis process. Nevertheless, the potential for bias remains. First, there is a risk of missed studies because relevant databases, such as CINAHL and PsycINFO, were not searched. Second, limitations of the qualitative synthesis method should be considered. According to Thorne (2017), synthesis methods include the risk of oversimplification and losing the context and meaning of the primary studies. Moreover, the inclusion of studies with lower methodological quality may have affected the validity of the synthesis. In particular, the appraisal of qualitative studies revealed limitations regarding crucial principles, including reflexivity, transferability, and investigator triangulation. The limited attention to these principles is problematic, especially because several studies were single-site or single-researcher studies (Malterud 2001; Morse 2015).

Additionally, several included studies used descriptive approaches (e.g. content analysis), which are limited in their potential to fully capture participants' experiences and to provide comprehensive interpretations about the complex dynamics underpinning their interaction with nurses (Cutcliffe & McKenna 2004). The limitations of the qualitative synthesis method were partly addressed by integrating the studies' contextual data in the thematic analysis and by prioritising investigator triangulation (Thorne 2017). The involvement of experts-by-experience could have strengthened the interpretation of data and contextual influences from a lived experience perspective and the formulation of recommendations for suicide prevention and treatment (Huisman & van Bergen 2018).

Third, the views of young people and older adults were excluded. This decision was based on the insight that certain aspects of suicidal ideation and behaviour are unique to each stage of life, and that this should be reflected in assessment and treatment strategies. While this decision supported the congruency of the findings, it can also be considered a limitation, given that suicidal ideation and behaviour occur across the life span (Steele et al. 2018).

Fourth, the findings are particularly restricted to inpatient mental health services. Therefore, no conclusions can be made about different needs of persons with suicidal ideation and behaviour based on the services where they interact with nurses (e.g. inpatient versus community).

Fifth, the extracted data did not allow a subanalysis of the individuals with and without a history of suicide attempts. According to The Interpersonal Theory of Suicide (Van Orden et al. 2010), suicidal desire emerges when individuals experience perceived burdensomeness (e.g. feeling like a burden) together with thwarted belongingness (e.g. feeling alone). Suicide attempts, in turn, occur in the simultaneous presence of suicidal desire and capability for suicide (e.g. not being afraid to die). In line with this theory, a differentiation between individuals with and without a history of suicide attempts could have provided additional insights regarding the nature of nurse-patient interaction and specific interventions for preventing suicide and treating suicidal ideation, such as social and therapeutic interventions (Van Orden et al. 2010).

Sixth, the identified literature was restricted to English language articles despite the aim to include Dutch, French, and German articles. This restriction may have biased the results and could be one reason why almost all included studies were conducted in Western cultures. This is significant because a person's experiences of talking about suicide, help-seeking, and procedural practices might be different in African, Asian, and South-American countries where suicide is still criminalised, professionals (e.g. nurses) have negative attitudes toward suicidality, and poor guidance in suicide prevention and treatment prevails (Giacchero Vedana et al. 2017, Marahatta et al. 2017, Osafo et al. 2018).

6.4.2. Recommendations for practice, policy, and future research

This systematic review shows a contrasting picture of the extent to which nurses interact, connect, and collaborate with persons with suicidal ideation and behaviour, and attempt to meet their multiple needs. The findings reflect that nurses must develop interpersonal skills and attitudes that enable their ability and capacity to connect and engage with persons with suicidal ideation and behaviour. In particular, the themes and subthemes shed light on the importance for nurses to initiate care-based contact with persons with suicidal ideation and behaviour; listen to and talk with them; understand their experiences; and provide collaborative responses. The importance that persons attach to emotional support, being acknowledged as a unique individual, and being taken seriously when discussing suicide is also prominent in their interactions with other professionals, including psychologists, psychiatrists, and physicians in inpatient and community-based services (Hom et al. 2017; Wiklander et al. 2003).

The findings can be translated into concrete strategies that aim to support the nurses' role in suicide prevention and promoting the recovery of persons with suicidal ideation and behaviour. Evidence suggests that education and clinical supervision are important strategies to improve nurse attitudes, knowledge, and skills in caring for persons with suicidal ideation and behaviour (Boukouvalas et al. 2019; Ferguson et al. 2019). Reflecting the findings, nurse education and clinical supervision must focus beyond the formal aspects of interaction (e.g. taking assessment) and incorporate content that helps nurses to develop interpersonal skills and attitudes. In addition, the findings could complement and update suicide prevention guidelines. For example, guidelines concerning 'how to talk about suicide' could recommend that nurses develop an open, sensitive, and personalised approach to discuss suicide. Such an approach recognises the challenges that persons with suicidal ideation and behaviour may encounter when discussing suicide, while also accentuating their experiences of relief, reduced isolation, and alleviated suffering when talking about suicide in an atmosphere of connectedness.

On a policy level, the perspectives of persons with suicidal ideation and behaviour advocate for (re-)organising mental health and emergency services to incorporate the principles and practices of recovery-oriented and Trauma-Informed Care approaches. These approaches organise services around values, including person orientation, self-determination and choice, growth potential, and involvement of relatives; values that provide the foundation to create services that are accessible, tailored to personal needs, and reflect emotionally and physically safe spaces (Farkas 2007; Hall et al. 2016; Musket 2014). Simultaneously, hospital leaders should consider the effectiveness of organisational multilevel models such as 'Safewards' (Bowers 2014) and 'REsTRAIN YOURSELF' (Duxbury et al. 2019) in terms of minimising restraint and subtle forms of coercion, and promoting the nurses' orientation on collaborating with persons with suicidal ideation and behaviour and using evidence-based interventions, such as co-producing safety plans.

In the complex domain of suicidality, future qualitative research should transcend the descriptive level to enable understanding by going beyond words, accessing hidden experiences, and revealing underlying social and cultural processes (Cutcliffe & McKenna 2004; Hjelmeland & Knizek 2010). In particular, the findings suggest that more understanding is needed about how nurses can meaningfully integrate their contributions to suicide risk assessment and management with an orientation on connecting and collaborating with the person (Jobes 2012).

Ensuring a focus on nurses connecting and collaborating with persons with suicidal ideation and behaviour is one of the future key challenges across services, and particularly in emergency services, where upcoming universal policies regarding suicide screening and access to lethal means must be implemented in supportive and caring environments

(Heyland et al. 2018; Runyan et al. 2018). Furthermore, future research could elaborate on the potential of nurse-led interventions, briefly mentioned in this review, including psychotherapeutic and follow-up interventions (Dekker et al. 2017; Guthrie et al. 2001). Also, practice could benefit from exploring the potential of service transition models relevant to nursing, such as the Transitional Discharge Model (Forchuk et al. 2020), to create better linkages between inpatient and community services in the context of suicide prevention and treatment (Chung et al. 2017).

6.5. Conclusion

This review of international studies, spanning almost 30 years, enhances the understanding of persons with suicidal ideation and behaviour perspectives regarding their interactions with nurses in mental health and emergency services. The findings emphasise the importance for nurses to care for and acknowledge persons with suicidal ideation and behaviour as unique individuals, connect and collaborate with them, and attend to their multiple needs. If nurses want to honour their crucial role in suicide prevention and treatment, then they must enable persons with suicidal ideation and behaviour to talk about suicide as part of an open, sensitive, and personalised approach. This review can inform practice, policy, and research from the authentic perspectives of persons with suicidal ideation and behaviour.

References

Beck, A., Brown, G., Berchick, R., Stewart, B., Steer, B. (1990). Relationship between hopelessness and ultimate suicide: a replication with psychiatric outpatients. *American Journal of Psychiatry*, 147, 190-195. doi.org/10.1176/ajp.147.2.190

Berg, S.H., Rørtveit, K. & Aase, K. (2017). Suicidal patients' experiences regarding their safety during psychiatric in-patient care: a systematic review of qualitative studies. *BMC Health Services Research*, 17, 73. doi.org/10.1186/s12913-017-2023-8

Berglund, S., Astrom, S. & Lindgren, B. M. (2016). Patients' experiences after attempted suicide: A literature review. *Issues in Mental Health Nursing*, 37, 715-726. doi.org/10.1080/01612840.2016.1192706

Bernert, R. A., Hom, M. A. & Roberts, L. W. (2014). A review of multidisciplinary clinical practice guidelines in suicide prevention: Toward an emerging standard in suicide risk assessment and management, training and practice. *Academic Psychiatry*, 38, 585-592. doi.org/10.1007/s40596-014-0180-1

Bilsen, J. (2018). Suicide and Youth: Risk Factors. *Frontiers in Psychiatry,* 9, 540. doi.org/10.3389/fpsyt.2018.00540

Bolster, C., Holliday, C., Oneal, G. & Shaw, M. (2015). Suicide assessment and nurses: What does the evidence show? *The Online Journal of Issues in Nursing*, 20, 2. doi.org/10.3912/OJIN.Vol20No01Man02

Borges, G., Nock, M. K., Haro Abad, J. M. et al. (2010). Twelve-month prevalence of and risk factors for suicide attempts in the World Health Organization World Mental Health Surveys. *The Journal of Clinical Psychiatry*, 71, 1617-1628. doi.org/10.4088/JCP.08m04967blu

Boukouvalas, E., El-Den, S., Murphy, A. L., Salvador-Carulla, L. & O'Reilly, C. L. (2019). Exploring health care professionals' knowledge of, attitudes towards, and confidence in caring for people at risk of suicide: A systematic review. *Archives of Suicide Research*, 1-31. doi.org/10.1080/13811118.2019.1586608

Bowers, L. (2014). Safewards: a new model of conflict and containment on psychiatric wards. *Journal of Psychiatric and Mental Health Nursing*, 21, 499-508. doi.org/10.1111/jpm.12129

Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3, 77-101. doi.org/10.1191/1478088706qp063oa

Cardell, R. & Pitula, C. R. (1999). Suicidal inpatients' perceptions of therapeutic and nontherapeutic aspects of constant observation. *Psychiatric Services*, 50, 1066-1070. doi.org/10.1176/ps.50.8.1066

Carrigan, J. T. (1994). The psychosocial needs of patients who have attempted suicide by overdose. *Journal of Advanced Nursing*, 20, 635-642. doi.org/10.1046/j.1365-2648.1994.20040635.x

Chung, D. T., Ryan, C. J., Hadzi-Pavlovic, D., Singh, S. P., Stanton, C. & Large, M. M. (2017). Suicide rates after discharge from psychiatric facilities: A systematic review and meta-analysis. *JAMA Psychiatry*, 74, 694-702. doi.org/10.1001/jamapsychiatry.2017.1044

Critical Appraisal Skills Programme (2019). CASP Qualitative Checklist. casp-uk.net/wp-content/uploads/2018/03/CASP-Qualitative-Checklist-2018_fillable_form.pdf. [Accessed: 15 June 2019]

Cutcliffe, J. R. & McKenna, H. P. (2004). Expert qualitative researchers and the use of audit trails. *Journal of Advanced Nursing*, 45, 126-133. doi.org/10.1046/j.1365-2648.2003.02874.x

Cutcliffe, J. R. & Stevenson, C. (2008). Feeling our way in the dark: the psychiatric nursing care of suicidal people - a literature review. *International Journal of Nursing Studies*, 45, 942-953. doi.org/10.1016/j.ijnurstu.2007.02.002

Cutcliffe, J. R., Stevenson, C., Jackson, S. & Smith, P. (2006). A modified grounded theory study of how psychiatric nurses work with suicidal people. *International Journal of Nursing Studies*, 43, 791-802. doi.org/10.1016/j.ijnurstu.2005.09.001

Dekker, W. P. H., Vergouwen, A. C. M., Buster, M. C. A., & Honig, A. (2017). Acceptance of guidance to care at the emergency department following attempted suicide. *BMC Psychiatry*, 17, 332. doi.org/10.1186/s12888-017-1491-z

Dixon-Woods, M., Agarwal, S., Jones, D., Young, B. & Sutton, A. (2005). Synthesising qualitative and quantitative evidence: a review of possible methods. *Journal of Health Services Research & Policy*, 101, 45-53. doi.org/10.1177/135581960501000110

Dunleavey, R. (1992). An adequate response to a cry for help? Parasuicide patients' perceptions of their nursing care. *Professional Nurse*, 7, 213-215.

Duxbury, J., Baker, J., Downe et al. (2019). Minimising the use of physical restraint in acute mental health services: The outcome of a restraint reduction programme ('REsTRAIN YOURSELF'). *International Journal of Nursing Studies*, 95, 40-48. doi.org/10.1016/j.ijnurstu.2019.03.016

Farkas, M. (2007). The vision of recovery today: what it is and what it means for services. *World Psychiatry: Official Journal of the World Psychiatric Association*, 6, 68-74.

Ferguson, M., Dollman, J., Jones, M. et al. (2019). Suicide prevention training - Improving the attitudes and confidence of rural Australian health and human service professionals. *Crisis*, 40, 15-26. doi.org/10.1027/0227-5910/a000524

Fletcher, R. F. (1999). The process of constant observation: perspectives of staff and suicidal patients. *Journal of Psychiatric and Mental Health Nursing*, 6, 9-14. doi.org/10.1046/j.1365-2850.1999.00181.x

Forchuk, C., Martin, M.-L., Sherman, D. et al. (2020). Healthcare professionals' perceptions of the implementation of the transitional discharge model for community integration of psychiatric clients. *International Journal of Mental Health Nursing*, 1-10 doi.org/10.1111/inm.12687

Frey, L. M., Hans, J. D., & Cerel, J. (2016). Perceptions of suicide stigma: How do social networks and treatment providers compare? *Crisis: The Journal of Crisis Intervention and Suicide Prevention*, 37, 95-103. doi.org/10.1027/0227-5910/a000358

Gamarra, J. M., Luciano, M. T., Gradus, J. L. & Wiltsey Stirman, S. (2015). Assessing variability and implementation fidelity of suicide prevention safety planning in a regional VA healthcare system. *Crisis*, 36, 433-439. doi.org/10.1027/0227-5910/a000345

Ghio, L., Zanelli, E., Gotelli, S., Rossi, P., Natta, W. & Gabrielli, F. (2011). Involving patients who attempt suicide in suicide prevention: a focus groups study. *Journal of Psychiatric and Mental Health Nursing*, 18, 510-518. doi.org/10.1111/j.1365-2850.2011.01697.x

Giacchero Vedana, K. G., Magrini, D. F., Zanetti, A. C. G., Miasso, A. I., Borges, T. L., & Dos Santos, M. A. (2017). Attitudes towards suicidal behaviour and associated factors among nursing professionals: A quantitative study. *Journal of Psychiatric and Mental Health Nursing,* 24, 651-659. doi.org/10.1111/jpm.12413

Goodfellow, B., Kõlves, K. & Leo, D. (2018). Contemporary nomenclatures of suicidal behaviors: A systematic literature review. *Suicide and Life-Threatening Behavior*, 48, 353-366. doi.org/10.1111/sltb.12354

Guthrie, E., Kapur, N., Mackway-Jones, K. et al. (2001). Randomised controlled trial of brief psychological intervention after deliberate self poisoning. *British Medical Journal*, 323, 135-138. doi.org:10.1136/bmj.323.7305.135

Hagen, J., Hjelmeland, H. & Knizek, B. L. (2017). Relational principles in the care of suicidal inpatients: Experiences of therapists and mental health nurses. *Issues in Mental Health Nursing*, 38, 99-106. doi.org/10.1080/01612840.2016.1246631

Hagen, J., Knizek, B. L. & Hjelmeland, H. (2018). Former suicidal inpatients' experiences of treatment and care in psychiatric wards in Norway. *International Journal of Qualitative Studies on Health and Well-being*, 13, 1461514. doi.org/10.1080/17482631.2018.1461514

Hall, A., McKenna, B., Dearie, V., Maguire, T., Charleston, R. & Furness, T. (2016). Educating emergency department nurses about trauma informed care for people presenting with mental health crisis: a pilot study. *BMC Nursing*, 15, 21. doi.org/10.1186/s12912-016-0141-y

Heyland, M., Delaney, K. R. & Shattell, M. (2018). Steps to achieve universal suicide screening in emergency departments: A call to action. *Journal of Psychosocial Nursing and Mental Health Services*, 56, 21-26. doi.org/10.3928/02793695-20180503-03

Hjelmeland, H. & Knizek, B. L. (2010). Why we need qualitative research in suicidology. *Suicide and Life-Threatening Behavior*, 40, 74-80. doi.org/10.1521/suli.2010.40.1.74

Holm, A. L. & Severinsson, E. (2011). Struggling to recover by changing suicidal behaviour: narratives from women with borderline personality disorder. *International Journal of Mental Health Nursing*, 20, 165-173. doi.org/10.1111/j.1447-0349.2010.00713.x

Hom, M.A., Stanley, I.H., Podlogar, M.C. & Joiner, T.E. (2017), “Are You Having Thoughts of Suicide?” Examining Experiences With Disclosing and Denying Suicidal Ideation. *Journal of Clinical Psychology*, 73, 1382-1392. doi.org/10.1002/jclp.22440

Hong, Q. N., Pluye, P., Bujold, M. & Wassef, M. (2017). Convergent and sequential synthesis designs: implications for conducting and reporting systematic reviews of qualitative and quantitative evidence. *Systematic Reviews*, 6, 61. doi.org/10.1186/s13643-017-0454-2

Huisman, A. & van Bergen, D. D. (2019). Peer specialists in suicide prevention: Possibilities and pitfalls. *Psychological Services*, 16, 372-380. doi.org/10.1037/ser0000255

Jobes, D. A. (2012). The Collaborative Assessment and Management of Suicidality (CAMS): an evolving evidence-based clinical approach to suicidal risk. *Suicide and Life-Threatening Behavior*, 42, 640-653. doi.org/10.1111/j.1943-278X.2012.00119.x

Jones, J., Ward, M., Wellman, N., Hall, J. & Lowe, T. (2000). Psychiatric inpatients' experience of nursing observation. A United Kingdom perspective. *Journal of Psychosocial Nursing and Mental Health Services*, 38, 10-20. doi.org/10.3928/0279-3695-20001201-08

Jordan, J., McKenna, H., Keeney, S. et al. (2012). Providing meaningful care: Learning from the experiences of suicidal young men. *Qualitative Health Research*, 22, 1207-1219. doi.org/10.1177/1049732312450367

Kmet L. M., Lee R. C., Cook L. S. (2004). Standard quality assessment criteria for evaluating primary research papers from a variety of fields. Retrieved from: www.ihe.ca/download/standard_quality_assessment_criteria_for_evaluating_primary_research_papers_from_a_variety_of_fields.pdf

Lees, D., Procter, N. & Fassett, D. (2014). Therapeutic engagement between consumers in suicidal crisis and mental health nurses. *International Journal of Mental Health Nursing*, 23, 306-315. doi.org/10.1111/inm.12061.

Longtin, Y., Sax, H., Leape, L., Sheridan, S., Donaldson, L., & Pittet, D. (2010). Patient participation: Current knowledge and applicabiliy to patient safety. *Mayo Clinical Proceedings*, 85, 53–62. doi.org/10.4065/mcp.2009.0248

Malterud, K. (2001). Qualitative research: Standards, challenges and guidelines. *The Lancet*, 358, 483–488. doi.org/10.1016/S0140-6736(01)05627-6

Marahatta, K., Samuel, R., Sharma, P., Dixit, L., & Shrestha, B. (2017). Suicide burden and prevention in Nepal: The need for a national strategy. *WHO South-East Asia Journal of Public Health,* 6, 45-49. doi.org/10.4103/2224-3151.206164

McAndrew, S., Chambers, M., Nolan, F., Thomas, B. & Watts, P. (2014). Measuring the evidence: reviewing the literature of the measurement of therapeutic engagement in acute mental health inpatient wards. *International Journal of Mental Health Nursing*, 23, 212-220. doi.org/10.1111/inm.12044

McLaughlin, C. (1999). An exploration of psychiatric nurses' and patients' opinions regarding in-patient care for suicidal patients. *Journal of Advanced Nursing*, 29, 1042-1051. doi.org/10.1046/j.1365-2648.1999.01000.x

Miklin, S., Mueller, A. S., Abrutyn, S. & Ordonez, K. (2019). What does it mean to be exposed to suicide?: Suicide exposure, suicide risk, and the importance of meaning-making. *Social Science & Medicine*, 233, 21-27. doi.org/10.1016/j.socscimed.2019.05.019

Miller I. W., Camargo C. A., Arias S. A. et al. (2017). Suicide prevention in an emergency department population: The ED-SAFE study. *JAMA Psychiatry*. 74, 563-570. doi.org/10.1001/jamapsychiatry.2017.0678

Moher, D., Liberati, A., Tetzlaff, J. & Altman, D. G. (2009). Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. *Annals of Internal Medicine*, 151, 264-269. doi.org/10.7326/0003-4819-151-4-200908180-00135

Morse, J. M. (2015). Critical analysis of strategies for determining rigor in qualitative inquiry. *Qualitative Health Research*, 25, 1212–1222. doi.org/10.1177/1049732315588501

Muskett, C. (2014). Trauma-informed care in inpatient mental health settings: a review of the literature. *International Journal of Mental Health Nursing*, 23, 51-59. doi.org/10.1111/inm.12012

Nock, M. K., Borges, G., Bromet, E. J. et al. (2008). Cross-national prevalence and risk factors for suicidal ideation, plans and attempts. *The British Journal of Psychiatry*, 192, 98-105. doi.org/10.1192/bjp.bp.107.040113

Osafo, J., Akotia, C. S., Boakye, K. E., & Dickson, E. (2018). Between moral infraction and existential crisis: Exploring physicians and nurses' attitudes to suicide and the suicidal patient in Ghana. *International Journal of Nursing Studies*, 85, 118-125. doi.org/10.1016/j.ijnurstu.2018.05.017

Ouzzani, M., Hammady, H., Fedorowicz, Z. & Elmagarmid, A. (2016). Rayyan - a web and mobile app for systematic reviews. *Systematic Reviews*, 5, 210. doi.org/10.1186/s13643-016-0384-4

Peplau, H. E. (1989). *Interpersonal theory in nursing practice: Selected works of Hildegard E. Peplau*. New York: Springer Publishing Company.

Pitula, C. R. & Cardell, R. (1996). Suicidal inpatients' experience of constant observation. *Psychiatric Services*, 47, 649-651. doi.org/10.1176/ps.47.6.649

Runyan, C. W., Brooks-Russell, A., Tung, G. et al. (2018). Hospital emergency department lethal means counseling for suicidal patients. *American Journal of Preventive Medicine*, 54, 259-265. doi.org/10.1016/j.amepre.2017.10.023

Samuelsson, M., Wiklander, M., Asberg, M. & Saveman, B. I. (2000). Psychiatric care as seen by the attempted suicide patient. *Journal of Advanced Nursing*, 32, 635-643. doi.org/10.1046/j.1365-2648.2000.01522.x

Sein Anand, J., Chodorowski, Z., Blok, J. & Barwina, M. (2005). The social support to patients after suicidal attempts provided by the nurses in Clinic of Acute Poisonings Medical University of Gdansk. *Przegląd Lekarski*, 62, 405-407.

Sellin, L., Asp, M., Wallsten, T. & Wiklund Gustin, L. (2017). Reconnecting with oneself while struggling between life and death: The phenomenon of recovery as experienced by

persons at risk of suicide. *International Journal of Mental Health Nursing*, 26, 200-207. doi.org/10.1111/inm.12249

Sellin, L., Kumlin, T., Wallsten, T. & Wiklund Gustin, L. (2019). Experiences of a recovery-oriented caring approach to suicidal behavior: A single-case study. *Qualitative Health Research*, 29, 2084-2095. doi.org/10.1177/1049732319854229

Shneidman, E. S. (1993). Suicide as psychache. *The Journal of Nervous and Mental Disease*, 181, 145-147. doi.org/10.1097/00005053-199303000-00001

Sitzman, K. & Watson, J. (2019). *Assessing and measuring caring in nursing and health sciences: Watson's caring science guide, Third edition*. New York: Springer Publishing.

Steele, I. H., Thrower, N., Noroian, P. & Saleh, F. M. (2018). Understanding suicide across the lifespan: A United States perspective of suicide risk factors, assessment & management. *Journal of Forensic Sciences*, 63, 162-171. doi.org/10.1111/1556-4029.13519

Stanley, I. H., Hom, M. A., Rogers, M. L., Hagan, C. R., & Joiner, T. E. (2016). Understanding suicide among older adults: a review of psychological and sociological theories of suicide. *Aging & Mental Health*, 20, 113-122. doi.org/10.1080/13607863.2015.1012045

Stene-Larsen, K. & Reneflot, A. (2019). Contact with primary and mental health care prior to suicide: A systematic review of the literature from 2000 to 2017. *Scandinavian Journal of Public Health*, 47, 9-17. doi.org/10.1177/1403494817746274

Sun, F.-K., Long, A., Boore, J. & Tsao, L.-I. (2006). A theory for the nursing care of patients at risk of suicide. *Journal of Advanced Nursing*, 53, 680-690. doi.org/10.1111/j.1365-2648.2006.03774.x

Takahashi, C., Chida, F., Nakamura, H. et al. (2011). The impact of inpatient suicide on psychiatric nurses and their need for support. *BMC Psychiatry*, 11, 38. doi.org/10.1186/1471-244X-11-38

Talseth, A.-G. & Gilje, F. L. (2018). Responses of persons at risk of suicide: A critical interpretive synthesis. *Nursing Open*, 5, 469-483. doi.org/10.1002/nop2.169

Talseth, A.-G., Gilje, F. L. & Norberg, A. (2003). Struggling to become ready for consolation: Experiences of suicidal patients. *Nursing Ethics*, 10, 614-623. doi.org/10.1191/0969733003ne651oa

Talseth, A.-G., Lindseth, A., Jacobsson, L. & Norberg, A. (1999). The meaning of suicidal psychiatric in-patients' experiences of being cared for by mental health nurses. *Journal of Advanced Nursing*, 29, 1034-1041. doi.org/10.1046/j.1365-2648.1999.00990.x

Taylor, P. (2019). System entrapment: Dehumanization while help-seeking for suicidality in women who have experienced intimate partner violence. *Qualitative Health Research*, 1-17, doi.org/10.1177/1049732319857671

Thorne, S. (2017). Metasynthetic Madness: What Kind of Monster Have We Created? *Qualitative Health Research*, 27, 3–12. doi.org/10.1177/1049732316679370

Tofthagen, R., Talseth, A.-G. & Fagerstrøm, L. M. (2017). Former patients' experiences of recovery from self-harm as an individual, prolonged learning process: a phenomenological hermeneutical study. *Journal of Advanced Nursing*, 73, 2306-2317. doi.org/10.1111/jan.13295

Vandewalle, J., Beeckman, D., Van Hecke, A., Debyser, B., Deproost, E. & Verhaeghe, S. (2019). Contact and communication with patients experiencing suicidal ideation: A qualitative study of nurses' perspectives. *Journal of Advanced Nursing*, 75, 2867-2877. doi.org/10.1111/jan.14113

Van Orden, K. A., Witte, T. K., Cukrowicz, K. C., Braithwaite, S., Selby, E. A., & Joiner, T. E. (2010). The interpersonal theory of suicide. *Psychological Review*, 117, 575–600. doi.org/10.1037/a0018697

Vatne, M. & Naden, D. (2018). Experiences that inspire hope: Perspectives of suicidal patients. *Nursing Ethics*, 25, 444-457. doi.org/10.1177/0969733016658794

World Health Organisation (WHO) (2018) Suicide data. Retrieved from: https://www.who.int/mental_health/prevention/suicide/suicideprevent/en/

Wiklander, M., Samuelsson, M. & Asberg, M. (2003). Shame reactions after suicide attempt. *Scandinavian Journal of Caring Sciences*, 17, 29-300. doi.org/10.1046/j.1471-6712.2003.00227.x

Chapter 7. Contact between patients with suicidal ideation and nurses in mental health wards: development and psychometric evaluation of a questionnaire

Based on:
Vandewalle, J., Duprez, V., Beeckman, D., Van Hecke, A., Verhaeghe, S. (2020).
Contact between patients with suicidal ideation and nurses in mental health wards: development and psychometric evaluation of a questionnaire
International Journal of Mental Health Nursing. doi.org/10.1111/inm.12776

Abstract

Suicide prevention and treatment opportunities often depend on interpersonal contact between patients and professionals. Presently, there is a lack of valid and reliable instruments to obtain the perspective of patients with suicidal ideation regarding their contact with professionals on mental health wards. This was a three-stage study to develop and psychometrically evaluate a questionnaire: the Contact with Nurses from the perspective of Patients with Suicidal ideation (CoNuPaS). First, the construct was defined by a systematic review, a qualitative study, and face validity among experts. Second, the content was validated through a Delphi procedure with professional experts (n = 14) and cognitive interviews with hospitalised patients (n = 12). Third, using a sample of adult patients with suicidal ideation in the past year (n = 405), the psychometric properties were assessed by an exploratory factor analysis, a test-retest procedure, and the internal consistency. The CoNuPaS is rated on a Likert scale and comprises 23 items and two subsections to examine patients' perceptions of how they experience contact with nurses (CoNuPaS-experience) and what they find important in that contact (CoNuPaS-importance). The subsections comprise four components: encountering a space to express suicidal thoughts and explore needs, being recognised as a unique and self-determining individual, encountering nurses' availability/information-sharing/transparency on expectations, and trusting nurses in communication about suicidality. Content validity scores were excellent (0.78-1.00), and test-retest intraclass correlation coefficient and internal consistency were > 0.90. Thus, the CoNuPaS demonstrated good psychometric properties. The availability of a valid questionnaire to examine patient-nurse contact in mental health wards is central to improving understanding of nurses' contributions to suicide prevention and treatment of suicidal ideation.

7.1. Introduction

In psychiatric hospitals, suicide prevention and treatment of suicidal ideation are imperative, given patients' high suicide risk during and after hospitalisation (Hunt et al. 2013; Madsen et al. 2017). With suicide prevention and treatment of suicidal ideation high on the policy agenda, psychiatric wards continue to focus on a medical and risk-dominated paradigm (Fitzpatrick & River 2018; Heller et al. 2015). This paradigm is evident in efforts to implement prediction models and suicide risk assessments, promote pharmacological treatments, and formalise surveillance and containment strategies (Belsher et al. 2019; Bolton et al. 2015; Manuel et al. 2018; Slemon et al. 2017).

In contrast to this emphasis on medical and risk-related factors of suicide prevention and suicidal ideation treatment, interpersonal aspects of clinical encounters receive limited attention (Cutcliffe & McKenna 2018). However, the importance of well-considered contact with patients cannot be overlooked, either in terms of its suicide preventative effect or its meaning for patients' care experiences (Berg et al. 2017). If patients perceive contact with professionals as trustful, non-judgemental, understanding, and emotionally supportive, this could help them express their suicidal ideation (Hom et al. 2017; Richards et al. 2019). Moreover, caring contact with professionals can enable patients to feel safe from their suicidal impulses and take the first steps towards (re)connecting with themselves, relatives, and treatment (Berg et al. 2017; Sellin et al. 2017).

Background

While all healthcare professionals should invest in contact with patients experiencing suicidal ideation, this is particularly evident for nurses in mental health wards. Within multidisciplinary teams, nurses are referred to as 'front-line carers' who provide direct care and are appreciated by patients for being accessible and spending time with them (Cutcliffe and Stevenson 2008, Vandewalle et al. 2020). Nurses' closeness to patients can serve as an interpersonal endeavour characterised by being with patients 'in the here and now', listening to and exploring individual needs, and building trusting partnerships (Cutcliffe and Stevenson 2008, Santangelo et al. 2018). Regarding a clinical perspective, nurses are well positioned to develop personal knowledge of patients, create conditions for discussing suicide, assess and respond to patients' risks and problems in daily life (Sellin et al. 2017, Vandewalle et al. 2019).

However, nurses' front-line position is described as emotionally demanding, and nurses can encounter difficulties during contact with patients who experience suicidal ideation (Cutcliffe and Stevenson 2008). Nurses may distance themselves from patients, lack empathy and

understanding (Samuelsson et al. 2000), lack engagement (Lees et al. 2014), and avoid conversations about suicide (Meerwijk et al. 2010). Moreover, patients report being watched and controlled by nurses imposing surveillance and containment strategies (Lees et al. 2014), while also overlooking patients' basic needs and desires to be understood as individuals (Berg et al. 2017).

This raises questions as to why impersonal, observation-led, and containment-focused nursing seems to prevail, and interpersonal aspects of care are overlooked (Cutcliffe & McKenna 2018). Nursing researchers assert this is partly attributable to a failure to incorporate interpersonal aspects of care into valid and reliable instruments, while simultaneously, nursing fundamentals remain unarticulated and undervalued (McAndrew et al. 2014; Sitzman and Watson 2019). Within the context of suicidality, the authors conducted a systematic review which suggested that there are no valid instruments from the perspective of patients with suicidal ideation regarding their contact with nurses on mental health wards (Vandewalle et al. 2020). Such an instrument could generate insight into interpersonal aspects often overlooked in nursing care (McAndrew et al. 2014), and in suicide prevention and treatment of suicidal ideation (Fitzpatrick & River 2018).

Thus, the authors considered other valid instruments that could potentially examine patient-nurse contact on psychiatric wards, including the Caring Attributes Questionnaire (Arthur et al. 2004) and Therapeutic Engagement Questionnaire (Chambers et al. 2017). However, while these instruments incorporate essential interpersonal aspects of care and contact, they lack specificity regarding suicidality. For example, these tools do not include items on conversations about suicide, which are essential to patient-nurse contact in mental health wards (Cutcliffe & Stevenson 2008; Hom et al. 2017). Given the lack of specific instruments and the evidence that interpersonal aspects of care are often overlooked, the present study aimed to develop and psychometrically evaluate a questionnaire to examine contact with nurses from the perspective of patients with suicidal ideation.

7.2. Methods

The study used a three-stage process to develop and psychometrically evaluate a questionnaire to examine contact with nurses from the perspective of patients with suicidal ideation (Figure 1). A checklist for reporting of questionnaire research was used (Kelley et al. 2003).

7.2.1. Stage one: questionnaire development and face validity

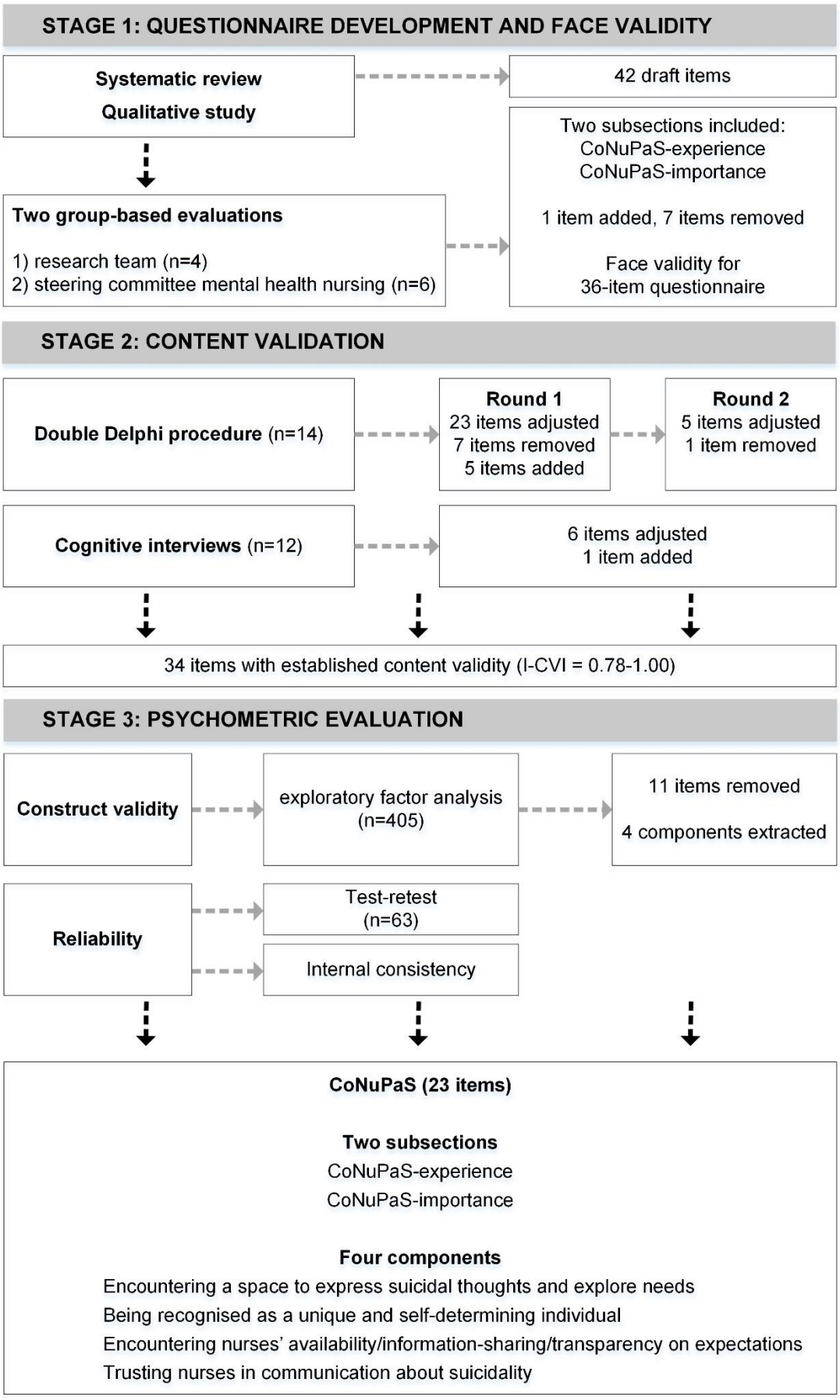

Figure 1. Developmental and psychometric evaluation process of the CoNuPaS

The questionnaire's conceptual foundation was informed by a systematic review (Vandewalle et al. 2020) and a qualitative study (Vandewalle et al. 2019). Draft items were generated based on both studies. Subsequently, two group-based evaluations were organised to establish face validity.

Systematic review and qualitative study

The systematic review aimed to synthesise the perspectives of people with suicidal ideation regarding interactions with nurses in mental health and emergency services (Vandewalle et al. 2020). The review involved a search of the databases PubMed, Web of Science, Embase, and PsycARTICLES, and included 26 studies. Most studies used qualitative approaches and focused on inpatient mental healthcare in Western countries. Three key themes were identified: 'being cared for and acknowledged as a unique individual', 'giving voice to myself in an atmosphere of connectedness', and 'encountering a nurturing space to address my suicidality'. For questionnaire development, core elements pertaining to patient-nurse contact on psychiatric wards were extracted.

Additionally, a qualitative study using a grounded theory approach was conducted (Vandewalle et al. 2019). This study aimed to elucidate the core elements of how nurses on mental health wards make contact with patients experiencing suicidal ideation. Nineteen nurses were interviewed. The findings revealed that nurses make contact with patients by 'creating conditions for open and genuine communication', while focusing on 'developing an accurate and meaningful picture of patients'. These interconnected core elements represented nurses' attention to both interpersonal and clinical aspects of practice, including building trust and assessing suicide risk. Incorporating nurses' perspectives when constructing the questionnaire enhanced attention to the reciprocal nature of interpersonal contact and the items' clinical appropriateness. Figure 2 presents core elements derived from the systematic review and qualitative study.

Group-based evaluations

Two group-based evaluations were organised to revise draft items, establish the questionnaire format, and establish face validity. First, four research team members held open discussions to develop the questionnaire to examine Contact with Nurses from the perspective of Patients with Suicidal ideation (CoNuPaS). These researchers held academic and clinical positions, and had diverse areas of expertise (e.g. nursing, mental health, psychometric evaluation).

During the revision process, the researchers added one item to further focus on patients' involvement in decision-making about their care and treatment. Subsequently, they focused on the questionnaire's format and decided to score the items on two subsections: to examine

patients' perceptions of how they experience contact with nurses (CoNuPaS-experience) and what they find important in that contact (CoNuPaS-importance). Adding these subsections allowed for detecting potential differences in—and discrepancies between—patients' experiences of contact with nurses and what patients find important in this contact.

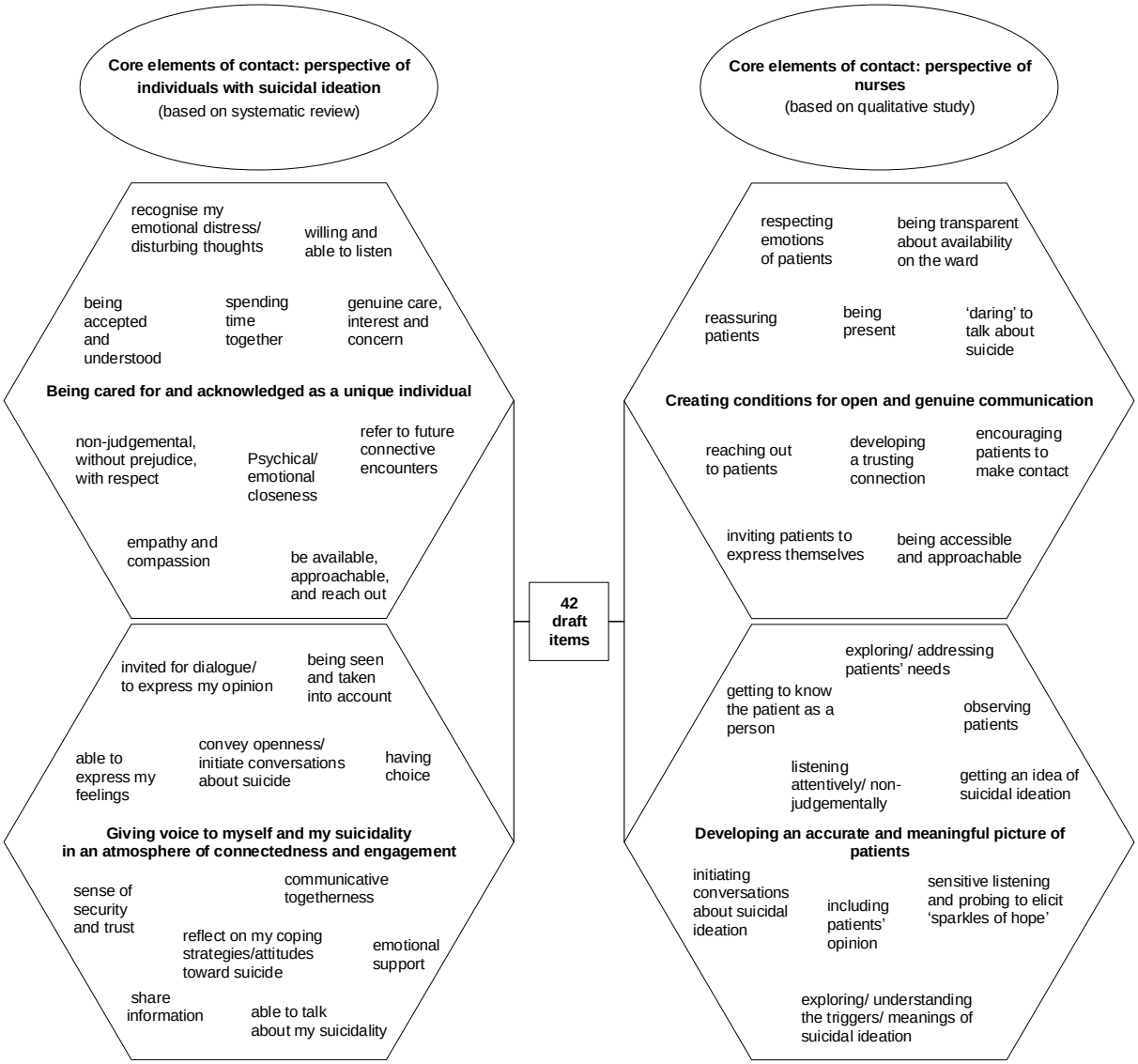

Figure 2. Core elements of contact: perspectives of individuals with suicidal ideation and nurses

Furthermore, subsection items were scored on a five-point Likert scale, ranging from one (strongly disagree/not important at all) to five (strongly agree/very important). A number of items were negatively formulated to minimise response-set bias (Polit & Beck 2017). Finally, instructions for completion were added. For example, patients were instructed to keep in mind the nurse with whom they had the most contact.

Second, the questionnaire was revised by a mental health nursing steering committee (n = 6), including two psychiatric hospital directors, two nursing academics, and two nursing

specialists. They discussed the items' relevance and clarity and the questionnaire's completeness during a two-hour meeting with the first and last authors. Seven items were removed due to overlapping meanings. Other adjustments reflected a need for more specific formulations. For example, 'I can tell everything to the nurse' was reformulated as 'I can talk honestly about my suicidal thoughts with the nurse'. Overall, feedback from the steering committee supported the questionnaire's face validity. They did not report missing aspects and indicated the content was representative of contact between patients with suicidal ideation and nurses on mental health wards. The two group-based evaluations resulted in a 36-item questionnaire with two subsections.

7.2.2. Stage two: content validation

In stage two, the content of the CoNuPaS was validated using a Delphi procedure among professional experts and cognitive interviews with patients.

Delphi procedure

In a double Delphi procedure, 14 experts assessed the 36-item questionnaire (Hsu & Sandford 2007). None of them participated in the previous stage. To provide a differentiated perspective on the content of the CoNuPaS, the experts differed in terms of gender, age, and education level, and represented clinical and academic positions, including nurses (n = 4) and nursing specialists (n = 4) in psychiatric hospitals, researchers and educators in mental healthcare (n = 5), and one coordinator of community mental health services.

The experts were asked to evaluate the items' relevance and clarity on a 4-point Likert scale (irrelevant to very relevant) and a dichotomous scale (unclear vs. clear). To guide this process, the experts were emailed a Delphi form that incorporated the scoring system and sufficient space to propose new items or improvements. The obtained feedback was analysed within the research team, leading to a feedback summary and revised questionnaire, which were communicated back to the experts for assessment (Hsu & Sandford 2007). The item-level Content Validity Index (I-CVI) was calculated; I-CVI scores ≥ 0.78 were considered evidence of good content validity (Polit et al. 2007).

During the double Delphi procedure, 28 items were adjusted, eight items were removed, and five items were added. Item adjustments were mainly focused on using more understandable and specific language. The main reasons for item removal were minimising meaning overlap and I-CVI scores < 0.78. Additionally, the expert feedback reflected a need to broaden the scope of patient-nurse contact. For example, some experts suggested adding an item about contact between nurses and patients' relatives. Following the double Delphi procedure, the

questionnaire comprised 34 items, with I-CVI scores between 0.78-1.00 for relevance and clarity.

Cognitive interviews

Individual cognitive interviews were conducted with 12 hospitalised adult patients. The aim was to evaluate each items' clarity and relevance, the questionnaire's completeness, feasibility, and user-friendliness, and the time needed to complete it (Beatty & Willis 2007). Ward managers invited eligible patients based on inclusion criteria: being admitted to a mental health ward, experiencing suicidal ideation in the past year, aged 18-65 years, having the mental capacity to consent to participate, and a good command of the Dutch language. As shown in Table 1, participants varied in terms of age, gender, number and duration of admission(s), and self-reported suicidal ideation.

The cognitive interviews were divided into three rounds with four, five, and three participants, respectively, to allow for intermittent adjustments (Beatty & Willis 2007). The interviews were conducted in a quiet room on each ward, audio-recorded, and transcribed verbatim. Participants were invited to express their thoughts aloud when considering each item and response options. Verbal probes such as, 'Can you tell me more about…' were used to elicit details regarding how patients interpreted and answered items. Discussions based on researcher triangulation were organised to analyse the transcripts and participants' suggestions (Beatty & Willis 2007).

Overall, participants perceived completing the questionnaire to be feasible. They found the instructions clear and indicated the questionnaire covered 'the most crucial aspects' of their contact with nurses. No participants expressed problems with the questionnaire's length. As evaluated in the third round, time needed to complete the questionnaire was, on average, 20-25 minutes. Participant feedback led to adjustment of six items. All items were (re)phrased positively, because participants expressed difficulties interpreting negatively phrased items. Additionally, one item—'the nurse controls me more when my suicidal thoughts are stronger'—was added, because participants suggested a double interpretation of the item: 'The nurse contacts me more when my suicidal thoughts are stronger'. They called into question whether 'more contact' stemmed from a nurse's controlling attitude or interpersonal engagement. Furthermore, the cognitive interviews provided insight into the middle answer option's meaning, which used the formulation 'neither/nor'. Participants endorsed the middle option when they both agreed and disagreed with a particular item. For example, they indicated a nurse may take time to discuss suicide one moment, but not the next. No participants indicated they endorsed the middle option because they felt indifferent, did not want to answer, or did not understand the item (Chyung et al. 2017).

7.2.3. Stage three: psychometric evaluation

In stage three, construct validity of the CoNuPaS was assessed by exploratory factor analysis. Additionally, reliability of the CoNuPaS was assessed using a test-retest procedure and measuring internal consistency.

Sample

A convenience sample of 430 patients in 55 mental health wards of one general hospital and ten psychiatric hospitals was established to determine the questionnaire's psychometric properties. The hospitals were geographically spread across Flanders, the Dutch-speaking part of Belgium. Inclusion criteria were the same as for the cognitive interviews.

Data collection

Data were collected between April 2018 and May 2019. Participants completed the self-report questionnaire and placed it in a sealed box. Data collection was organised once on each ward, in a quiet room where participants were convened for a group meeting and completed the questionnaire individually.

Only the researcher was present, to avoid any bias in responses due to staff presence. Questionnaires with < 75% of the items answered were removed from data analysis (n = 15). All questionnaires were also checked for potential response-set bias (Polit & Beck 2017). Questionnaires for which all items received the same score were deleted (n = 10). Ultimately, 405 questionnaires were used for analysis.

In a test-retest procedure to determine the questionnaire's stability, 63 patients completed the questionnaire twice. They were recruited from 13 wards of three psychiatric hospitals. A short time interval of three to five hours was set between the tests to minimise confounding factors (Polit & Beck 2017), including effects resulting from intermittent therapeutic sessions or participants' suicidal ideation, which can fluctuate hourly (Kleiman et al. 2017).

Data analysis

Data were analysed using SPSS Statistics 25 (IBM Corp., Armonk, NY, USA). Item normality was assessed both visually (histogram and quantile-quantile plot) and through normality tests (skewness/kurtosis values and Shapiro-Wilk tests) (Ghasemi & Saleh Zahediasl 2012). The data were also checked for floor and ceiling effects. The authors determined a priori that floor and ceiling effects occurred when >15% of participants scored in the 12.5% lower and upper bound, respectively, on subsection and component levels.

First, construct validity of the CoNuPaS-experience and CoNuPaS-importance was assessed using exploratory factor analysis. This method was used to identify the underlying structure and inform item reduction. The Kaiser-Meyer-Olkin measure of sampling adequacy (≥ 0.80) and Bartlett's test of sphericity ($p < 0.05$) were used to determine the appropriateness of exploratory factor analysis. The sample size ($n = 405$) was adequate for factor analysis on the 34 items, given the recommendation to pursue 10 participants per item (Costello & Osborne 2005). The principal axis factoring method and varimax rotation were used. Eigenvalues over one and an inspection of the scree plot were applied to determine the number of extracted components. As per rule of thumb, items were retained if they loaded > 0.40 on the component, and cross-loading items were considered for removal to obtain a unidimensional structure (Costello & Osborne 2005).

Second, reliability of the CoNuPaS-experience and CoNuPaS-importance were assessed by a test-rest procedure and internal consistency analysis. For the test-retest procedure, the intraclass correlation coefficient (ICC) was calculated using a single-measurement—two-way mixed-effects model with absolute-agreement (Koo & Li 2016). Stability was assessed as moderate (ICC 0.50-0.75), good (0.75-0.90), or excellent (> 0.90; Koo & Li 2016). Cronbach's α was calculated to measure internal consistency. Cronbach's α values > 0.75 were considered satisfactory (Gliem & Gliem 2003). Additionally, mean inter-item correlations were reviewed, with scores > 0.3 indicating an acceptable correlation (Tabachnick & Fidell 2019).

7.2.4. Ethical considerations

The Ethical Committees of the Ghent University Hospital and participating hospitals approved this study (B670201630531). Permission was obtained through informed consent from the hospital directors. Two hospital directors declined to participate, and in two participating hospitals, three ward managers stated participation was not possible or desirable for their patients. All participants were informed about the study's objectives and procedures and assured of their confidentiality. Regarding the cognitive interviews and psychometric evaluation, patients were informed verbally and through informed consent that participation was voluntary and their care would not be affected by their decision (not) to participate. Additionally, a researcher explained the instructions, time was provided for questions, and participants were given as much time as required to complete the questionnaire. All participants provided written informed consent before completing the questionnaire.

The researchers recognised that the CoNuPaS covers a sensitive topic. Although the items do not focus on suicidality *per se*, it was anticipated that completing the CoNuPaS may evoke distress. Therefore, the researchers ensured that a supportive network of

multidisciplinary team members was present on each ward. Additionally, the data collection organised during group meetings provided the researchers the opportunity to identify patients' emerging distress and respond accordingly. Participants were also informed verbally and in the questionnaire that they could contact a multidisciplinary team member whenever they needed to talk or had questions about suicide.

7.3. Results

7.3.1. Sample characteristics

The psychometric evaluation sample (n = 405) comprised 237 women and 168 men. Most participants were between 36-45 years old (n = 103, 25.4%). Most participants reported they sometimes (n = 118, 29.5%) or often (n = 177, 44.2%) experienced suicidal ideation during the past year. Additionally, for the past week, most participants reported no suicidal thoughts (n = 163, 38%) or brief passing thoughts (n = 161, 37.5%), while 18% reported strong suicidal thoughts (n = 76). Participants were admitted to wards mostly divided according to psychiatric diagnoses (e.g. psychotic disorders), age (e.g. young adults), or service delivery focus (e.g. crisis vs. rehabilitation services). Participant demographics are shown in Table 1.

Table 1. Participant demographics in the cognitive interviews and psychometric evaluation

	Cognitive interviews		Psychometric evaluation	
	n = 12	**%**	**n = 405**	**%**
Gender				
Male	4	33.3	168	41.5
Female	8	66.7	237	58.5
	12		**405**	
Age (years)				
18 - 25	4	33.3	71	17.5
26 - 35	5	41.7	95	23.5
36 - 45	1	8.3	103	25.4
46 - 55	1	8.3	83	20.5
56 - 65	1	8.3	53	13.1
	12		**405**	
Previous admission to a psychiatric ward?				
Yes	10	83.3	282	69.6
No	2	16.7	123	30.4
	12		**405**	
Previous admission to the current ward?				
Yes	4	33.3	116	28.6
No	8	66.7	289	71.4
	12		**405**	
Duration of current admission				
≤ 1 week	-	-	28	7.0
1 week - 1 month	1	8.3	77	19.2
1 month - 3 months	4	33.3	109	27.1
3 months - 6 months	3	25.0	95	23.6
> 6 months	4	33.3	93	23.1
	12		**403**	
Frequency of suicidal ideation				
Past year				
seldom	1	8.3	70	17.5
sometimes	3	25.0	118	29.5
often	7	58.3	177	44.2
always	1	8.3	35	8.8
	12		**400**	

Past month				
never	1	8.3	62	16.0
seldom	2	16.7	70	18.0
sometimes	4	33.3	114	29.4
often	4	33.3	111	28.6
always	1	8.3	31	8.0
	12		**388**	
Past week				
never	6	50.0	104	26.9
seldom	1	8.3	78	20.2
sometimes	3	25.0	103	26.7
often	-	-	70	18.1
always	2	16.7	31	8.0
	12		**386**	
Severity of suicidal ideation (past week)				
I had no thoughts of suicide	6	50.0	150	37.0
I had only brief passing thoughts	5	41.7	155	38.3
I had strong thoughts of suicide	1	8.3	74	18.3
I made plans to attempt suicide	-	-	21	5.2
I made a suicide attempt	-	-	5	1.2
	12		**405**	
Type of ward				
Ward for mood, anxiety, personality disorders	6	50	119	29.4
Ward for day services and treatment	-	-	51	12.6
Ward for rehabilitation services	3	25	47	11.6
Ward for substance abuse treatment	-	-	58	14.3
Ward for treatment of psychotic disorders	1	8.3	42	10.4
Secure wards (crisis and forensic services)	-	-	25	6.2
Psychiatric ward in a general hospital	-	-	21	5.2
Ward for young adults	2	16.7	15	3.7
Ward for short/intensive treatment	-	-	27	6.7
	12		**405**	

7.3.2. Psychometric evaluation

The conditions for performing an exploratory factor analysis were satisfied, including the Kaiser-Meyer-Olkin measure (CoNuPaS-experience: 0.94; CoNuPaS-importance: 0.93) and Bartlett's test of sphericity (CoNuPaS-experience: $\chi^2 = 4600.421$, df = 253, $p < 0.001$; CoNuPaS-importance: $\chi^2 = 5136.624$, df = 253, $p < 0.001$).

Factor analysis resulted in a four-component model. The item loadings on each component were > 0.40. Item reduction appeared to be possible. Respecting the conceptual foundation of the CoNuPaS, item reduction was based not only on statistical measures but also on careful assessment by the research team. The main reason for removing items was overlapping meaning, especially for cross-loading items. Moreover, some items were removed because they appeared to focus on potential 'effects' of patient-nurse contact (e.g. increased hope/insight) rather than on 'how' nurses make contact, which is the focus of the CoNuPaS. The item 'I have a good relationship with the nurse' was removed because, conceptually, patient-nurse contact is not necessarily linked with a 'relationship', which might require long-term contact (Priebe & McCabe 2006). Overall, 11 items were removed, resulting in a 23-item questionnaire with four components. Table 2 shows descriptive statistics and factor loadings for all items.

The explained variance of the four components was 63.76% for the CoNuPaS-experience and 61.24% for the CoNuPaS-importance. Factor analysis resulted in a similar fit between the CoNuPaS-experience and CoNuPaS-importance, except for two items. Given that these items had a cross-loading, they were classified in the same component to preserve congruency between subsections. Component 1 (8 items) was labelled 'Encountering a space to express suicidal thoughts and explore needs'. It indicates the importance of contact with nurses who initiate conversations about suicide, explore patients' needs, and take patients' suicidal expressions seriously. Component 2 (7 items) was labelled 'Being recognised as a unique and self-determining individual'. This component emphasises an encounter between two individuals, wherein nurses demonstrate care and concern, and patients can exercise self-determination in decision-making about their care and treatment. Component 3 (5 items) was labelled 'Encountering nurses' availability/information-sharing/transparency on expectations'. It highlights patients' ability to access a nurse when needed and experience nurses' engagement in providing information and discussing expectations. Component 4 (3 items) was labelled 'Trusting nurses in communication about suicidality'. It underlines the necessity of trust in patient-nurse contact, especially for patients' perceived ability to communicate openly and honestly about their suicidality. Table 3 presents the explained variance on subsection and component levels.

Table 2. Descriptive statistics and factor loadings of the 23-item questionnaire

		CoNuPaS-importance							CoNuPaS-experience				
		Nvalid	Mean	SD	Median	Interquartile range		Factor loading	Nvalid	Median	Interquartile range		Factor loading
						25%	75%				25%	75%	
Component 1: Encountering a space to express suicidal thoughts and explore needs													
1	The nurse takes time to talk with me about my suicidal thoughts	405	3.34	1.21	4	3	4	0.80	401	4	4	5	0.80
2	The nurse invites me to have a conversation about my suicidal thoughts	405	3.04	1.25	3	2	4	0.79	401	4	3	5	0.80
3	The nurse asks me about my problems that give rise to my suicidal thoughts	404	3.47	1.18	4	3	4	0.77	401	4	4	5	0.72
4	The nurse brings my thoughts about suicide into conversation when I need it	404	2.90	1.15	3	2	4	0.74	402	4	4	5	0.77
5	The nurse explores with me what I need to make my suicidal thoughts more tolerable	405	3.30	1.17	3	3	4	0.72	400	4	4	5	0.70
6	The nurse contacts me more when my suicidal thoughts are stronger	403	3.20	1.17	3	2	4	0.65	401	4	4	5	0.64
7	The nurse takes me seriously when I talk about my suicidal thoughts	405	N/A	N/A	4	3	5	0.64	402	5	4	5	0.71
8	The nurse asks me about my suicidal thoughts	404	3.20	1.17	3	2	4	0.62	400	4	4	5	0.48
Component 2: Being recognised as a unique and self-determining individual													
9	The nurse pays attention to my feelings	399	N/A	N/A	4	4	5	0.77	399	5	4	5	0.70
10	The nurse treats me as a unique person with individual needs	402	N/A	N/A	4	4	5	0.76	398	5	4	5	0.69
11	The nurse listens to me without prejudice	405	N/A	N/A	4	4	5	0.75	402	5	4	5	0.70
12	The nurse takes my opinion into account	405	N/A	N/A	4	4	4	0.72	402	4	4	5	0.62
13	The nurse is genuinely concerned about how I am doing	403	N/A	N/A	4	4	5	0.71	400	5	4	5	0.69
14	I have the opportunity to make decisions about the care I need together with the nurse	405	3.78	0.98	4	3	4	0.59	401	4	4	5	0.50

15	I have the opportunity to ask for a conversation with the nurse when I need it	403	N/A	N/A	4	4	5	0.54	399	5	4	5	0.41
Component 3: Encountering nurses' availability/information-sharing/transparency on expectations													
16	The nurse discusses with me what I can expect of her/him during our contact	404	3.51	1.01	4	3	4	0.78	401	4	4	5	0.81
17	The nurse informs me when she/he is available on the ward	404	3.61	1.16	4	3	4	0.74	401	4	4	5	0.70
18	The nurse discusses with me what she/he will do with the content of our contact	404	3.23	1.11	3	2	4	0.69	401	4	4	5	0.72
19	I know when our next contact-moment is planned	404	3.41	1.23	4	2	4	0.66	400	4	4	5	0.64
20	The nurse is there when I need her/him	405	3.48	0.99	4	3	3	0.50	402	4	4	5	0.59
Component 4: Trusting nurses in communication about suicidality													
21	I am open about my suicidal thoughts with the nurse	404	3.19	1.30	3	2	4	0.82	399	4	4	5	0.74
22	I trust the nurse enough to talk about my suicidal thoughts	405	3.67	1.14	4	3	4.50	0.69	401	5	4	5	0.56
23	I can talk honestly about my suicidal thoughts with the nurse	405	3.60	1.17	4	3	4	0.68	401	4	4	5	0.71

N/A = not applicable: the mean and standard deviation (SD) are not reported for the non-normally distributed items.

Item distribution

For the CoNuPaS-experience, 16 of 23 items followed a normal distribution. All items of the CoNuPaS-importance followed a non-normal distribution. In Table 2, non-normally distributed items are described by their median and interquartile range; normally distributed items are described by their mean and standard deviation (SD). Additionally, Table 3 presents the proportion of patients who achieved the 12.5% lower and upper bound, respectively, on the subsection and component levels. No floor effects were found. Ceiling effects were found in the second component of the CoNuPaS-experience (23.30%) and in all components of the CoNuPaS-importance (range 25.20%-53.10%).

Stability

Sixty-three patients completed the questionnaire twice. On the first administration, the mean score was 3.59 (SD 0.71) for the CoNuPaS-experience and 4.26 (SD 0.49) for the CoNuPaS-importance. At retest, the corresponding scores were 3.65 (SD 0.73) and 4.28 (SD 0.51), respectively. The overall ICC was 0.95 (95% CI = [0.92-0.97]) for the CoNuPaS-experience and 0.91 (95% CI = [0.85-0.94]) for the CoNuPaS-importance. Table 3 displays ICCs for subsections and components.

Internal consistency

Cronbach's α was 0.93 for the CoNuPaS-experience and 0.93 for the CoNuPaS-importance. Cronbach's α values for the components ranged between 0.79 and 0.93 (Table 3). Mean inter-item correlation was 0.38 for the CoNuPaS-experience and 0.35 for the CoNuPaS-importance, which reflected acceptable correlations (Tabachnick & Fidell 2019)

Table 3. Subsection and component values, including Cronbach's α, explained variance, and floor and ceiling effects

	Median	Interquartile range		floor/ceiling	explained	ICC	Cronbach's α
CoNuPaS-experience		25%	75%	effect %†	variance %	(95% CI)	
Component 1: Encountering a space to express suicidal thoughts and explore needs	3.38	2.75	4.00	7.20/5.70	21.30	0.91 (0.85-0.95)	0.91
Component 2: Being recognised as a unique and self-determining individual	4.00	3.71	4.43	1.50/23.30	19.17	0.94 (0.90-0.96)	0.88
Component 3: Encountering nurses' availability/information-sharing/transparency on expectations	3.40	3.00	4.00	1.70/9.00	13.21	0.78 (0.67-0.86)	0.79
Component 4: Trusting nurses in communication about suicidality	3.50	2.75	4.00	4.90/11.20	10.08	0.91 (0.86-0.95)	0.84
Subsection level	3.65	3.17	4.04	1.20/7.40	63.76	0.95 (0.92-0.97)	0.93
CoNuPaS-importance							
Component 1: Encountering a space to express suicidal thoughts and explore needs	4.25	3.88	4.63	1.70/28.90	20.92	0.92 (0.87-0.95)	0.91
Component 2: Being recognised as a unique and self-determining individual	4.57	4.14	4.86	0.20/53.10	15.01	0.80 (0.70-0.88)	0.83
Component 3: Encountering nurses' availability/information-sharing/transparency on expectations	4.00	3.80	4.60	0.00/25.20	13.14	0.59 (0.40-0.73)	0.79
Component 4: Trusting nurses in communication about suicidality	4.33	4.00	5.00	1.00/43.20	12.16	0.86 (0.78-0.91)	0.80
Subsection level	4.30	3.96	4.61	0.20/32.40	61.24	0.91 (0.85-0.94)	0.93

† Floor and ceiling effects occurred when >15% of the participants scored in the 12.5% lower and upper bound, respectively, on subsection and component levels; ICC: Intraclass Correlation Coefficient

7.4. Discussion

Evidence from the perspective of patients with suicidal ideation regarding their contact with nurses is largely restricted to qualitative research (Vandewalle et al. 2020). While qualitative research is crucial to 'understand' the dynamics and processes involved in patient-nurse contact (Hjelmeland 2010), a valid instrument could facilitate the numerical visibility of patient-nurse contact in suicide prevention and suicidal ideation treatment, and quality of care (McAndrew et al. 2014). Therefore, this study developed and psychometrically evaluated the CoNuPaS, a questionnaire to examine contact with nurses from the perspective of patients with suicidal ideation. The CoNuPaS includes 23 items (scored on a five-point Likert scale) and two subsections to examine and compare patients' experiences of contact with nurses (CoNuPaS-experience) *and* what they find important in that contact (CoNuPaS-importance).

The CoNuPaS includes four components, which represent patients' opportunities for expressing suicidal ideation and exploring needs, being recognised as a unique and self-determining individual, encountering nurses' availability/information-sharing/transparency on expectations, and trusting nurses in communication about suicidality. The significance of these aspects must be recognised. Regarding the patient's perspective, being able to express suicide-related experiences and explore needs as part of open, validating, and trusting contact is often the first step in recovering from suicidal ideation, including alleviating distress, regaining hope, and (re)connecting with oneself (Cutcliffe and Stevenson 2008, Sellin et al. 2017). Simultaneously, prevention and treatment efforts often depend on patients' expression of suicidal ideation, and the effects depend on meeting patients' needs, including needs for connection, support, acceptance, and validation (Berg et al. 2017, Hom et al. 2017, Van Orden et al. 2010).

For clinical purposes, the CoNuPaS can be completed upon admission—and repeated during admission—to generate data about the presence and development of crucial aspects of patient-nurse contact, including trust and communication about suicide. Moreover, data pertaining to patients' needs to be recognised as a unique and self-determining individual (i.e. component 2) might point to stigmatic views of nurses. This is important because patients expressed that nurses might minimise their feelings or approach them as a 'risk object' (Vandewalle et al. 2020), and nurses may listen and talk to patients as part of an instrumental approach rather than an interpersonal approach (Vandewalle et al. 2019). Considering this, the CoNuPaS can make the interpersonal and communicative skills and qualities that patients value in nurses more explicit and visible. Such data can inform training and feedback initiatives that aim to foster nurses' skills, qualities, and confidence to discuss suicide and assess suicide risk as part of an interpersonal approach (Berg et al. 2017,

Vandewalle et al. 2019). For research purposes, the instrument can encourage studies that identify multilevel factors—such as severity of suicidality and type of ward—, which may influence patients' perceptions of their contact with nurses. Such knowledge can trigger reflection among healthcare policymakers, professionals, educators, and researchers about the fundamental need to attune to patients' interactional needs.

While quantitative research can help visualise and articulate interpersonal aspects of nursing care, the pitfalls must be considered. The literature indicates the risk that results obtained with instruments like the CoNuPaS may be interpreted from a risk-dominated and professionally led perspective (Slemon et al. 2017). Discussing suicide and building dialogue with patients may represent mechanisms to enhance patient compliance and control patients as 'risk objects', rather than genuine ways to understand what patients are experiencing, validate them as unique individuals, and involve them in decision-making (Felton et al. 2018, Fitzpatrick and River 2018). Likewise, in current healthcare systems where administrators are eager to meet performance indicators (Kilbourne et al. 2018), making contact with patients is easily viewed as 'a duty', instead of an interpersonal expression of openness and genuineness. To prevent the emergence of such untoward mechanisms, the CoNuPaS must be used from a holistic perspective, meaning that the obtained results must be located back into the questionnaire's conceptual foundation and into the context in which the results acquire their meaning.

Methodological considerations

The CoNuPaS has a sound conceptual foundation and demonstrated good psychometric properties in a mental health ward context. A Delphi procedure with experts and cognitive interviews with hospitalised patients indicated that the questionnaire is user-friendly and has excellent content validity. The construct validity of the CoNuPaS-experience and CoNuPaS-importance was strong, with explained variances of >60%. Additionally, the subsections and components exhibited sound internal consistency (≥0.79) and moderate to excellent stability (ICC=0.59-0.95).

The rather high test-retest ICC values must be interpreted in light of the three- to five-hour interval. While this short time interval may have minimised confounding factors, as mentioned previously, one might argue that such an interval inflates ICC values, due to recall bias (Polit and Beck 2017). Simultaneously, common sense may tell us that the CoNuPaS items, which reflect an interpersonal construct, may be not as susceptible to recall bias as items on, for instance, a knowledge test (Althubaiti 2016).

Attention is needed for ceiling effects in the CoNuPaS-importance. As the CoNuPaS reflects meaningful aspects of contact from a patient's perspective, ceiling effects were expected on

the CoNuPaS-importance. However, this ceiling effect impedes the possibility of distinguishing patients from each other; therefore, the CoNuPaS-importance is less recommended for use in intervention studies (Terwee et al. 2007). While the authors attempted to minimise response-set bias by including positively and negatively formulated items, participants in the cognitive interviews informed us that this induced interpretation difficulties. Additionally, the self-report method is prone to overestimation and social desirability bias, and this may partly explain why CoNuPaS-experience item scores were relatively high (Althubaiti 2016). Social desirability bias should be considered, as people with suicidal ideation might perceive themselves as a burden or have a need to feel accepted by others (Van Orden et al. 2010). This may influence patients' responses to private and sensitive items, such as whether they can discuss suicide with a nurse.

Individuals with lived experience could have been more explicitly involved throughout the study, to better include and attune to their perspective in developing and evaluating the questionnaire. Starting out with a systematic review (Vandewalle et al. 2020) and conducting cognitive interviews ensured that patients' perspectives were prioritised. However, peer specialists with lived experience of suicidal ideation (Huisman and van Bergen 2019) were not involved in the Delphi procedure. This decision was pragmatic in nature to preserve the study timeframe, partly because the ethical committee requested a lengthy patient approval process for involving peer specialists.

Furthermore, underrepresentation bias must be considered, given the lack of non-response data (Polit and Beck 2017). Certain subpopulations may be underrepresented; including patients with severe suicidal intent and severe mental disorders, and patients could not participate if they did not have a good command of the Dutch language, including people of non-Belgian origin. Recruitment issues are also relevant in this respect. Two hospital directors declined to participate in the study, mainly out of concern that data collection in a group would trigger adverse reactions, including manipulative interactions between patients with personality disorders. Additionally, three ward managers indicated that their patients (e.g. patients with psychotic disorders) lacked the mental capacity to participate, and that participation would exacerbate their distress. While the authors acknowledge that some patients in the settings that declined participation may not have been able to participate or were susceptible to risk that justified their exclusion (Emanuel et al. 2000), they questioned whether this was true for all patients. If not, then excluding patients who are able and willing to participate not only perpetuates bias but also precludes patients' possibilities of having a meaningful experience, making a social contribution, and managing their own lives (Littlewood et al. 2019, Sellin et al. 2017).

Contextual considerations

The CoNuPaS was developed and tested in the context of nursing care in mental health wards. This exclusive focus is a limitation given that persons at risk of suicide may not access mental health wards, and they interact with many other professionals across different healthcare settings (Hom et al. 2015). Considering this, efforts are required for cross-contextual adaptation and validation of the CoNuPaS. In accordance with the guideline of Sousa and Rojjanasrirat (2011), such efforts require a comprehensive process, where the development of a conceptual foundation is prioritised, followed by rigorous expert evaluation and careful psychometric testing.

To adapt the CoNuPaS for use across mental health professions, the instrument should be elaborated through conceptual understanding of the interactions between patients and other professionals. This understanding would enable sensitivity for differences in multidisciplinary practices. For example, compared to nurses, psychiatrists' contacts with patients might occur more often within delineated therapies (Hagen et al. 2017) and psychologists might perceive suicide prevention less as a 'duty' and may have fewer condemning attitudes towards suicide (Norheim et al. 2016). Additionally, future research should aim to adapt the CoNuPaS for use across healthcare settings. This is necessary because crucial aspects of patient-nurse contact, like discussing suicide, are equally important, for instance, in community-based services and emergency departments. Emergency departments in particular are considered a 'starting point', were people often enter the healthcare system following a suicide attempt, and where their contact with professionals influences future help-seeking and disclosure of suicidal ideation (Hom et al. 2015).

Research efforts to adapt the CoNuPaS for use in emergency departments should acknowledge the lack of conceptual understanding of patient-nurse contact in this context (Vandewalle et al. 2020). Enhancing this understanding should be prioritised to identify relevant cross-contextual differences. For example, patient-nurse contacts in emergency departments may be influenced by brief admissions and intense clinical requirements, including suicide screening and early intervention (Ceniti et al. 2020). Moreover, persons with suicidal ideation and behaviour might experience more stigma from emergency professionals than from mental health professionals (Frey et al. 2016). Furthermore, a rigorous approach will be needed to translate, adapt, and validate the CoNuPaS for use across cultures (Sousa and Rojjanasrirat 2011). For instance, it is likely that not all CoNuPaS items account for patient-nurse contact in non-Western cultures, where suicide may neither be acknowledged nor discussed, or is still viewed as a crime (WHO 2018).

7.5. Conclusion

The CoNuPaS is a self-report questionnaire with the potential to generate new insight from the perspective of patients with suicidal ideation regarding their contact with nurses in mental health wards. The 23-item questionnaire has a sound conceptual foundation and demonstrated good psychometric properties. By including two subsections and four components, the CoNuPaS can facilitate in-depth and differentiated perspectives on the aspects of contact that patients with suicidal ideation perceive as most helpful.

7.6. Relevance to clinical practice

The availability of a valid questionnaire to examine patient-nurse contact in mental health wards is central to an improved understanding of nurses' roles and contributions to suicide prevention and suicidal ideation treatment. The CoNuPaS can highlight those aspects of contact that require attention and, subsequently, inform developments in nursing practice that contribute to a better fit between patients' contact with nurses and what they find important when experiencing suicidal ideation. Overall, when used thoughtfully, the CoNuPaS can provide insights that stimulate person-centred and collaborative approaches in nursing care (McAndrew et al. 2014), as well as suicide prevention and treatment of suicidal ideation (Fitzpatrick and River 2018).

References

Althubaiti, A. (2016). Information bias in health research: definition, pitfalls, and adjustment methods. *Journal of Multidisciplinary Healthcare*, 9, 211-217. doi.org/10.2147/JMDH.S104807

Arthur, D., Chong, C., Rujkorakarn, D., Wong, D. & Wongpanarak, N. (2004). A profile of the caring attributes of Hong Kong and Thailand psychiatric nurses. *International Journal of Mental Health Nursing*, 13, 100-106. doi.org/10.1111/j.1440-0979.2004.00313.x

Beatty, P. C., & Willis, G. B. (2007). Research Synthesis The Practice of Cognitive Interviewing. *Public Opinion Quarterly*, 71, 287-311. doi.org/10.1093/poq/nfm006

Belsher, B. E., Smolenski, D. J., Pruitt, L. D. et al. (2019). Prediction Models for Suicide Attempts and Deaths: A Systematic Review and Simulation. *JAMA Psychiatry*, 76, 642-651. doi.org/10.1001/jamapsychiatry.2019.0174

Berg, S. H., Rørtveit, K. & Aase, K. (2017). Suicidal patients' experiences regarding their safety during psychiatric in-patient care: a systematic review of qualitative studies. *BMC Health Services Research*, 17, 73. doi.org/10.1186/s12913-017-2023-8

Bolton, J. M., Gunnell, D. & Turecki, G. (2015). Suicide risk assessment and intervention in people with mental illness. *British Medical Journal*, 351, h4978. doi.org/10.1136/bmj.h4978

Bowers, L., Banda, T. & Nijman, H. (2010). Suicide inside: a systematic review of inpatient suicides. *The Journal of Nervous and Mental Disease*, 198, 315-328. doi.org/10.1097/NMD.0b013e3181da47e2

Ceniti, A. K., Heinecke, N. & McInerney, S. J. (2020). Examining suicide-related presentations to the emergency department. *General Hospital Psychiatry*, 63, 152-157. doi.org/10.1016/j.genhosppsych.2018.09.006

Chambers, M., McAndrew, S., Nolan, F., Thomas, B., Watts, P. & Kantaris, X. (2017). Service user involvement in the coproduction of a mental health nursing metric: The Therapeutic Engagement Questionnaire. *Health Expectations*, 20, 871–877. doi.org/10.1111/hex.12526

Chyung, S. Y., Roberts, K., Swanson, I. & Hankinson, A. (2017), Evidence-Based Survey Design: The Use of a Midpoint on the Likert Scale. *Performance Improvement*, 56, 15–23. doi.org/10.1002/pfi.21727

Costello, A. B. & Osborne, J. W. (2005). Best practices in exploratory factor analysis: Four recommendations for getting the most from your analysis. *Practical Assessment, Research, & Evaluation,* 10: 1–9.

Cutcliffe, J. R., & McKenna, H. (2018). Psychiatric/mental health nursing in the 21st century: It's 'déjà vu' all over again! *International Journal of Nursing Studies*, *81*. doi.org/10.1016/j.ijnurstu.2018.03.004

Cutcliffe, J. R. & Stevenson, C. (2008). Feeling our way in the dark: the psychiatric nursing care of suicidal people--a literature review. *International Journal of Nursing Studies*, 45, 942–953. doi.org/10.1016/j.ijnurstu.2007.02.002

Emanuel, E. J., Wendler, D. & Grady, C. (2000). What makes clinical research ethical? *Journal of the American Medical Association*, 283, 2701–2711. doi.org/10.1001/jama.283.20.2701

Felton, A., Repper, J. & Avis, M. (2018). Therapeutic relationships, risk, and mental health practice. *International Journal of Mental Health Nursing*, 27, 1137–1148. doi.org/10.1111/inm.12430

Fitzpatrick, S. J. & River, J. (2018). Beyond the Medical Model: Future Directions for Suicide Intervention Services. *International Journal of Health Services: Planning, Administration, Evaluation*, 48, 189–203. doi.org/10.1177/0020731417716086

Frey, L. M., Hans, J. D. & Cerel, J. (2016). Perceptions of suicide stigma: How do social networks and treatment providers compare? *Crisis: The Journal of Crisis Intervention and Suicide Prevention*, 37, 95-103. doi.org/10.1027/0227-5910/a000358

Ghasemi, A. & Zahediasl, S. (2012). Normality tests for statistical analysis: a guide for non-statisticians. *International Journal of Endocrinology and Metabolism,* 10, 486–489. doi.org/10.5812/ijem.3505

Gliem J. & Gliem R. (2003). Calculating, interpreting and reporting Cronbach's alpha reliability coefficient for Likert-type scales*. Midwest Research-to-Practice Conference. Adult and Continuing Communication and Education*, 82–88.

Hagen, J., Hjelmeland, H. & Knizek, B. L. (2017). Relational principles in the care of suicidal inpatients: Experiences of therapists and mental health nurses. *Issues in Mental Health Nursing*, 38, 99-106. doi.org/10.1080/01612 840.2016.1246631

Heller, N. R. (2015). Risk, Hope and Recovery: Converging Paradigms for Mental Health Approaches with Suicidal Clients. *The British Journal of Social Work*, 45, 1788–1803. doi.org/10.1093/bjsw/bcu007

Hjelmeland, H., & Knizek, B. L. (2010). Why we need qualitative research in suicidology. *Suicide and Life-Threatening Behavior*, 40, 74-80. doi.org/10.1521/suli.2010.40.1.74

Hom, M. A., Stanley, I. H. & Joiner, T. E. (2015). Evaluating factors and interventions that influence help-seeking and mental health service utilization among suicidal individuals: A review of the literature. *Clinical Psychology Review*, 40, 28–39. doi.org/10.1016/j.cpr.2015.05.006

Hom, M. A., Stanley, I. H., Podlogar, M. C. & Joiner, T. E., Jr. (2017). "Are You Having Thoughts of Suicide?" Examining Experiences With Disclosing and Denying Suicidal Ideation. *Journal of Clinical Psychology*, 73, 1382–1392. doi.org/10.1002/jclp.22440

Hsu, C.-C. & Sandford, B. A. (2007) The Delphi technique: making sense of consensus. *Practical Assessment, Research & Evaluation,* 12, 1–8. doi.org/10.7275/pdz9-th90

Huisman, A. & van Bergen, D. D. (2019). Peer specialists in suicide prevention: Possibilities and pitfalls. *Psychological Services*, 16, 372–380. doi.org/10.1037/ser0000255

Hunt, I. M., Bickley, H., Windfuhr, K., Shaw, J., Appleby, L. & Kapur, N. (2013). Suicide in recently admitted psychiatric in-patients: A case-control study. *Journal of Affective Disorders*, 144, 123–128. doi.org/10.1016/j.jad.2012.06.019

Kelley, K., Clark, B., Brown, V., Sitzia, J. (2003). Good practice in the conduct and reporting of survey research. *International Journal for Quality in Health Care*, 15. 261-266. doi.org/10.1093/intqhc/mzg031

Kilbourne, A.M., Beck, K., Spaeth-Rublee, et al. (2018). Measuring and improving the quality of mental health care: a global perspective. *World Psychiatry*, 17, 30-38. doi.org/10.1002/wps.20482

Kleiman, E. M., Turner, B. J., Fedor, S., Beale, E. E., Huffman, J. C., & Nock, M. K. (2017). Examination of real-time fluctuations in suicidal ideation and its risk factors: Results

from two ecological momentary assessment studies. *Journal of Abnormal Psychology*, 126, 726–738. doi.org/10.1037/abn0000273

Koo, T. K. & Li, M. Y. (2016). A Guideline of Selecting and Reporting Intraclass Correlation Coefficients for Reliability Research. *Journal of Chiropractic Medicine*, 15, 155–163. doi.org/10.1016/j.jcm.2016.02.012

Lees, D., Procter, N. & Fassett, D. (2014). Therapeutic engagement between consumers in suicidal crisis and mental health nurses. *International Journal of Mental Health Nursing*, 23, 306–315. doi.org/10.1111/inm.1206

Littlewood, D. L., Harris, K., Gooding, P., Pratt, D., Haddock, G. & Peters, S. (2019). Using my Demons to Make Good: The Short- and Long-Term Impact of Participating in Suicide-Related Research. *Archives of Suicide Research*, 1–25. doi.org/10.1080/13811118.2019.1663330

Madsen, T., Erlangsen, A., Nordentoft, M. (2017). Risk Estimates and Risk Factors Related to Psychiatric Inpatient Suicide–An Overview. *International Journal of Environmental Research and Public Health*, 14*,* 253. doi.org/10.3390/ijerph14030253

Manuel, J., Crowe, M., Inder, M. & Henaghan, M. (2018). Suicide prevention in mental health services: A qualitative analysis of coroners' reports. *International Journal of Mental Health Nursing*, 27, 642–651. doi.org/10.1111/inm.12349

McAndrew, S., Chambers, M., Nolan, F., Thomas, B. & Watts, P. (2014). Measuring the evidence: reviewing the literature of the measurement of therapeutic engagement in acute mental health inpatient wards. *International Journal of Mental Health Nursing*, 23, 212–220. doi.org10.1111/inm.12044

Meerwijk, E. L., van Meijel, B., van den Bout, J., Kerkhof, A., de Vogel, W. & Grypdonck, M. (2010). Development and evaluation of a guideline for nursing care of suicidal patients with schizophrenia. *Perspectives in Psychiatric Care*, 46, 65–73. doi.org/10.1111/j.1744-6163.2009.00239.x

Norheim, A. B., Grimholt, T. K., Loskutova, E. & Ekeberg, O. (2016). Attitudes toward suicidal behaviour among professionals at mental health outpatient clinics in Stavropol, Russia and Oslo, Norway. *BMC Psychiatry,* 16. doi.org/10.1186/s12888-016-0976-5

Polit, D. F. & Beck, C. T. (2017) *Nursing Research: Generating and Assessing Evidence for Nursing Practice*. 10th Edition. Wolters Kluwer Health, Philadelphia.

Polit, D. F., Beck, C. T. & Owen, S. V. (2007), Is the CVI an acceptable indicator of content validity? Appraisal and recommendations. *Research in Nursing and Health*, 30: 459–467. doi.org/10.1002/nur.20199

Priebe, S. & McCabe, R. (2006), The therapeutic relationship in psychiatric settings. *Acta Psychiatrica Scandinavica*, 113, 69–72. doi.org/10.1111/j.1600-0447.2005.00721.x

Richards, J. E., Whiteside, U., Ludman, E. J. et al. (2019). Understanding why patients may not report suicidal ideation at a health care visit prior to a suicide attempt: a qualitative study. *Psychiatric Services*, 70, 40–45. doi.org/10.1176/appi.ps.201800342

Samuelsson, M., Wiklander, M., Asberg, M. & Saveman, B.I. (2000). Psychiatric care as seen by the attempted suicide patient. *Journal of Advanced Nursing*, 32, 635–643. doi.org/10.1046/j.1365-2648.2000.01522.x

Santangelo, P., Procter, N. & Fassett, D. (2018). Mental health nursing: Daring to be different, special and leading recovery-focused care? *International Journal of Mental Health Nursing,* 27, 258-266. doi.org/10.1111/inm.12316

Sellin, L., Asp, M., Wallsten, T. & Wiklund Gustin, L. (2017). Reconnecting with oneself while struggling between life and death: The phenomenon of recovery as experienced by persons at risk of suicide. International *Journal of Mental Health Nursing*, 26, 200–207. doi.org/10.1111/inm.12249

Sitzman, K. & Watson, J. (2019). *Assessing and Measuring Caring in Nursing and Health Sciences: Watson's Caring Science Guide*. 3rd Edition. New York: Springer Publishing.

Slemon, A., Jenkins, E. & Bungay, V. (2017). Safety in psychiatric inpatient care: The impact of risk management culture on mental health nursing practice. *Nursing Inquiry*, 24, e12199. doi.org10.1111/nin.12199

Sousa, V.D. & Rojjanasrirat, W. (2011). Translation, adaptation and validation of instruments or scales for use in cross-cultural health care research: a clear and user-friendly guideline. *Journal of Evaluation in Clinical Practice,* 17*,* 268-274. doi.org/10.1111/j.1365-2753.2010.01434.x

Tabachnick, B. G. & Fidell, L. S. (2019). *Using multivariate statistics*. 7th Edition. Pearson Education.

Terwee C. B., Bot S. D., de Boer M. R. et al. (2007) Quality criteria were proposed for measurement properties of health status questionnaires. *Journal of Clinical Epidemiology*, 60, 34–42. doi.org/10.1016/j.jclinepi.2006.03.012

Vandewalle, J., Beeckman, D., Van Hecke, A., Debyser, B., Deproost, E. & Verhaeghe, S. (2019). Contact and communication with patients experiencing suicidal ideation: A qualitative study of nurses' perspectives*. Journal of Advanced Nursing*, 75, 2867–2877 doi.org/10.1111/jan.14113

Vandewalle, J., Van Bos, L., Goossens, P. et al. (2020). The perspectives of adults with suicidal ideation and behaviour regarding their interactions with nurses in mental health and emergency services: a systematic review. *International Journal of Nursing Studies*, doi.org/10.1016/j.ijnurstu.2020.103692

Van Orden, K. A., Witte, T. K., Cukrowicz, K. C., Braithwaite, S., Selby, E. A. & Joiner, T. E. (2010). The Interpersonal Theory of Suicide. *Psychological review*, 117, 575–600. doi.org/10.1037/a0018697

World Health Organization (WHO) (2018). National Suicide Prevention Strategies: Progress, Examples and Indicators. https://www.who.int/mental_health/suicide-prevention/national_strategies_2019/en/. Accessed: 9 August 2019.

Chapter 8. The working alliance with people who experience suicidal ideation: a qualitative study of nurses' perspectives

Based on:
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Abstract

Aims: The aim of the study was to enhance the conceptual understanding of the working alliance in the context of nursing care for patients experiencing suicidal ideation.

Design: A qualitative study based on grounded theory was conducted.

Methods: Two authours conducted individual semi-structured interviews from September 2017 to January 2019. Twenty-eight nurses on thirteen wards of four psychiatric hospitals participated. The Qualitative Analysis Guide of Leuven was used to support constant data comparisons and the cyclic processes of data collection and data analysis.

Findings: The nurses' perspectives reflect that the working alliance can be understood as an interpersonal and collaborative relational process. This relational process is underpinned by the core variable 'seeking connectedness and attunement with the person at risk of suicide'. The core variable underpins three clusters: investing in the foundations of the working alliance, nourishing the clinical dimension of the working alliance, and realising an impact with the working alliance.

Conclusion: This study highlights the importance for nurses to assess, evaluate, and respond to patients' suicidal ideation in harmony with a commitment to connect with patients and attune to their perspective.

Impact: The relational process uncovered through this study offers valuable insights to support advanced nursing practice, in which nurses meaningfully integrate relational elements of care with their contributions to suicide prevention and treatment of suicidal ideation.

8.1. Introduction

Suicide is a global public health problem that extracts enormous personal, societal, and economic burdens. Consequently, suicide prevention has become a high priority on the global public health agenda (Turecki & Brent 2016; Zalsman et al. 2016). The current study focused on suicidal ideation, a phenomenon that is often overlooked in suicide-related research and refers to the range of thoughts and feelings associated with thinking about, considering, or planning suicide (Jobes & Joiner 2019; Klonsky et al. 2016).

Qualitative studies have increased the understanding of elements that play a role in suicidal ideation, including hopelessness and ambivalence; loneliness and lack of self-worth; disconnection from humanity; and an inability to maintain control and cope with life (Berglund et al. 2016; Talseth & Gilje 2018). Quantitative studies have also developed a clearer picture of factors that increase suicide risk—including previous suicide attempts, social isolation, and mental health difficulties—and factors that protect against suicide—including coping skills, hopefulness, and connectedness (Batty et al. 2018; Franklin et al. 2017).

Connected to the particular personal and interpersonal nature of suicidal ideation, there is a body of evidence across healthcare disciplines that highlights the working alliance as a cornerstone in suicide prevention and treatment of suicidal ideation (Dunster-Page et al. 2017; Gysin-Maillart et al. 2017; Hagen et al. 2017).

Background

The working alliance is a well-known relational concept in the field of psychotherapy, and involves agreeing on goals, assigning tasks, and developing bonds (Bordin 1979). Positive associations have been reported between the working alliance and therapy outcomes for individuals with mental health difficulties (Flückiger et al. 2018). Horvath and colleagues (2011, p. 15) described the working alliance as an integrative relationship that is influenced by and is an essential and inseparable part of everything that happens in therapy.

In nursing practice, the fundamental need to develop interpersonal relationships with patients is emphasised throughout nursing theories (Peplau 1989; Watson 1979). However, literature across healthcare settings suggests that nurses struggle to develop interpersonal relationships with patients, and to reconcile these relationships with medical-technical standards of practice (McAllister et al. 2019; Wiechula et al. 2016). In caring for patients who experience suicidal ideation, nurses often find it difficult to meaningfully integrate relational elements of care with suicide risk assessment and management (Hagen et al. 2017). This is evident in the perspectives of patients experiencing suicidal ideation, who assert that they do not want to be ‘objectified’ or ‘treated mechanically’ by custodial practices, and impersonal

and controlling interactions, but prefer a human, close relationship with nurses (Cutcliffe et al. 2015; Hagen et al. 2018; Lees et al. 2014).

These insights reflect a need to enhance the understanding of nurse-patient relationships that facilitate an integrative perspective in nursing practice, such as the working alliance. Previous work described the working alliance as a relationship that underpins effective suicide risk assessment and management (Fowler 2012; Jobes 2012). However, in nursing care for patients experiencing suicidal ideation, the working alliance remains elusive in terms of what it means and how it is expressed in practice. A qualitative research approach can enhance understanding of the working alliance concepts and processes.

8.2. The study

8.2.1. Aim

The aim of the study was to enhance the understanding of the working alliance in the context of nursing care for patients who experience suicidal ideation from the perspective of nurses on psychiatric wards.

8.2.2. Design

A qualitative interview study based on grounded theory was conducted. This approach was used to uncover and understand the concepts and processes that are grounded in nurse-patient relationships (Glaser & Strauss, 1967). Constant data comparison and cyclic processes of data collection and analysis were prioritised (Hallberg 2006).

8.2.3. Participants

Nurses were recruited from thirteen adult wards of four psychiatric hospitals, geographically spread across Flanders, the Dutch-speaking part of Belgium. The wards had an open or closed entrance and were mainly divided according to patients' psychiatric disorder (e.g. anxiety disorders) or age (e.g. 35-65 years). Potential participants were first informed and invited by the head nurses on the wards. To guide this process, the interviewers organised discussions with the head nurses to provide detailed information about the nature and goal of the study and the inclusion criteria. Nurses could participate if they had clinical experience in caring for patients with suicidal ideation within the past year. The interviewers approached the potential participants by e-mail to schedule the interviews. The nurses (n=28) were

employed in adult wards, which were divided according to psychotherapeutic orientation (e.g., psychodynamic), psychiatric disorder (e.g., anxiety disorders), or age group (e.g., 35-65 years). Nineteen nurses identified themselves as female and nine as male. The nurses were aged between 22 and 61; more than half of them had worked for more than nine years as nurses.

8.2.4. Data collection

The first and fourth authour conducted individual semi-structured interviews from September 2017 to January 2019. These male interviewers had prior experience as nurses in psychiatric hospitals. The last authour had advanced expertise with qualitative research. She followed the interview process closely and supported the interviewers in developing their interview style. Interviews were guided by the verbal accounts of the nurses, the interviewers' active listening skills, and an interview guide with open-ended questions concerning nurse-patient relationships. Table 1 presents a sample of the interview questions. The interviews were held in the hospitals, lasted between 59 and 120 minutes (mean 77), and were audio-recorded and transcribed verbatim. The interviewers made field notes of each interview to capture relevant non-verbal and contextual data (Phillippi & Lauderdale 2018).

Participants were initially selected through purposive sampling, followed by waves of theoretical sampling. In keeping with grounded theory, this stepwise process ensured conceptual development from the emerging insights (Draucker et al. 2007), and supported recruiting nurses with varying demographic characteristics. For example, an analyses of the first interviews showed that nurses emphasised more instrumental or interpersonal ways of forming relationships with patients experiencing suicidal ideation. Open discussions in the research team facilitated decision-making regarding the next steps that could enhance the understanding of this insight. Then, in consultation with the head nurses, nurses with differing perceptions regarding their relationship with patients were recruited, as well as nurses of different ages and nurses across different types of wards. This led to an increase of the heterogeneity of participants' experiences and characteristics, which allowed an in-depth exploration of the dynamics, concepts, and processes involved in the nurse-patient relationships. This understanding was further enhanced by formulating more specific interview questions as the data analysis progressed.

Table 1. Sample of the questions used during the semi-structured interviews with nurses

Questions to start the interviews

- How do you experience your encounters with patients who have suicidal thoughts and feelings?
- What is, based on your experience as a nurse, important in working with patients who experience suicidal ideation?

Questions to explore nurses' accounts regarding the nurse-patient relationship

- You spoke about forming a connection with patients who experience suicidal ideation.
  - How do you form that connection?
  - What aspects of your interaction with patients make you think that this connection becomes stronger?
  - What meaning does this connection have in working with patients who experience suicidal ideation?
- You mentioned that you try to be present for patients who experience suicidal ideation.
  - What does that mean for you as a nurse?
  - How would you describe: 'now I demonstrate genuineness to a patient'?
- What meaning does trust have for you/ for the patient/ for the relationship?
  - How does this sense of trust evolve in your relationship with patients with suicidal ideation?
  - What signs make you think that there is trust in your relationship with the patient?
- How does it feel for you to interact with patients who experience suicidal ideation? How do you cope with these personal feelings?

Questions to explore nurses' accounts regarding clinical and organisational aspects

- How do you assess/ evaluate patients' suicidal thoughts and feelings?
  - Can you tell me more about this intuitive understanding?
  - How do you initiate/ build conversations with patients about suicide?
- How do you use these safety/ suicide prevention procedures (such as observations, restraint, seclusion)?
  - What is your role as a nurse in using these procedures?
  - How do you reconcile your efforts to assess/ manage suicide risk with the relationship you have with patients?
- Is your approach to patients who are at high risk of suicide similar or different?
- How do you determine this point: 'now I have to take over control of the patient'? Do you have an example of this?
- What aspects support or hinder your work with patients who experience suicidal

ideation (e.g., team-related aspects)?

Questions at the end of the interviews

- Would you like to share anything else that you think is important when working with patients with suicidal ideation?
- How did you experience the interview? How was it for you to talk about this topic?

8.2.5. Ethical considerations

The Ethical Committees of the Ghent University Hospital and the participating hospitals approved this study (B670201630531). Using an informed consent document and face-to-face interaction, researchers informed participants of the nature and goal of the study and assured them that participation was voluntary, that they could stop participating at any time, and that confidentiality was assured. All participants provided written and verbal informed consent prior to their participation.

8.2.6. Data analysis

The Qualitative Analysis Guide of Leuven was used to support the iterative processes of gradually deepening the analysis based on constant data comparison (Dierckx de Casterlé, Gastmans et al. 2012). The first and fourth authour immersed themselves in the data by reading the transcripts repeatedly and listening to the audio recordings, developing narrative reports and conceptual schemes of each interview, and adding memos. The last authour read all transcripts and added memos. The three authours engaged in open discussions about the emerging data and concepts to develop preliminary insights and guide decisions to collect new data (Draucker et al. 2007). Additional discussions were held with three other researchers who read some of the transcripts. This researcher triangulation process inspired constant comparison of text fragments within and between the interviews (Morse 2015). In line with the analysis guide (Dierckx de Casterlé et al. 2012), this helped the research team discover the core processes involved in the working alliance and to generate a list of concepts used by the first and fourth authour to initiate a coding process in NVivo 12 (QSR International). The final stage was characterised by rereading the interviews and discussions within the research team to fully uncover and understand the essential structure. Finally, the concepts and processes were organised into three clusters and a core variable. Data saturation was reached within each cluster, but not for all the relationships between the clusters.

8.2.7. Rigour

Several strategies were used to increase the trustworthiness of the study. Researcher triangulation was prioritised to expand the depth and the credibility of the conceptual meanings and dynamics (Morse 2015). In addition, an audit trail was used for transparent reporting of decision-making throughout the study (Bowen 2009). Furthermore, prior to the interviews, the first and fourth authour prioritised reflexivity by reflecting systematically on their personal and professional experiences and by discussing transcripts of these reflections with each other and with the last authour. This supported the explicit recognition of how their preconceptions might impact their interview style and data interpretation (Brunero et al. 2015).

8.3. Findings

From the nurses' perspectives, the working alliance is understood as an interpersonal and collaborative relational process. In this non-linear process, the authours identified a core variable and three clusters: investing in the foundations of the working alliance, nourishing the clinical dimension of the working alliance, and realising an impact with the working alliance. The findings are presented in Figure 1 and illustrated by the participant quotes in Table 2.

8.3.1. Core variable

The core variable for developing a working alliance with patients experiencing suicidal ideation was 'seeking connectedness and attunement with the person at risk of suicide'. This core variable captured the ways by which nurses tried to achieve meaningful contact with patients; assess, evaluate, and respond to patients' suicidal ideation; and reach their goal to safeguard patients against suicide and help them turn away from suicidal ideation. The core variable was linked with a power dynamic in nurse-patient relationships. Nurses sometimes developed an 'instrumental tie' with patients that encompassed a controlling and directing approach. Forming a working alliance required nurses to carefully use their professional power, thereby opening doors to involve patients, connect with them as persons, and attune to their needs and perspectives. Consequently, nurses laid the foundation for an interpersonal and collaborative relational process.

In this relational process, seeking connectedness and attunement motivated the nurses to establish a basis of trust and open communication, and to demonstrate a commitment from person to person. Moreover, this core variable interacted with the way nurses nourished the clinical dimension of the working alliance. Nurses tried to assess, evaluate, and respond to patients' suicidal ideation in a way that harmonised with their focus on connecting with patients and attuning to their perspective. For this purpose, nurses developed a range of interpersonal and collaborative strategies. Furthermore, by seeking connectedness and attunement, nurses perceived that they could have an impact with the working alliance in the form of 'establishing relational security' and 'creating lifelines in difficult times'.

8.3.2. Investing in the foundations of the working alliance

Three constructs were uncovered in this cluster: 'establishing a basis of trust and open communication', 'demonstrating a commitment from person to person', and 'experiencing adequate contextual support'.

Establishing a basis of trust and open communication

The data highlighted that nurses and patients need a minimal amount of trust in each other to work together. Nurses expressed that trust is fragile and often not present from the start; patients with suicidal ideation often lack trust, especially when they do not yet know the nurse or are dealing with extreme distress or psychiatric symptoms, such as psychosis. Similarly, nurses indicated that their sense of trust in patients is lower when they do not yet know the patients, and it can be compromised when patients express self-destructive behaviour (e.g. overdose) or appear to hide or lie about their suicidal ideation.

Nurses commonly expressed that trust is a prerequisite for patients to become more open and honest in their communication. For example, they referred to patient expressions that reflect a growing trust (e.g. "he began to ask me about practicalities"). Nurses tried to promote a basis of open communication by initiating and facilitating contact with patients. Therefore, they present themselves as available and accessible, reach out to patients, and encourage patients to come and talk to them. Furthermore, most nurses indicated that they should 'dare to talk' about suicidal ideation because, otherwise, patients may not disclose their suicidal ideation. In addition, nurses emphasised that they reassure patients that they can disclose their suicidal ideation, but also that they should not force disclosure since this can undermine patients' trust.

The nurses' accounts highlighted that some framed trust and open communication as part of an 'instrumental tie' that enabled them to influence and control the management of suicide risk. Their perspectives reflected efforts to 'gain' trust from patients and to create conditions

for open communication that serves instrumental aims to gather suicide-related information from patients, assign a risk level, and coordinate patient surveillance. Other nurses framed trust and open communication as a foundation upon which patients can approach them and engage in collaborative interactions. These accounts made it clear that a crucial foundation for developing a working alliance is the nurses' commitment from person to person.

Demonstrating a commitment from person to person

Nurses stressed the importance of demonstrating person to person commitment, highlighting their intention to be genuine and transparent in their contact with patients. Being genuine included nurses' expression of authentic concern and appropriate levels of self disclosure to foster a sense of shared humanity. Likewise, nurses used expressions such as 'not acting as a robot' to emphasise their intention to interact with patients by their personal involvement, as opposed to interacting with patients in a strictly procedural manner. Closely related to being genuine, nurses invested in being transparent, which they framed as a means for sharing each other's expectations and experiences regarding the working alliance. For example, several nurses found it important to be transparent with patients about emerging relational difficulties, not to blame patients, but to resolve disruptions in the course of interaction and, simultaneously, to confirm their willingness to connect with patients and attune to their perspective.

In addition, nurses stressed the importance of conveying closeness and support through regularly being with patients, being approachable, asking how they can help, and providing encouragement. Nurses also highlighted the moments of togetherness they established with patients, such as walking outside together. Furthermore, nurses found it important to attend to patients' narratives, by presenting themselves as non-judgemental, interested, willing to listen, and by validating patients' emotions. While nurses expressed the need for a commitment from person to person, the data also highlighted that this is not an obvious pursuit and that some nurses are not oriented to demonstrating such commitment.

Nurses emphasised that interacting with patients—including talking about suicide, retaining a constant alertness, and dealing with uncertainties—can put high demands on them, and evoke feelings of anxiety, helplessness, and responsibility, which can leave them feeling emotionally exhausted or paralysed and unable to continue patient interactions at the same frequency or intensity. Considering these experiences, nurses elaborated on the need to be reflective and self-aware to centre their interactions on connecting with patients and attuning to their perspective. This reflection enabled nurses to become aware of the feelings that patients evoke in them, and to regulate these feelings when responding to patients. For example, several nurses stressed that reflection is needed to regulate their anxiety, because otherwise this may trigger them to assess suicide risk as higher than it is and respond in

ways they perceived as ‘too controlling and instrumental’. Likewise, such notions of reflexive practice were largely absent in nurses who appeared to interact with patients as part of an ‘instrumental tie’.

Experiencing adequate contextual support

Regarding the demands of developing a working alliance, nurses commonly expressed the need to experience adequate contextual support, emphasising their need to be validated and supported in the team by being allowed to ventilate adverse emotions, ask advice, share responsibilities, and receive confirmation of their contributions. The team support enabled them to regulate their emotions and uncertainties around their interactions with patients who experience suicidal ideation. However, some nurses stated that they did not feel safe expressing their emotions and opinions, feeling that they were not heard or that their professionalism was being questioned. For example, they perceived that their co-workers did not appreciate their intentions to convey closeness to patients or labelled them ‘too sensitive’ when being emotional after talking with a patient at risk of suicide.

Experiencing adequate contextual support was also related to the ward culture and organisation. Some nurses referred to heavy workloads, multiple patient assignments, and staffing shortage as conditions that impede their ability to interact with patients. Simultaneously, nurses across open and closed wards referred to their experiences of working in ward cultures that enforce defensive and procedural practices, such as intensive reporting, and restraining and secluding patients at risk of suicide. Some nurses conformed rigidly to these methods, especially when they focused on developing an ‘instrumental tie’ with patients and when they dealt with fears of blame and litigation concerning possible adverse outcomes, including suicide. However, with the aim of developing a working alliance, nurses criticised overly defensive and procedural practices, asserting that these practices give rise to interactions steeped in control, which can undermine patients’ trust and open communication. Instead, these nurses preferred a ward culture that supported them in demonstrating a commitment from person to person and establishing collaborative interactions with patients.

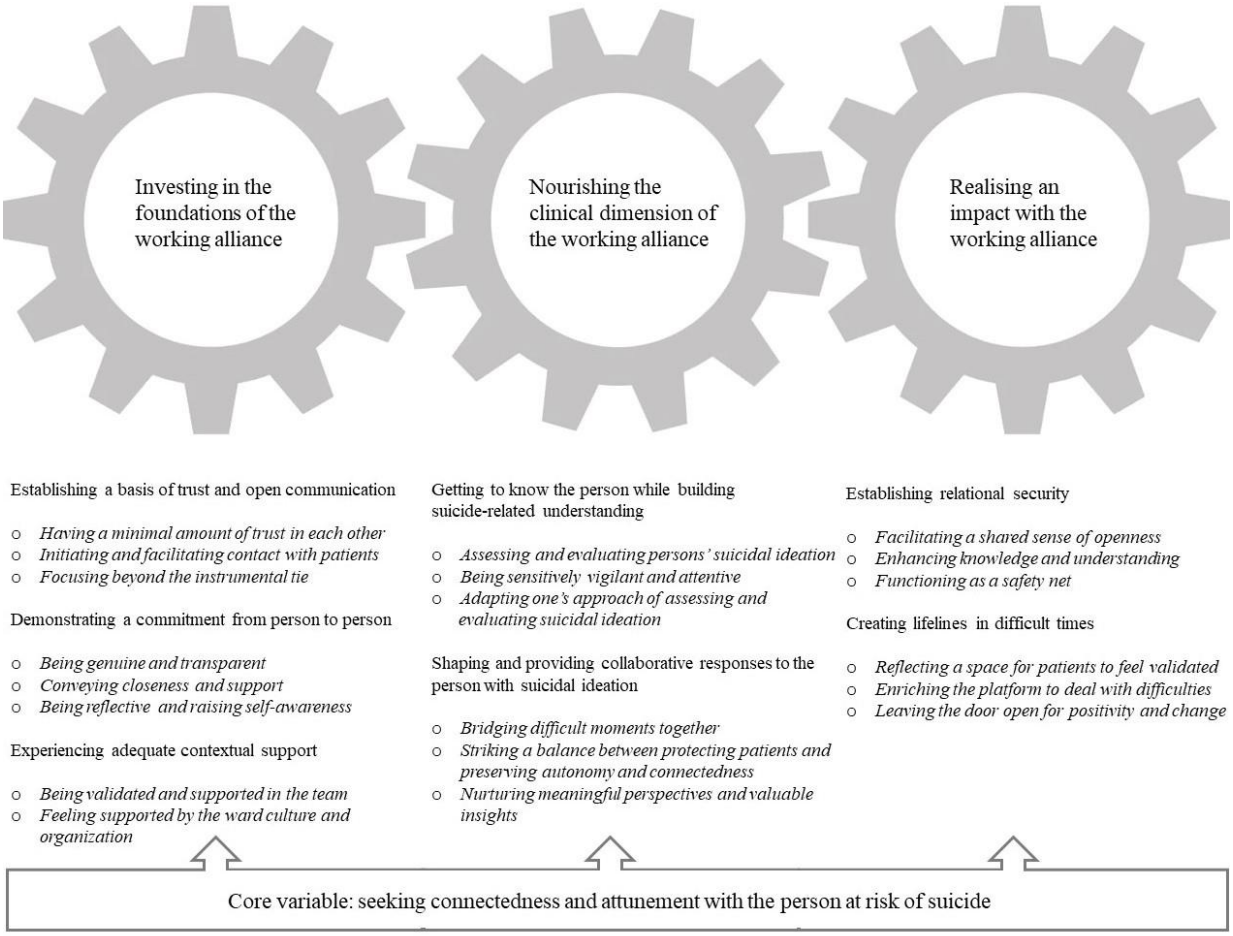

Figure 1. The processes and concepts involved in the working alliance

8.3.3. Nourishing the clinical dimension of the working alliance

Two constructs were uncovered in this cluster: 'getting to know the person while building suicide-related understanding' and 'shaping and providing collaborative responses to the person with suicidal ideation'.

Getting to know the person while building suicide-related understanding

Nurses were focused on assessing and evaluating patients' suicidal ideation, especially at admission and before situations they perceived as 'risky' (e.g. ward leave). They aimed to assess the presence and severity of patients' suicidal ideation, primarily by talking with, listening to, and observing patients, and by seeking assistance from co-workers. Opposed to interacting with patients as part of an 'instrumental tie', the nurses emphasised that assessing and evaluating suicidal ideation comprises more than gathering information with a view to preventing suicide. Nurses found it important to enable patients to express their feelings, thoughts, and experiences, for instance, by taking assessments as part of an open conversation. Nurses indicated that this allows them to get to know each patient as a person.

Some nurses also expressed that this could help them to understand the nature (e.g. loneliness) and function of patients' suicidal expressions.

In addition, nurses commonly emphasised the need to be sensitively vigilant and attentive, which involves being alert and using intuition to foresee dangerous situations and detect warning signs of emerging suicidal ideation. This enabled nurses to notice verbal and behavioural cues that otherwise may pass unnoticed (e.g. a patient's absence). Moreover, according to several nurses, being sensitively vigilant and attentive is a prerequisite to recognising needs and positive signs in patients, which may be subtle and hard to notice. Some nurses also expressed a sensitivity to identify medical issues relevant to patients' suicidal ideation (e.g. psychiatric symptoms) or to capture information that can inform patients' treatment or safety plan.

The data highlighted that nurses adapt their approach toward assessing and evaluating suicidal ideation to their personal style and relationship with patients. Some nurses presented themselves as 'direct', focusing more on asking patients explicitly about suicidal ideation, even in the first contact and in the absence of apparent signs of suicidal ideation. They believed that their direct approach provides clear information and conveys the message to patients that it is acceptable to talk about suicide. Others voiced a more indirect approach, focusing on searching ways to build conversations toward asking about suicide, for instance by responding to behavioural cues, asking about patients' mood, and using patients' language (e.g. 'dark thoughts'). Nurses believed that approaching patients in this way allows a natural and nonthreatening interaction that felt more comfortable for themselves and enabled patients to disclose sensitive issues. These nurses expressed ambivalence toward conducting suicide risk assessments when they did not yet have a connection with patients. Moreover, some nurses refrained from using structured assessment instruments because they feel it reflects a formal approach that hampers their connectedness with patients.

Shaping and providing collaborative responses to the person with suicidal ideation

Nurses aimed to respond to the person with suicidal ideation in ways they considered joint and collaborative. 'Bridging difficult moments together' involved being approachable, establishing moments of togetherness, and clarifying their connection with patients (e.g. "We will meet again tomorrow."). Moreover, this process involved nurses encouraging patients to approach their co-workers when needed, and raising co-workers' awareness for patients' suicide risk and their wishes regarding care and treatment. A minority of nurses also expressed that they motivate family members' involvement, for instance to support the safe coordination of ward leave. Furthermore, nurses were involved in building dialogue with patients. Dialogue reflected a power dynamic in the relationship. Whereas nurses used dialogue to explore risks together with patients and shape shared agreements about safety;

dialogue could also follow an instrumental discourse through which nurses converted patients to believe in and accept their viewpoints of which actions would be best to ensure safety (e.g. enhanced observations).

Shaping and providing collaborative responses reflected the difficulty of striking a balance between protecting patients and preserving their sense of autonomy and connectedness. Nurses expressed that trust can be the tipping point in striking this balance. They were, for instance, more inclined to support patients' ward leave when they had more trust in patients, that is, from the moment they got to know the patients and had an idea of their suicidal ideation. This again reflected a power dynamic, where some nurses shifted easily towards taking control of patients, such as by invoking detention orders, whereas others left the door open for dialogue to explore the possibility to give trust to patients and enable them to take responsibility. Simultaneously, nurses perceived that some patients were so preoccupied with suicidal plans that it was not possible to collaborate with them, and that they needed to assist patients to prevent imminent suicide risk.

In this context, nurses often contemplated about 'when' and 'how' to protect patients, and the potential consequences. The nurses who prioritised interpersonal and collaborative interaction often referred to containment interventions that impeded their connectedness with patients, such as seclusion, or 'automatically' restricted patients' autonomy by increasing observation levels. Accordingly, nurses refrained from initiating containment interventions or tried to use these interventions within a flow of connectedness and attunement. They voiced strategies that reflected this intention, such as involving patients in decision-making about restrictions; conveying closeness and support to patients while conducting observations or when attending to patients in a locked room; and convincing patients that they must not interpret restrictions punitively but as an act that is in their best interest.

Nurses' responses to the person with suicidal ideation also focus on nurturing meaningful perspectives. They differed in their approach, with some nurses focused more on encouraging patients' sense of meaningful activity, for instance by inviting patients to do sports or drink a coffee together. Others focused more on establishing encouraging conversations in which they express their belief in patients, acknowledge 'small' achievements, and create opportunities to talk about meaningful aspects in patients' lives (e.g. children). Additionally, some nurses expressed uncertainty about the appropriateness of nurturing meaningful perspectives, believing that explicit efforts, such as encouraging physical activity, may not be attuned to patients' preferences or their experiences of hopelessness. In addition, several nurses stressed their aim to nurture valuable insights in patients. They referred to conversations in which they tried to help patients raise awareness of their suicidal ideation and to identify and organise their disturbing, sometimes chaotic, thoughts and feelings. Also, some nurses elaborated safety plans with patients, either to

support patients' insights about coping with suicidal ideation (e.g., recognise warning signs) or incorporate professionally-informed strategies to protect or distract patients.

Table 2. Quotes illustrating the findings

Investing in the foundations of the working alliance
Establishing a basis of trust and open communication
Having a minimal amount of trust in each other
"I invested a lot of time in contact with him. That was important for him in order to be able to trust me. Although approaching others was very difficult for him, upon that sense of trust he could occasionally come and talk to me." (Participant 5)
Initiating and facilitating contact with patients
"Some people do not dare to contact me in the beginning. But the fact that I regularly reach out to them often provides a little encouragement, or a step toward approaching me, to open up about their suicidality. So people know: 'If I want to talk about it, then I'm able to do so'." (Participant 24)
Focusing beyond the instrumental tie
"Our regular contact with patients is often called 'surveillance', but I prefer to call it 'being there for that person'… Of course it involves some controlling, but for me it's not primarily about controlling the person. It is not like: 'Okay, you're still alive', and I go further. It's really trying to make contact with patients: 'How do you feel?', 'What do you need?'" (Participant 19)
Demonstrating a commitment from person to person
Being genuine and transparent
"I'm as transparent as possible about what I think and feel. Then I feel genuine toward patients. You know, I'm a nurse but also a person. So, sometimes I tell something about my personal life. I consider this as a form of human contact. It's not merely about: "I administer medication, I observe, and I write." (Participant 9)
Conveying closeness and support
"I belief that conveying closeness is important, seeking attunement, showing that I understand that struggling with these [suicidal] thoughts must be very difficult for them… I think you should be able to allow yourself to be touched in a genuine way. But not in a way

that knocks you down... That you listen carefully to your patient but also reflect about what these interactions do to yourself." (Participant 11)

Being reflective and raising self-awareness

"When interacting with patients who have suicidal thoughts, I sometimes carry a burden with me. And then it's crucial for me to carefully reflect about this, so that I can continue to respond in an attuned way; not being too protective but also not being too *laissez-faire*. Therefore, I often reflect about how I experience situations; What was her intention with this suicidal expression?" (Participant 28)

Experiencing adequate contextual support

Being validated and supported in the team

"You do carry that concern with you as a nurse. While I was very happy that the conversation brought him some relief, his suicidal expressions were also very confronting for me. Then it was important for me to ventilate about this in my team and to notice that they validated my concern. So, I could relieve my burden, otherwise I cannot maintain that contact with the same frequency or intensity." (Participant 17)

Feeling supported by the ward culture and organisation

"Unfortunately, many of my co-workers have the reflex: 'we're going to protect you'. And they make sure that everything is documented in order to cover themselves, and to meet the expectations in our organisation concerning suicide prevention. I struggle with that. I believe we should focus more on good care for patients, on forming that connection, and supporting their healthy part. I do this by creating moments of togetherness, such as doing the dishes together, sitting next to patients, or talking about their hobbies." (Participant 4)

Nourishing the clinical dimension of the working alliance

Getting to know the person while building suicide-related understanding

Assessing and evaluating the person's suicidal ideation

"It's very insightful for me to explore what the function is of their suicidal expressions, and to attune my interventions to this… I notice that many patients do not necessarily want to die, but that something has to change in their life. It's something that overwhelms them, making suicide the only possible option." (Participant 22)

Being sensitively vigilant and attentive

"I don't have a crystal ball, I cannot look into their head. So, I have to make contact, and start a conversation with patients. But even then, you sometimes don't know or observe

that people have suicidal thoughts. So, you have to be vigilant. For example, to notice that someone makes an instant switch from being very suicidal to being very happy." (Participant 7)

Adapting one's approach toward assessing and evaluating suicidal ideation to personal style and connectedness

"There's a protocol in the hospital which expects us to literally question: 'Do you have suicidal thoughts?'. I can understand the hospital's perspective, that this serves safety and is a cover in case something happens. But I find it difficult to focus directly on that during a first conversation, because this feels forced and uncomfortable. I prefer to have a natural conversation, instead of that protocol, and build on the things I hear in their story." (Participant 18)

Shaping and providing collaborative responses to the person with suicidal ideation

Bridging difficult moments together

"I belief it's important to convey closeness to patients who struggle with these [suicidal] feelings, and to make agreements with them. So I can be there for them if they need me, without putting patients at the highest observation level. Otherwise you intensively restrict patients based on a rigid framework, which is not attuned to the person." (Participant 8)

Striking a balance between protecting patients and preserving their sense of autonomy and connectedness

"If people want to leave for the weekend then I make an assessment, give trust to them, and allow them to take responsibility. I don't think that it makes sense to take every bit of responsibility away of them. Often, people are moms, dads, employees; they still fulfil roles and responsibilities, they can still do things! It's not because someone is suicidal that you must be very protective and take over control." (Participant 1)

Nurturing meaningful perspectives and valuable insights

"I also try to get an indication of the things that still drive them, that have meaning for them. No matter how small these things are: 'what are your reasons to stay alive', and how can we try to enlarge these reasons in such a way that these become large enough to find some strength?" (Participant 21)

Realising an impact with the working alliance

Establishing relational security

Facilitating a shared sense of openness

“It’s of utmost importance to establish a relationship in which there is trust, in which people feel something genuine about me, look for me, and can come to me. Then I feel that connection; that I get more access to patients, and that there is a sense of openness, which reassures them, secures them. Then, people can be open about their thoughts and feelings, and what these mean to them.” (Participant 12)

Enhancing knowledge and understanding

“People say for instance, ‘I want to drive into a tree’, as a suicidal expression. But often there is something underneath, which I don’t know directly. It may be caused by a sense of being rejected or feeling hopeless? And the more I have a connection with people, and can attune to them, the more I can understand this.” (Participant 2)

Functioning as a safety net

“She said to me: ‘I like to go for a walk’. And then I replied, ‘You like to go for a walk but you also said: I don't want to live anymore’. Simultaneously, I had a connection with her, and I know that walking can provide relief for her distress. With this in mind, we agreed that she could leave the ward, provided that she took her phone with her… When she returned, she said, ‘I came back because we made an agreement, then I cannot suddenly attempt suicide’.” (Participant 23)

Creating lifelines in difficult times

Reflecting a space for patients to feel validated

“Recently a patient said to me: ‘I feel you’re genuinely concerned about me’. That man had not had that feeling for a very long time. And then it’s nice to hear that my way of being and doing could gave him that feeling, and that it relieved his suffering. I really believe that patients can feel it when I’m open about my concern for them, and that this can do good for them, and make things clearer. And it's genuine, I wouldn't say that if I didn't mean it. I hope nobody does.” (Participant 14)

Enriching the platform to dealing with difficulties

“I feel that with this safety plan, patients become more aware of their suicidal thoughts and get valuable insights. Then, I hope they start to recognise earlier: ‘I’m in that phase, what could I do to de-escalate my emerging suicidal thoughts’… The safety plan is also valuable for myself. As a nurse, I observe and sense a number of things, like patients who increasingly withdraw themselves. Then, being able to document these things in patients’ safety plan provides a clear picture, and helps me to recognise warning signs together with

patients." (Participant 27)

Leaving the door open for positivity and change

"I prefer to give freedom and opportunities to people, even though they are suicidal. So, I facilitate people leaving for the weekend, provided that we can make agreements. For example, we can agree to make a phone call, to discuss how they are doing, to stay in contact… I do so because I feel that being too restrictive is not the right way. I mean, you can keep people on the ward but, then, I believe, and I really speak from experience, that people sometimes develop more suicidal thoughts." (Participant 16)

8.3.4. Realising an impact with the working alliance

Two constructs were uncovered in this cluster: 'establishing relational security' and 'creating lifelines in difficult times'.

Establishing relational security

This construct reflects the nurses' perceived impact of the working alliance in terms of safeguarding patients against suicide. Nurses emphasised that developing a working alliance can facilitate a shared sense of openness. Seeking connectedness and attunement can produce a sense of security that enables patients to trust them, and subsequently, to approach them, engage in dialogue, and more freely express their suicidal ideation. Simultaneously, nurses expressed an increased confidence in communicating with patients when they perceived that patients approached them and disclosed their suicidal ideation. Some nurses even indicated that they do not undertake explicit suicide risk assessments when they 'sense' that their connectedness with patients is sufficient to assume that patients would approach and talk with them when needed.

Establishing relational security also involves 'enhanced knowing and understanding'. Nurses referred to the sense of security resulting from getting to know each other and building understanding about patients' suicidal ideation. Nurses expressed that deeper forms of knowing and understanding are predicated on their everyday closeness to patients. They pointed to their increased ability to know and understand once they feel more connected and attuned to patients. From that moment, nurses feel more able to sense patients' needs, 'truly' feel their suffering, or recognise signs of emerging suicidal ideation.

Establishing relational security also involves what nurses perceived as 'safety nets'. They asserted that their connectedness and agreements with patients may function as a 'secure base to hold onto', and subsequently, support patients' safety over a period, even without

direct contact. This was exemplified in expressions such as, ‘patients stay alive because of the connection we have’, or ‘patients do not attempt suicide because of the agreements we made’. In addition, nurses referred to the safety nets they can create by advocating for patients in the multidisciplinary team. Once they developed a connection with patients, nurses felt more able to set patients up for further help-seeking, for instance, by encouraging patients to approach other nurses or referring patients to the therapist or psychiatrist.

Creating lifelines in difficult times

This construct reflects the perceived impact of the working alliance in terms of helping patients turn away from suicidal ideation. Nurses indicated that the working alliance can ‘reflect a space for patients to feel validated’. By seeking connectedness and attunement, nurses can convey the message to patients that, after all, they may have some worth and meaning as a person. Nurses perceived that this validating space is supported by their potential for being genuine and transparent; talking with and listening to patients with interest and without judgement; providing confirmations of connectedness (e.g. expressing concern), and offering patients a level of freedom and choice.

In addition, creating lifelines is underpinned by ‘enriching the platform to deal with difficulties’. As part of the developing working alliance, nurses often perceived themselves as more able to facilitate ‘small gains’ in patients, which reflects their experience that patients are often not, or only a little, focused on ‘staying alive’. This was revealed in their expressions, such as trying to create ‘a spark of hope’ or ‘a bright spot’. Nurses were concerned with facilitating conversations and activities that could provide encouragement to patients, relieve distress (e.g. by expressing suicidal ideation), and help patients distract themselves from suicidal ideation. In addition, ‘enriching the platform to deal with difficulties’ represents the nurses’ conversations with patients about ‘how to deal with suicidal ideation’, sometimes as part of safety planning. Several nurses perceived that such conversations enable their own capacity to respond to patients’ difficulties, and can be therapeutic for patients through nurturing insight into their suicidal ideation and supporting their coping strategies. However, the conversations with patients were not always part of collaborative interactions. Some nurses were primarily concerned with gathering suicide-related information and using this information to exercise control and influence over patients, such as when building dialogue.

Furthermore, nurses try to create lifelines by ‘leaving the door open for positivity and change’, reflecting the effects that nurses attributed to their thoughtful balancing between protecting patients and preserving their sense of autonomy and connectedness. To strike this balance, nurses often referred to their dialogue with patients to prepare and facilitate ward leave, believing that by giving trust to patients to take such steps, as opposed to ‘taking all responsibilities away’, they preserve opportunities for patients to maintain control, stay

connected with their natural context, and still have positive experiences. Several nurses also perceived that, by using containment interventions (e.g. seclusion) judiciously, they can prevent patients from experiencing a deterioration in their condition, such as increased hopelessness.

8.4. Discussion

This grounded theory study enhances the conceptual understanding of the working alliance in the context of nursing care for patients experiencing suicidal ideation on psychiatric wards. The working alliance can be understood as an interpersonal and collaborative relational process, which is underpinned by the core variable 'seeking connectedness and attunement with the person at risk of suicide'. The nurses' perspectives highlight that trust, open communication, and a commitment from person to person are foundational constructs in the working alliance. This understanding is strengthened by the insight that an interpersonal and collaborative orientation was sometimes largely absent. Indeed, nurses might form relationships with patients that are more accurately conceptualised as an 'instrumental tie', which encompasses a controlling and directing approach. Then, nurses prioritise the management of suicide risk by enforcing containment interventions. More subtly, their verbal acts, such as talking about suicide and making agreements represent a mechanism to control patients and enhance patients' compliance with clinical routines.

These insights highlight a power dynamic in nurse-patient relationships. Nurses can influence or control the level of patients' choice and involvement in relation to decision-making, such as decisions about restrictions and ward leave. The literature suggests that the indiscriminate use of such professional power can create negative consequences for patients, including feeling objectified and disempowered, as well as for nurse-patient relationships, including disruption of communication and connection (Berg et al. 2017). Hence, forming a working alliance requires nurses to strive for a well-considered use of their professional power. Nurses should consciously use themselves, their knowledge, and relational processes (e.g., trust) in a way that opens doors for connecting and collaborating with patients as persons, and attuning to their needs and perspectives. To this end, the findings highlight the skills and qualities nurses employ to develop a working alliance, including being genuine and transparent and conveying closeness and support. Simultaneously, nurses should be reflective and self-aware, especially regarding their own emotions (e.g., anxiety), which can disturb their clinical judgement and make them act too controlling and instrumental. The findings also suggest that certain patient-related conditions, such as lack of trust and communication, and preoccupation with suicide plans, can reinforce the challenge for nurses to connect with patients and attune to their perspective. In view of

such challenges, previous literature highlighted the possibility of 'mutual withdrawal', where nurses and patients start to avoid each other (Coatsworth-Puspoky, Forchuk, & Ward-Greffin, 2006; Peplau, 1989).

The present study is one of few that have examined the interaction between the relational and clinical aspects of nursing practice. Consistent with previous research, the findings reflect core processes underpinning the nurses' clinical judgement, including getting to know patients as a person and being sensitively vigilant and attentive (Bowers et al. 2011; Cameron et al. 2005). Here, it should be noted that, opposed to conceptualisations in previous studies (Bowers et al. 2011), 'being sensitively vigilant and attentive' was not restricted to a focus on 'danger'. It also involves an ability to recognise needs and positive signs in patients, and to capture medical issues or information that could inform the patients' treatment plan.

In addition, nurses try to balance diverse, sometimes competing, roles and responsibilities. For example, some nurses refrained from using structured suicide risk assessment instruments because they believed that they hamper their focus on connecting with patients and attuning to their perspective. Others indicated that they conduct enhanced observations, but only in a way that conveys closeness and support to patients. These insights expand the evidence that a high emphasis on protection and containment interventions puts the nurses' focus on connectedness and attunement under pressure, and thereby undermines patients' relational and emotional needs (Berg et al. 2017; Hagen et al. 2017).

Simultaneously, at least for some nurses, the focus on connectedness and attunement may impede the systematic nature of their contributions to suicide prevention. Recognising suicidal ideation as a multidimensional and fluctuating phenomenon (Klonsky et al., 2016), one may argue that relying on relational processes (e.g. connection, trust) while refraining from systematic and structured assessment, is insufficient and may have adverse effects when it overshadows the nurses' attention to the realities of risk (Slemon et al. 2017). Toward a more integrative perspective, researchers call for combining clinical judgement with suicide risk assessment instruments (Cutcliffe, & Barker 2004; Runeson et al. 2017). Nurses can use assessment instruments in a way that facilitates meaningful conversations about suicide, and a shared understanding with patients about suicidal ideation, including risk and protective factors. Additionally, the findings suggest that evidence-based practices, such as safety planning and psychotherapy, can facilitate the collaborative and therapeutic orientation of nurses within the working alliance (Cahill et al. 2013; Cameron et al. 2005; Stanley & Brown 2012).

The findings also highlight the perceived impact of the working alliance. This understanding is crucial in the context of nursing, where nurses fight against invisibility, and lack clear articulation of their contribution to patient outcomes (Santangelo et al. 2018; Santos &

Amaral 2011). While nurses indicated that developing a working alliance can enhance their own potential (e.g. enhanced knowing and understanding), they also referred to the impact of the working alliance on patients and their interaction with patients. For example, nurses perceived that the working alliance could facilitate a shared sense of openness; function as a safety net; and reflect a space for patients to feel validated. The findings seem to align with patient experiences, indicating that forming connections with professionals facilitates the expression of suicidal ideation, and supports a sense of safety and security (Berg et al. 2017; Hagen et al. 2018). In addition, patients voice their desire to interact with nurses who genuinely care and listen, communicate acceptance and understanding, and adopt a collaborative stance. These elements in nurse-patient relationships can support patients' autonomy, inspire their hope, and provide 'contrary experiences' that help them think more positively about themselves (Cutcliffe et al. 2006; Vatne & Naden 2018). Simultaneously, the findings suggest that nurses have little attention for the involvement of supportive relatives, although this is central to patients' recovery of suicidal ideation (Sellin et al. 2017).

From a conceptual perspective, similarities and differences can be considered between the working alliance and other nurse-patient relationships. In addition to the distinction between the working alliance and the 'instrumental tie' mentioned above, the working alliance can also be associated with the 'therapeutic relationship'. Without being exhaustive and acknowledging the lack of patient perspectives, it seems that the foundational constructs of both relationships are similar, including regular interaction, mutual trust, interpersonal communication, and knowledge and understanding of the person (Forchuk & Reynolds 2000; Peplau 1989). Additionally, therapeutic relationships embody consistent interactions to support therapeutic progress in patients, where nurses assist patients to learn, generate self-understanding, and resolve their own mental health problems (Forchuk & Reynolds 2000; Peplau 1989). However, such a central therapeutic role was not voiced by the nurses. Rather, their perspective reflected that therapeutic activities occur within a care coordinating role, which includes multiple responsibilities for assessing and managing suicide risk. Moreover, the findings show that, within a context where a patient's life is at stake, nurses are sometimes more driven by preventative than therapeutic concerns.

From a conceptual perspective, similarities and differences can be considered between the working alliance and other nurse-patient relationships. In addition to the distinction between the working alliance and the 'instrumental tie' mentioned above, the working alliance can also be associated with the 'therapeutic relationship'. Without being exhaustive and acknowledging the lack of patient perspectives, it seems that the foundational constructs of both relationships are similar, including regular interaction, mutual trust, interpersonal communication, and knowledge and understanding of the person (Forchuk, & Reynolds, 2000; Peplau, 1989). Additionally, therapeutic relationships embody consistent interactions to

support therapeutic progress in patients, where nurses assist patients to learn, generate self-understanding, and resolve their own mental health problems (Forchuk, & Reynolds, 2000; Peplau, 1989). However, such a central therapeutic role was not voiced by the nurses. This may be explained by nurses' lack of orientation or capacity to support therapeutic progress in patients. Simultaneously, nurses were strongly involved in a coordinating role, including assessment, evaluation, and documentation. Whereas the findings suggest that nurses' coordinating activities are crucial in the multidisciplinary teamwork and can generate therapeutic effects (e.g., safety planning), they also show that overemphasis on coordinating activities undermines nurses' interpersonal engagement. Then, interactions with patients reflect an instrumental discourse to gather suicide-related information and steer decision-making, rather than a vehicle to be genuinely present, collaborate with patients, and support their therapeutic progress.

Hospital and ward leaders should create conditions that support nurses in developing a working alliance with patients experiencing suicidal ideation. This requires a 'complex intervention' as the working alliance encompasses an interaction between nurses' interpersonal qualities and skills, the clinical dimensions of care, and the care context (Craig et al. 2008). From this perspective, hospital and ward leaders should implement a recovery-orientated model of care, which embraces interpersonal and collaborative relationships, and makes the experiences of patients and their relatives the focal point of treatment (Barker & Buchanan-Barker 2011; Zugai et al. 2015). In addition, leaders have an important responsibility to promote teamwork and support so that it feeds constructively into the nurse-patient working alliance. The findings suggest that nurses need a safe and supportive environment wherein they feel empowered and are encouraged to discuss and reflect on their interactions with patients who experience suicidal ideation. They can benefit from support systems, such as debriefings, supervision, and reflection groups, which enable the critical reflection, emotional regulation, and open attitude necessary to centre their interactions on connecting with patients and attuning to their perspective (Lees et al. 2014; Hagen et al. 2017; Talseth & Gilje 2011). Likewise, factors that enable consistency in developing a working alliance should be considered, including available time and reasonable workloads (Zugai et al. 2015).

Limitations

This study lacks an integrative analysis of nurse and patient perspectives. The need to integrate both perspectives is underlined in the context of psychotherapy, where therapist and patient perceptions of the working alliance do not necessarily match (Horvath et al. 2011). More insight into patients' perspectives is especially needed to further investigate the

impact of the working alliance, because nurses' perceptions of favourable patient outcomes may not reflect patient perspectives.

In addition, the limitations of one-time semi-structured interviews must be considered. A longitudinal design consisting of repeated interviews with nurses would better illuminate how the working alliance develops over time. Furthermore, triangulation of data collection methods might have strengthened the study (Morse 2015). Additional participant observations would have been useful, for instance, to 'observe' how nurses use clinical skills and procedures and thereby elaborate the understanding of how nurses adapt their approach to assessing suicidal ideation to their relationship with patients. Acknowledging these potential limitations; that the data were approached through collaboration among multiple researchers is a strength, because this supported the conceptual density of the findings.

Furthermore, it should be known that this study was conducted in Flanders (Belgium), a region where the rates of psychiatric hospitalisation and suicide are among the highest in Europe (Mistiaen et al. 2019). These rates influence the organisational priorities of the Flemish mental healthcare. For example, the nurses' perspectives may have been influenced by the current reforms aimed at promoting person-centred mental healthcare (Mistiaen et al. 2019), supporting patient participation in psychiatric hospitals (Vandewalle et al. 2018), and implementing suicide prevention guidelines, which highlight the need for nurses to 'actively discuss suicide'. Reflecting these local evolutions, there is a risk that the sample particularly included nurses with more actual or perceived competence to talk about suicide and to collaborate with patients. This may affect the transferability of the findings, despite that, congruent with the study design, nurses were recruited from multiple wards at different geographical locations (Glaser, & Strauss 1967; Malterud 2001).

8.5. Conclusion

This study examined the working alliance from the perspective of nurses in psychiatric wards. The findings reveal that the working alliance is an interpersonal and collaborative relational process, underpinned by the core variable 'seeking connectedness and attunement with the person at risk of suicide'. Nurses highlighted the value of the working alliance in helping patients turn away from suicidal ideation and safeguarding them against suicide.

Forming a working alliance is not to be taken for granted. Whereas the working alliance is conceptualised as an interpersonal and collaborative process, nurses might also develop an instrumental tie with patients. This kind of relationship is fuelled by a narrow view on preventing suicide and it encompasses a—sometimes subtle—controlling and directing approach to patients. Thus, forming a working alliance requires nurses to carefully balance

the power dynamic in their relationships with patients, thereby opening doors to involve patients, connect with them as persons, and attune to their needs and perspectives.

The study's relevance also lies in integrating relational and clinical aspects of nursing practice. Nurses need adequate support and a range of skills and qualities to develop a working alliance. Moreover, the findings highlight the challenges and opportunities for nurses to integrate relational care with their contributions to suicide prevention and treatment of suicidal ideation. Complex interventions are needed to support advanced nursing practice, in which nurses assess, evaluate, and respond to patients' suicidal ideation in harmony with a commitment to connect with patients and attune to their perspective. Consequently, patients with suicidal ideation may feel truly listened to, understood, and acknowledged by nurses, and perceive that their relational and emotional needs are met.

References

Barker, P. & Buchanan-Barker, P. (2011). Myth of mental health nursing and the challenge of recovery. *International Journal of Mental Health Nursing*, 20, 337-344. doi.org/10.1111/j.1447-0349.2010.00734.x

Batty, G. D, Kivimäki, M., Bell, S. et al. (2018). Psychosocial characteristics as potential predictors of suicide in adults: an overview of the evidence with new results from prospective cohort studies. *Transcultural Psychiatry*, 8. doi.org/10.1038/s41398-017-0072-8

Berg, S. H., Rørtveit, K. & Aase, K. (2017). Suicidal patients' experiences regarding their safety during psychiatric in-patient care: a systematic review of qualitative studies. *BMC Health Services Research*, 17. doi.org/10.1186/s12913-017-2023-8

Berglund, S., Astrom, S. & Lindgren, B. M. (2016). Patients' experiences after attempted suicide: A literature review. *Issues in Mental Health Nursing*, 37, 715-726. doi.org/10.1080/01612840.2016.1192706

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research & Practice*, 16, 252-260. doi.org/10.1037/h0085885

Bowen, G. A. (2009). Supporting a grounded theory with an audit trail: an illustration. *International Journal of Social Research Methodology*, 12, 305-316. doi.org/10.1080/13645570802156196

Bowers, L., Dack, C., Gul, N., Thomas, B. & James, K. (2011). Learning from prevented suicide in psychiatric inpatient care: an analysis of data from the National Patient Safety Agency. *International Journal of Nursing Studies*, 48, 1459-1465. doi.org/10.1016/j.ijnurstu.2011.05.008

Brunero, S. J., Jeon, Y. H., & Foster, K. (2015). The journey of positioning self as both mental health nurse and qualitative researcher: a critical reflection. *Journal of Psychiatric and Mental Health Nursing*, *22*, 543-548. doi.org/10.1111/jpm.12238

Cahill, J., Paley, G. & Hardy, G. (2013). What do patients find helpful in psychotherapy? Implications for the therapeutic relationship in mental health nursing. *Journal of Psychiatric and Mental Health Nursing*, 20, 782-791. doi.org/10.1111/jpm.12015

Cameron, D., Kapur, R. & Campbell, P. (2005). Releasing the therapeutic potential of the psychiatric nurse: a human relations perspective of the nurse–patient relationship. *Journal of Psychiatric and Mental Health Nursing*, 12, 64-74. doi.org/10.1111/j.1365-2850.2004.00796.x

Coatsworth-Puspoky, R., Forchuk, C. & Ward-Greffin, C. (2006). Nurse-client processes in mental health: recipients' perspectives. *Journal of Psychiatric and Mental Health Nursing*, 13, 347-355. doi.org/10.1111/j.1365-2850.2006.00968.x

Craig P., Dieppe P., Macintyre S., Michie S., Nazarerth I. & Petticrew M. (2008). Developing and evaluating complex interventions: new guidance. *British Medical Journal*, 337, a1655. doi.org/10.1136/bmj.a1655

Cutcliffe, J. R. & Barker, P. (2004). The Nurses' Global Assessment of Suicide Risk (NGASR): developing a tool for clinical practice. *Journal of Psychiatric and Mental Health Nursing*, 11, 393-400. doi.org/10.1111/j.1365-2850.2003.00721.x

Cutcliffe, J. R., Santos, J. C., Kozel, B., Taylor, P. & Lees, D. (2015). Raiders of the Lost Art: A review of published evaluations of inpatient mental health care experiences emanating from the United Kingdom, Portugal, Canada, Switzerland, Germany and Australia. *International Journal of Mental Health Nursing*, 24, 375-385. doi.org/10.1111/inm.12159

Cutcliffe, J. R., Stevenson, C., Jackson, S. & Smith, P. (2006). A modified grounded theory study of how psychiatric nurses work with suicidal people. *International Journal of Nursing Studies*, 43, 791-802. doi.org/10.1016/j.ijnurstu.2005.09.001

Dierckx de Casterlé, B., Gastmans, C., Bryon, E. & Denier, Y. (2012). QUAGOL: a guide for qualitative data analysis. *International Journal of Nursing Studies*, 49, 360-371. doi.org/10.1016/j.ijnurstu.2011.09.012

Draucker, C. B., Martsolf, D. S., Ratchneewan, R. & Rusk, T. B. (2007). Theoretical sampling and category development in grounded theory. *Qualitative Health Research*, 17, 1137-1148. doi.org/10.1177/1049732307308450

Dunster-Page, C., Haddock, G., Wainwright, L. & Berry, K. (2017). The relationship between therapeutic alliance and patient's suicidal thoughts, self-harming behaviours and suicide attempts: A systematic review. *Journal of Affective Disorders*, 223, 165-174. doi.org/10.1016/j.jad.2017.07.040

Flückiger, C., Del Re, A. C., Wampold, B. E. & Horvath, A. O. (2018). The alliance in adult psychotherapy: A meta-analytic synthesis. *Psychotherapy*, 55*,* 316-340. doi.org/10.1037/pst0000172

Forchuk, C. & Reynolds, W. (2000). Clients' reflections on relationships with nurses: comparisons from Canada and Scotland. *Journal of Psychiatric and Mental Health Nursing*, 8, 45-51. doi.org/10.1046/j.1365-2850.2001.00344.x

Fowler, J. C. (2012). Suicide risk assessment in clinical practice: pragmatic guidelines for imperfect assessments. *Psychotherapy*, 49, 81-90. doi.org/10.1037/a0026148

Franklin, J. C., Ribeiro, J. D., Fox, K. R. et al. (2017). Risk factors for suicidal thoughts and behaviors: A meta-analysis of 50 years of research. *Psychological Bulletin*, 143, 187-232. doi.org/10.1037/bul0000084

Glaser, B. & Strauss, A. L. (1967). *The Discovery of Grounded Theory: Strategies for Qualitative Research*. Chicago, IL: Aldine.

Gysin-Maillart, A. C., Soravia, L. M., Gemperli, A. & Michel, K. (2017). Suicide ideation is related to therapeutic alliance in a brief therapy for attempted suicide. *Archives of Suicide Research*, 21, 113-126. doi.org/10.1080/13811118.2016.1162242

Hagen, J., Hjelmeland, H. & Knizek, B. L. (2017). Relational principles in the care of suicidal inpatients: Experiences of therapists and mental health nurses. *Issues in Mental Health Nursing*, 38, 99-106. doi.org/10.1080/01612840.2016.1246631

Hagen, J., Knizek, B. L. & Hjelmeland, H. (2018). Former suicidal inpatients' experiences of treatment and care in psychiatric wards in Norway. *International Journal of Qualitative Studies on Health and Well-being*, 13, 1461514. doi.org/10.1080/17482631.2018.1461514

Hallberg, L. R.-M. (2006). The 'core category' of grounded theory: making constant comparisons. *International Journal of Qualitative Studies on Health and Well-Being*, 1, 141-148. doi.org/10.1080/17482620600858399

Horvath, A. O., Del Re, A. C., Flückiger, C. & Symonds, D. (2011). Alliance in individual psychotherapy. *Psychotherapy (Chicago, Ill.)*, 48, 9-16. doi.org/10.1037/a0022186

Jobes, D. A. (2012). The Collaborative Assessment and Management of Suicidality (CAMS): an evolving evidence-based clinical approach to suicidal risk. *Suicide and Life-Threatening Behavior*, 42, 640-653. doi.org/10.1111/j.1943-278X.2012.00119.x

Jobes, D. A. & Joiner, T. E. (2019). Reflections on suicidal ideation. *Crisis*, 40, 227-230. doi.org/10.1027/0227-5910/a000615

Klonsky, E. D., May, A. M. & Saffer, B. Y. (2016). Suicide, suicide attempts, and suicidal ideation alliance. *Annual Review of Clinical Psychology*, 12, 307-330. doi.org/10.1146/annurev-clinpsy-021815-093204

Lees, D., Procter, N. & Fassett, D. (2014). Therapeutic engagement between consumers in suicidal crisis and mental health nurses. *International Journal of Mental Health Nursing*, 23, 306-315. doi.org/10.1111/inm.12061

McAllister, S., Robert, G., Tsianakas, V. & McCrae, N. (2019). Conceptualising nurse-patient therapeutic engagement on acute mental health wards: An integrative review. *International Journal of Nursing Studies*, 93, 106-118. doi.org/10.1016/j.ijnurstu.2019.02.013

Mistiaen, P., Cornelis. J., Detollenaere, J., Devriese, S., Farfan-Portet, M. I. & Ricour, C. Organisation of mental health care for adults in Belgium. Brussels: Belgian Health Care Knowledge Centre. Avaliable at: kce.fgov.be/content/about-copyrights-for-kce-publications [Accessed: 22 October 2019]

Morse, J. M. (2015). Critical analysis of strategies for determining rigor in qualitative inquiry. *Qualitative Health Research*, 25, 1212-1222. doi.org/10.1177/1049732315588501

Peplau, H. E. (1989). *Interpersonal theory in nursing practice: Selected works of Hildegard E. Peplau*. New York: Springer Publishing Company.

Phillippi, J. & Lauderdale, J. (2018). A guide to field notes for qualitative research: Context and conversation. *Qualitative Health Research*, 28, 381-388. doi.org/10.1177/1049732317697102

Runeson, B., Odeberg, J., Pettersson, A., Edbom, T., Jildevik Adamsson, I., & Waern, M. (2017). Instruments for the assessment of suicide risk: A systematic review evaluating the certainty of the evidence. *Public Library of Science One*, 12, e0180292. doi.org/10.1371/journal.pone.0180292

Santangelo, P., Procter, N. & Fassett, D. (2018). Mental health nursing: Daring to be different, special and leading recovery-focused care? *International Journal of Mental Health Nursing*, 27, 258-266. doi.org/10.1111/inm.12316

Santos, J. C. & Amaral, A. F. (2011). Effectiveness of psychiatric mental health nurses: can we save the core of the profession in an economically constrained world? *Archives of Psychiatric Nursing*, 25, 329-338. doi.org/10.1016/j.apnu.2011.03.005

Sellin, L., Asp, M., Wallsten, T. & Wiklund Gustin, L. (2017). Reconnecting with oneself while struggling between life and death: The phenomenon of recovery as experienced by persons at risk of suicide. *International Journal of Mental Health Nursing*, 26, 200-207. doi.org/10.1111/inm.12249

Slemon, A., Jenkins, E. & Bungay, V. (2017). Safety in psychiatric inpatient care: The impact of risk management culture on mental health nursing practice. *Nursing Inquiry*, 24. doi.org/10.1111/nin.12199

Stanley, B. & Brown, G. K. (2012). Safety planning intervention: A brief intervention to mitigate suicide risk. *Cognitive and Behavioral Practice*, 19, 256-264. doi.org/10.1016/j.cbpra.2011.01.001

Talseth, A. G. & Gilje, F. L. (2011). Nurses' responses to suicide and suicidal patients: a critical interpretive synthesis. *Journal of Clinical Nursing*, 20, 1651-1667. doi.org/10.1111/j.1365-2702.2010.03490.x

Talseth, A. G. & Gilje, F. L. (2018). Responses of persons at risk of suicide: A critical interpretive synthesis. *Nursing Open*, 5, 469-483. doi.org/10.1002/nop2.169

Turecki, G. & Brent, D. A. (2016). Suicide and suicidal behaviour. *The Lancet*, 387, 1227-1239. doi.org/10.1016/S0140-6736(15)00234-2

Vandewalle, J., Beeckman, D., Van Hecke, A., Debyser, B., Deproost, E. & Verhaeghe, S. (2018). Patient safety on psychiatric wards: A cross-sectional, multilevel study of factors influencing nurses' willingness to share power and responsibility with patients. *International Journal of Mental Health Nursing*, 27, 877-890. doi.org/10.1111/inm.12376

Vatne, M. & Naden, D. (2018). Experiences that inspire hope: Perspectives of suicidal patients. *Nursing Ethics*, 25, 444-457. doi.org/10.1177/0969733016658794

Watson, J. (1979). *Nursing: The philosophy and science of caring.* Boston: Little, Brown.

Wiechula, R., Conroy, T., Kitson, A. L., Marshall, R.J., Whitaker, N., & Rasmussen, P. (2016). Umbrella review of the evidence: what factors influence the caring relationship between a nurse and patient?. *Journal of Advanced Nursing*, 72, 723–734. doi.org/10.1111/jan.12862

Zalsman, G., Hawton, K., Wasserman, D. et al. (2016). Suicide prevention strategies revisited: 10-year systematic review. *The Lancet Psychiatry*, 3, 646-659. doi.org/10.1016/S2215-0366(16)30030-X

Zugai, J. S., Stein-Parbury, J. & Roche, M. (2015). Therapeutic alliance in mental health nursing: an evolutionary concept analysis. *Issues in Mental Health Nursing*, 36, 249-257. doi.org/10.3109/01612840.2014.969795

Chapter 9: General discussion

The overarching objective of this dissertation was to better understand the interpersonal interactions and relationships in the context of providing nursing care for persons with suicidal ideation. The studies provide insights that have an essential place in the knowledge base of nursing care, and can be used to inform meaningful reform in inpatient mental healthcare, and in suicide prevention and the treatment of suicidal ideation.

The first two studies provide valuable data on patient participation as an important topic in mental healthcare (Chapters 2–3). The four subsequent studies focus on understanding nurse-patient interaction from the perspective of nurses and persons with suicidal ideation (Chapters 4–7). The final study provides insights into the working alliance with patients experiencing suicidal ideation from the perspective of nurses (Chapter 8).

These studies highlight several dynamics, processes, concepts, and factors that are at the core of nurse-patient interactions and relationships. This general discussion addresses four issues: connecting the perspectives of nurses and persons with suicidal ideation; micro-, meso-, and macro-level factors that mediate the nature of nurse-patient interactions; methodological considerations; and recommendations for clinical practice and policy, education, and further research.

9.1. Connecting nurse and patient perspectives of their interactions and relationships

This section addresses three key dynamics in nurse–patient interaction from the nurse and patient perspective: the nature and role of different approaches in the nursing practice, the lack of an integrative perspective in the nursing practice, and the nurturing potential of nurse–patient interactions and relationships.

9.1.1. Considering the nature and role of different approaches in the nursing practice

A key insight derived from the studies of nurses and persons with suicidal ideation is that **two main approaches can be identified in nursing practice**. From a conceptual perspective, some nurses are more oriented towards acknowledging patients and connecting and collaborating with them as unique and self-determining individuals, while others are more oriented towards checking, controlling, and directing patients as ‘risk objects’ that need to be managed.

The approach based around **acknowledging patients and connecting and collaborating with them as unique and self-determining individuals** reflects an interpersonal engagement. This engagement is grounded in interpersonal processes, such as being genuinely present with patients, validating their emotions, getting to know them as individuals, and attuning to patients' perspectives. Persons with suicidal ideation (Chapters 6–7) underscore the value of such an interpersonal engagement. They want to interact with genuine nurses who care for and acknowledge them as unique individuals; nurses who meet their basic needs, connect with them, and try to accept and understand what they are going through. Moreover, they stress the value of sensitive nurses who enable them to voice their thoughts, feelings, and needs, for example by conveying openness and inviting them to dialogue.

Other nurses were more oriented on **checking, controlling, and directing patients as 'risk objects' that need to be managed.** The studies underline that nurses can be strongly oriented on performing practical tasks, gathering information about suicide risk, and controlling suicide risk by acting in accordance with surveillance and containment-oriented procedures. Based on the analyses, their interactions with patients served an instrumental function (for example, building conversations towards 'hearing what we must hear') rather than an orientation on interpersonal contact and genuine collaboration (Chapters 4-8). The checking, controlling, and directing approach in nursing is also highlighted in the perspective of patients with suicidal ideation. Patients often think of themselves as being in a 'system' where they have no voice or choice. They feel powerless in interactions with nurses, caused by nurses' verbal and non-verbal expressions, or by nurses who keep them under observation, impose restrictions on them, or control aspects of daily living (e.g. dismissing a patient's request to go jogging). Moreover, patients perceive that some nurses are distant or only approach them with an emphasis on diagnosis and suicide risk (Chapter 6).

The main approaches were often not readily observable in the interviews with nurses. In fact, commonly verbalised efforts, such as 'talking about suicide' and 'making agreements' sometimes represent **'hidden' mechanisms to control patients, achieve patient compliance, and ensure continuity of clinical routines** (Chapter 8). Making agreements or 'making deals' (Morrissey and Higgins 2019) is sometimes used as a professionally-oriented, defensive strategy to control patients and protect oneself, rather than as an attempt to engage patients in shared decision-making. Such defensive strategy involves subtle processes of persuasive communication through which nurses convert patients to believe in and accept their viewpoints on how to ensure safety (Chapter 8). This perspective on persuading patients is also seen in the subtle ways through which nurses implement and communicate about procedural practices. Nurses sometimes try to remediate the intrusive character of procedures, for instance, by involving patients in the decision-making about

restrictions or by explaining to patients how procedures contribute to safe and effective care (Chapters 4 and 8). While some nurses merely stress these issues to preserve the functional course of clinical routines, others do this as part of a genuine effort to explore patient's needs, connect with patients, and attune to their perspective.

The hidden mechanisms in nurse-patient interaction can be related to **the concept of 'invisible power'**, as described by Cutcliffe and Happell (2009). These authors indicate that manifestations of power are present in verbal and non-verbal acts to exercise control. Nurses must be sensitively attentive to such 'invisible power'. This reflection was already made in the study on patient participation in Chapter 3 when explaining the positive self-reports of nurses about their willingness to share power and responsibility with patients concerning patient safety. These positive responses could reflect a genuine effort to engage patients in collaborative risk management, but equally, could reflect an orientation on avoiding risks and keeping control. Such hidden mechanisms of exercising power seem to impede nurses' capacity to connect with and attune to patients through genuine listening and understanding (Chapters 4-8). More importantly, this reduces patients to risk objects with limited opportunities to express themselves, participate in their care and treatment, or develop self-management (Felton et al. 2018, Fitzpatrick and River 2018).

A key consideration in respect to the 'two main approaches' is that **nurses should carefully and consciously use their professional power**, including their professional views, skills, knowledge, and expertise. The findings suggest, for instance, that nurses influence and control the direction of conversations about suicide and the agreements they make with patients about safety. **Nurses can use this power position in a way that they decide about what is or what is not allowed to be discussed or negotiated**. For example, in Chapter 4, nurses appeared to constrain the level of patients' choice and involvement in relation to decisions about restrictions and ward leave. Others indicated that they interrupt conversations when patients share repeated expressions of hopelessness and then focus on offering quick solutions. However, this way of steering the conversation will likely preclude nurses from hearing, understanding and responding to what patients want to share with them. This, in turn, leaves patients in a dependent position and constrains their opportunities to communicate and explore their suffering, and as a result to feel recognised, relieved, and understood (Cutcliffe and Happell 2009). This aligns with the Tidal model of Barker (2003, p. 100) which attempts to address directly 'the most common form of disempowerment – the failure to afford a proper hearing to the personal story of the experience of problems of living'.

In contrast, nurses can **use their power position in a way that lays the foundation for an interpersonal and collaborative relational process**. The findings suggest that nurses can present themselves in a way that they convey openness, listen to patients, enable patients to

express themselves, and facilitate negotiation and collaboration. Their way of engaging with patients can open doors to involve patients in shared decision-making, connect with them as persons, attune to their needs and perspectives, and enable them to take responsibility (Chapters 4, 5, 6, 8). According to Zugai and colleagues (2015) the **power dynamic in nurse-patient relationships can have a therapeutic merit** provided that nurses place the patient's needs at the forefront of their attention and concern, and that their power and influence is carefully directed to facilitate patients leading their own recovery. Considering this from Peplau's theory of interpersonal relations (Peplau 1997), nurses' power position can be therapeutic, not through providing instant solutions or instructing patients what to do, but through demonstrating a capacity to investigate what patients share with them and provide input that helps them to generate greater self-understanding. Then, patients might gradually assume a more independent position because they are enabled in their ability to learn about and solve their problems, and (re)gain a sense of control about their suicidal feelings, thoughts, and behaviours (Cutcliffe and Stevenson 2008).

The constraining or enabling effects of **power were also seen in the way nurses perform specific interventions**. Whereas nurses could elaborate safety and crisis response plans 'with' patients to support patients' insights about coping with suicidal ideation (e.g. through early recognition of warning signs), they could also elaborate safety and crisis response plans 'for' patients in which they incorporate professionally-informed strategies to protect or distract patients (Chapters 4 and 8). These insights reflect that constraining effects of power are not only related to medical interventions. Indeed, in the study of Verbeke and colleagues (2019), former patients in Flemish psychiatric hospitals indicated that they sometimes felt approached by mental health professionals who **abused their power by imposing coercive acts and treatment regimens** on them. This aligns with a recent study with patients who experience suicidal ideation, indicating that nurses might implement therapeutically-intended interventions as a 'professional logic' that is imposed on patients (Vandewalle et al. 2020b; unpublished results). In this respect, the patients perceived that nurses appeared to 'test' or 'push them', or 'use tactics' to learn more about their suicidality without first attempting to make contact from person to person. Simultaneously, some patients expressed that they valued nurses who took the time to listen and empathise with their feelings, yet, at the same time they wanted to interact with nurses who enabled them in challenging their suicidal ideation (Vandewalle et al. 2020b; unpublished results).

Overall, the identification of these two main approaches deepens the insight raised in previous works. Summarised, these approaches are focused on 'connection and care' versus 'duty and control' (Hagen et al. 2017) and on 'engagement and hope inspiration' versus 'observation' (Cutcliffe and Barker 2002). It is important, however, to reason beyond such dichotomous conceptualisation. Indeed, while this dissertation shows that the main

approaches represent other viewpoints from the nurse and patient perspective in relation to their interactions, it also indicates that **the approaches are, to a certain extent, intertwined**. For example, some nurses shift easily toward a controlling approach when they perceive a heightened suicide risk in patients (Chapter 3). Simultaneously, conflicts between the approaches are highlighted, such as when nurses express concern regarding defensive practices (such as door-locking) that potentially impede their ability to be genuinely present with patients (Chapter 4). Therefore, a closer look into the two main approaches is important in relation to risk assessment and management practices. This is elaborated further below.

9.1.2. The lack of an integrative perspective in the nursing practice

Another overarching insight developed throughout this doctoral study is that there is a lack of an integrative perspective in the nursing practice.

Within this view, the first issue to consider is the difficulty for nurses to **embed practices for suicide risk assessment and management within a foundation of interpersonal engagement and vice versa**. The qualitative studies suggest that nurses might not always evaluate suicidal ideation in a process-oriented and structured manner. Some nurses express reluctance toward standardised assessments or believe that it is not necessary to assess suicide risk on a regular basis. For example, in Chapter 8, nurses indicate that they do not undertake suicide risk assessments when they do not yet have a connection with the patient, or, contrarily, when they have a connection with the patient and assume that this will support the patient to approach and talk with them when needed. Additionally, some nurses refrain from using assessment instruments, because, according to them, this reflects a formal approach that is incongruent with their orientation on acknowledging and connecting with the patient as a person.

These insights raise the question of whether nurses can **effectively respond to a patient's suicidal ideation** without a process-oriented and structured evaluation of the person's suicidal ideation? This question is fueled by the knowledge that suicidal ideation is a complex process that can fluctuate hourly (Kleiman et al. 2017) and is subject to multidimensional influences (Van Orden et al. 2010). Against this backdrop, one might argue that solely relying on interpersonal processes, such as trust and connectedness, may have adverse effects when it overshadows nurses' attention to the realities of risk (Slemon et al. 2017). Within this understanding, contemporary practice guidelines and approaches indicate that repeated assessments and assessment instruments are useful provided that they are used within a therapeutic framework that emphasises a collaborative assessment and treatment planning process (Jobes 2012, Higgins et al. 2015).

Indeed, suicide prevention **guidelines do not support the use of suicide assessment instruments as a stand-alone intervention** because they lack sensitivity and specificity to inform clinically useful decision-making (Aerts et al. 2017). Moreover, this dissertation suggests that nurses easily implement instruments as part of a checking approach in which they have a reductionistic focus on risk factors and categorising patients into risk categories (Chapter 4). Such a reductionistic and categorising focus is often reinforced by risk assessment formats that do not adequately voice the patient's perspective or promote a truly comprehensive assessment by exploring a patient's abilities, strengths, and hopes (Wand et al. 2020).

Within this context, this dissertation shows that the most important aspect of suicide risk assessment is an **open, sensitive, and personalised contact to discuss suicide** (Chapters 5-7). Such a contact is essentially underpinned by building trust, active listening, understanding, emotional support, and initiating conversations about suicide. These aspects in contact can contribute to a safe atmosphere, in which patients can approach nurses and feel enabled to explore their needs, and narrate their suicidal thoughts, feelings, and experiences (Chapter 6-7). Nurses highlight that when patients can communicate in an open and genuine way, they are able to get to know patients, can assess suicidal ideation, and also identify risk and protective factors (Chapter 5).

An open, sensitive, and personalised contact provides a basis for a **structured clinical judgement**, in which nurses meaningfully combine the use of assessment instruments with their clinical judgement (Higgins et al. 2015). Regarding this clinical judgement, the findings stress the relevance of the nurses' sensitivity for suicide cues, as well as for patient's needs and positive signs. For example, some nurses refer to their ability to intuitively feel emerging suicidal ideation in patients without observing concrete warning signs (Chapter 5). This ability seems to align with the value that patients attach to nurses who recognise their emotional distress and disturbing thoughts. Patients indicate that such sensitive involvement of nurses enables them to express their thoughts and feelings. However, patients also report that some nurses are not sensitive (such as when they minimise their feelings) or give them no chance to speak about their suicidality. This, in turn, appeared to intensify their challenges to discuss suicide, including shame, lack of trust, and stigma-related concerns (Chapter 6).

The findings also show different nuances in the way **suicide risk management practices are implemented in nurse-patient interaction**. Chapter 4 emphasises that safety and crisis response plans could be underpinned by paternalistic aims. Then, based on their professional assessments, nurses use a directive style to impose input for safety plans with the intention to protect patients from harm or correct their hopelessness (such as by incorporating distracting activities into the safety plan). However, using safety planning in such a way is unlikely to have the intended self-management outcomes for patients,

including enhancing a patient's capacity to respond to a suicidal crisis and become aware of warning signs (Stanley & Brown 2012). This is because a nurse's directive style is contradictory to the collaborative treatment approach to suicidal ideation, where negotiating shared responsibilities, collaborative decision-making, and assisting patients in developing self-understanding and coping strategies are the primary focus (Jobes 2012). Without this focus on collaboration, safety planning only serves professional and institutional interests and is not necessarily more therapeutic than a no-suicide contract, which is a strongly discouraged practice whereby patients pledge not to harm themselves (Bryan et al. 2017, McMyler & Pryjmachuk 2008).

Reflecting a more **interpersonal engagement approach**, there are nurses who do not initiate restrictive practices, such as door-locking, or who only want to use such practices in a way that still allows patients to feel a sense of human interaction. For example, these nurses try to convey closeness and support to patients while conducting observations or when attending to patients in a locked room (Chapters 3 and 8). In the presence of such interpersonal engagement, patients express feelings of safety and security during formal observations (Chapter 6). Moreover, according to Lindgren and colleagues (2019), when nurses engage interpersonally with patients during seclusion, this may remediate the objectifying and alienating nature of this intervention, and even make it a 'sheltered experience'.

However, in the absence of interpersonal engagement, the **counterproductive effects of practices such as observation, restraint, and seclusion** are emphasised. Then, patients report that observation is the intrusive, impersonal experience of 'being watched'; nurses increase their distrust by searching their belongings; and being put in seclusion is a disempowering, humiliating, and punishing experience (Hawsawi et al. 2020). Closely related to these insights, the findings from a nurse and patient perspective highlight the potential **counter-reactions of patients in response to controlling and restricting interventions.** Patients sometimes lose trust in nurses, become agitated, or begin to conceal their suicidal ideation to avoid or stop the controlling and restricting interventions (Chapter 4). These counter-reactions may be partly explained by Bowers' Safewards model (2014), which provides explanation of how conflicts, such as a patient's suicidal behaviour, may trigger containment (such as seclusion, restraint, or observation) and, in turn, how containment may induce further conflict. According to this model, choosing not to use containment is most often the better option.

However, while coercion as a standard approach is considered malpractice (Superior Health Council 2016a), nurses may come to a point where they should use **protective interventions as a last resort to maintain safety.** In Chapter 6, patients referred to periods during which they felt unsafe from their 'suicidal impulses' or neglected their own basic needs

(such as food intake). Moreover, in Chapter 8, nurses perceived that patients may be so preoccupied with suicidal plans that it is impossible to collaborate with them. In such circumstances, nurses may perceive it necessary to temporarily take control and use protective measures to assist patients in preventing imminent suicide risk. Reflecting the rudiments of trauma-informed care (Muskett 2014), such initiatives must reflect a focus on creating physically and emotionally safe environments that maximise interpersonal interactions (such as ongoing emotional support) and which are responsive in maintaining and returning patients' self-determination and control to the greatest degree possible.

This section, which emphasises the lack of an integrative perspective in the nursing practice, ends with some considerations about the **potential lack of a holistic perspective on the needs of patients.** First, the studies offer indications that nurses might not be attentive or provide support for a person's physical health or lifestyle. In Chapter 6, individuals with suicidal ideation referred to their need for personal hygiene, food, sleep and rest, fresh air, and physical activity. They expressed positive and negative experiences regarding the investment of nurses to support these needs. While some nurses were attentive and supportive toward their physical needs, others neglected these needs or addressed them without any effort to engage on a personal level. In comparison, in the nurse perspective, there was little evidence regarding the support of patients' psychical care needs (Chapters 4, 5, and 8).

These observations warrant attention, given the strong interaction between a patient's physical health, lifestyle, and mental health problems (De Hert et al. 2011) and evidence that a deficiency of food, exercise, or sleep is associated with suicidality (Littlewood et al. 2018, Vancampfort et al. 2018). Furthermore, in this dissertation, there is little evidence of explicit efforts of nurses to meet a patient's social needs. From this perspective, it was seen that nurses might not actively involve a patient's relatives. While nurses may refer to 'family' as a topic of conversation with patients, only a minority of nurses express that they actively motivate family members' involvement. For example, some involved family members to incorporate their impressions of the patient into risk assessments or to support the safe coordination of the patient's ward leave (Chapters 4, 5, and 8). This issue is elaborated further in the section 'Recommendations for clinical practice and policy'.

9.1.3. The nurturing potential of nursing: addressed to a variable extent

Further connecting nurse and patient perspectives, nurse-patient interactions and relationships can be considered for the **'nurturing potential'** they represent. Nurturing is a central construct in nursing. In her theory of interpersonal relations, Peplau (1997) asserted that nurses have, as a primary responsibility, 'nurturing patients in their personal

development'. Additionally, Watson (1997), in her theory of human caring, described nurturing as a process of caring and healing created in and through interpersonal nurse–patient relationships. More recently, within their inquiry on 'what makes an excellent mental health nurse', Gunasekara and colleagues (2014) concluded that nurses should attend more to the basics of relationships so they can nurture the processes that enable patient recovery.

This dissertation provides insights concerning the nurturing potential of nurses' interactions with patients who experience suicidal ideation. Based on discussions in the research team, two interconnected dimensions of nurturing are distinguished: **'nurturing as caring'** and **'nurturing as healing'** (Deproost 1995, 2018). These dimensions are best understood as a dynamic process in which the fundamentals of caring interact with processes to support a patient's healing, including aspects of change, development, and growth. In what follows, the caring and healing dimensions of nurturing, as well as their interaction, are discussed. This discussion includes critical reflections about the vital importance of a caring and healing orientation, as well as the variable extent to which this orientation is addressed in the nursing practice. Simultaneously, readers should know that this discussion is not meant to be exhaustive nor does it represent a prescriptive format that accounts for (or must be strived for in) every nurse-patient interaction. This would do injustice to the complexities of nurse-patient interaction and the patient's experience of suicidal ideation.

Nurturing as caring reflects fundamentals in nurse-patient interaction. Foremost, the findings stress the importance of **enabling patient's sense of being acknowledged as a person**. To this end, the findings indicate a need for care that is underpinned by treating the person with respect and dignity, conveying openness (such as through listening and showing interest and kindness), expressing compassion and empathy, and communicating acceptance and understanding. Moreover, patients value nurses who are genuine, express their belief in them, provide comfort, and support their basic needs.

However, in Chapter 6, it was highlighted that patients may develop a **sense of not being acknowledged as a person** by nurses. Essentially, this represents the experience of interacting with nurses who demonstrate non-caring, judgemental, and impersonal attitudes. The patients dealt with nurses who were distant, did not listen (or not in ways they felt taken seriously), approached them as 'a risk object', and sometimes even condemned their suicidality. When converging these findings with the 'main approaches' discussed previously, it is suggested that nurses' emphasis on checking, controlling, and directing patients can induce in patients a sense of not being acknowledged as a person.

These insights reflect that **patients are highly vulnerable to the nurses' responses and sensitive to their attitudes.** This has important implications for the nurturing potential of nurse-patient interaction. Indeed, patients can encounter 'mirror experiences' or 'contrary experiences' in their interactions with nurses (Chapter 6). Mirror experiences reflect the

insight that nurses with non-caring, judgemental, and impersonal attitudes might perpetuate or reinforce patients' perceptions that nobody cares about them and exacerbate their feelings of isolation, burdensomeness, and hopelessness. Simultaneously, this deteriorates their interaction with nurses; they lose trust in nurses, become silent, withdraw, and are reluctant to seek help.

In contrast, nurses who demonstrate genuine care, acceptance, and understanding might enable contrary experiences in patients. In this case, patients can develop a sense of being cared for and acknowledged, which counters their feelings of isolation, burdensomeness, and hopelessness and creates a basis for developing more realistic and positive views about themselves and their lifeworld (Chapter 6). These contrary experiences of patients may be partly related to what, from a nurse perspective, is conceptualised as 'reflecting a space for patients to feel validated' (Chapter 8). Nurses indicate that a focus on connectedness and attunement could convey the message to patients that, after all, they may have some worth and meaning as a person. Previous research underscores the nurturing potential of enabling contrary experiences, indicating it as one of the psychosocial processes through which nurses help individuals move from a 'death-oriented' to a 'life-oriented' position (Cutcliffe et al. 2006).

Nurturing as caring interacts closely with **enabling a space for patients to feel safe and secure**. Patients indicate that nurses' encouragement to attend to their own basic needs (such as the need for rest) could make them feel stabilised and secure, and enable them to find a vital rhythm in life (Chapter 6). Moreover, some patients refer to the importance of physical protection to make them feel safe and secure from their 'suicidal impulses'. However, more often, patients indicate that the protective interventions enforced by nurses makes them feel less safe and secure (Chapter 6). This paradoxical effect can be explained by the insight that, when protective interventions compromise patients' emotional and relational needs, they may increase their emotional insecurity and trigger a sense of mistrust and disempowerment (Berg et al. 2017, Björkdahl et al. 2010). Thus, following the critical reflection of Cutcliffe and Stevenson (2008), what the present text considers as 'caring', is not synonymous with practices that are primarily concerned with observing, restraining, and secluding patients.

Conversely, patients refer to the value of nurses' psychical and emotional closeness, which makes them feel less anxious and more secure in moments of loneliness. This refers to nurses who express genuine concern for them, validate their feelings, and recognise their emotional distress. Thus, feelings of safety and security are promoted by nurses who provide sensitively attuned care (McAndrew et al. 2014). Sensitively attuned care interacts closely with **enabling a patient's self-expression of personal needs, experiences, and suicidal ideation.** The sensitive and genuine involvement of nurses enables a safe atmosphere,

thereby promoting a sense of trust for approaching nurses and expressing themselves. This, in turn, may facilitate experiences of relief and alleviated suffering (Chapters 6). These perceptions of 'a safe atmosphere' seem to align with the nurses who express that their commitment to seek connectedness and attunement with patients could enable openness in communication and represent a 'secure base' to hold onto during crisis situations (Chapter 8). However, patients also refer to nurses who dismiss or minimise their feelings, and thereby do not take their perspective of suffering into account. This creates a sense of mistrust and disempowerment, and the perception of not being able to share their pain and suffering with nurses (Chapter 6).

Furthermore, **facilitating meaningful patient participation** appears to be central to the nurturing potential of nurse–patient interaction. Aspects of patient participation such as dialogue, information-sharing, and transparency on expectations are central in PaCT-PSY and CoNuPaS (Chapters 2 and 7). Facilitating patient participation also plays an important role in the working alliance. Nurses try to attune to the patients' perspective by engaging them in dialogue within the process of 'bridging difficult moments together' (Chapter 8). Similarly, patients value being included in their care and treatment. This is in reference to nurses who invite them for dialogue, are open to their opinions, inform them about treatment options, and enable choice about aspects of their daily living. This interaction gives patients opportunities to feel reassured, (re)gain control, and it triggers a sense of being seen and taken into account. However, patients were often left disempowered by nurses in decision-making about their care, treatment, and aspects of daily living (Chapter 6). Regarding such contrasting findings, research indicates patient participation can have an empowering and hope-generating effect, provided that it supports patients in having choice, exercising self-determination, and taking personal responsibility (Sellin et al. 2017, Vatne & Naden 2018).

The insights discussed above present an argument for understanding **caring as a foundation for healing** (Deproost 1995, 2018). From this standpoint, caring has a pivotal role in stimulating an openness for change, development, and growth. Here, this pivotal role is briefly considered in relation to the patient, the nurse, and the nurse-patient interaction. Regarding the patient, the findings suggest that the care provided by nurses can alleviate a patient's distressing emotions (e.g. relieve anxiety), create a 'spark of hope', and enable patients to give voice to themselves in an atmosphere of connectedness (Chapter 6). Perceiving these processes as pivotal accords with theoretical understandings in nursing that anxiety management, narrative (e.g. putting words to experience), and connection are fundamental to a patient's ability to learn and develop oneself (Peplau 1997, Wheeler 2011). Regarding the nurse, the provision of care can enable a process of getting to know patients as individuals and how they give meaning to their suicidal ideation. According to Cameron

and colleagues (2005) this process is a prerequisite for creating a shared understanding of patients' experiences and essential to nurses' therapeutic potential. Finally, regarding nurse-patient interaction, caring is pivotal for healing because it can foster interpersonal experiences of trust and engagement in nurse-patient interaction. Such experiences are fundamental for collaborative interaction (Delaney et al. 2017).

Nurturing as healing includes a focus on **helping patients to cope with and make sense of themselves and their suicidality.** A number of nurses engage in conversations with patients to support them in identifying and organising their suicidal thoughts and feelings. Similarly, some nurses indicate that they explore warning signs and coping strategies with patients, sometimes as part of safety and crisis response planning. They believe that this could help patients to recognise emerging suicidal ideation (such as through understanding triggers and warning signs) and thereby increase their capacity to respond to a suicidal crisis. Also, some nurses explain their experience that subtle processes, such as demonstrating genuine concern for patients, might raise a patient's awareness of their suicidal ideation (Chapters 4 and 8).

Patients positively reflect on the **nurturing space they experience when nurses talk with and question them** in a way that stimulates discussion about their feelings and coping strategies toward suicide. They indicate that these conversations—when accompanied by emotional support—provide a space to explore their difficulties and to gradually develop constructive coping strategies (Chapter 6). When converging these insights with the nurses' perspectives, it appears that nurses may listen to patients and enable them to narrate their thoughts, feelings, and experiences. However, nurses seem to lack an orientation or capacity to investigate what patients share with them and provide input that helps them to generate greater self-understanding (Peplau 1997). Indeed, a large number of nurses do not use conversations as a vehicle to support therapeutic progress in patients. Rather, conversations are a means to develop a picture of patients that informs their coordinating activities (like documentation) or preventative actions (such as assigning risk levels to patients) (Chapter 8).

Nurturing as healing is also related to **engaging (with) patients in collaborative decision-making about their own safety.** Nurses engage with patients in dialogue that facilitates an understanding of risks and potentially risky situations and what can be done to address risks. For instance, while nurses might dismiss a patient's request to go outside (Chapter 6), there were other nurses who engage with patients in dialogue as a means to prepare and support ward leave. They believed that by giving trust to patients to take such steps, as opposed to 'taking all responsibilities away', they preserve opportunities for patients to maintain control and still have positive experiences (Chapters 4 and 8). Such findings also suggest that a

nurturing potential lies in striving for a judicious balance in the use of protective interventions. This perspective was central in Chapter 8, where nurses were concerned with 'leaving the door open for positivity and change'.

However, nurses' efforts to **promote change in patients is not always based on collaborative interaction**. As noted previously, nurses sometimes used safety and crisis response planning as a tool to direct patients on what to do or how to feel during suicidal crises, and this clearly does not support a patient's self-management (Stanley & Brown 2012). Moreover, patients perceive that some nurses do nothing more than suggesting sedatives, communicating quick advice, or directing them to distract themselves from suicidal ideation (Chapter 3). While patients suggest that interventions with a focus on distraction might have value, they often expect a more enduring and constructive form of assistance from nurses (Chapter 6).

Besides the hope nurtured within the caring processes, nurses often have a more explicit focus on **fostering hope in patients and helping to ameliorate their hopelessness**. Some nurses are oriented on inspiring hope through interpersonal interaction. They attend to the patients' narrative by showing interest, expressing their belief in patients, acknowledging positive signs, and involving in sensitive listening and probing to facilitate the expression of 'sparks of hope' (Chapters 4-5). Moreover, some nurses focus on nurturing meaningful perspectives by encouraging patients' sense of meaningful activity or by establishing encouraging conversations (such as talking about meaningful topics). Also, nurturing meaningful perspectives is supported by **'**little things', such as a daily greeting or the use of humour (Chapters 4-8). Furthermore, patients indicate that nurses can inspire hope in them by facilitating their access to peer groups in the community or activities that help them to regain a sense of competence (Chapter 6). In line with contemporary conceptual understandings, it seems that such subtle processes and 'little things' in nurse-patient interaction represent a potential to enable patients to attribute new purpose and meaning to life (Leamy et al. 2011, Martela and Steger 2016).

However, nuances should be considered. A number of nurses appear to be concerned with explicit efforts to **correct a patient's hopelessness**, such as inventorying hopeful elements and distracting patients by encouraging physical activity. Moreover, some nurses interrupt conversations when patients share repeated expressions of hopelessness and then offer 'quick solutions'. This seems to align with the research of Morrissey and Higgins (2019, p. 952), who found that some nurses are pre-occupied with 'instilling hope'. Then, nurses work hard to find something for patients to hang onto, but simultaneously, do not truly attend to the patients' feelings of hopelessness. Such instrumental approaches with focus on instilling hope or correcting hopelessness warrant attention.

According to Cutcliffe and Barker (2002, p. 617), hope is inspired by the presence of the nurse as a human being who demonstrates acceptance and understanding. Moreover, they indicate: 'hope cannot be forced; it should be inspired in subtle and unobtrusive ways rather than through explicit efforts'. This potential of 'forcing hope' was seen in the perspective of nurses. Some even expressed uncertainty regarding the appropriateness of their attempts to foster patients' hope or indicated that explicit efforts to foster hope could evoke agitation or disappointment in patients when they do not match patients' preferences or lack realism in terms of future prospects (Chapter 4). Such findings seem to reflect the concerns that **professional views of 'recovery' are increasingly imposed onto patients**. According to Stuart and colleagues (2017), an overly professionally imposed view of recovery might blame individuals rather than empower them. This is especially the case when patients are not able to actively engage in their recovery.

Against this background, it also becomes clear that **a focus on healing might not be possible or desirable for some patients, or in some situations.** For example, an intense focus on exploring a patient's feelings or co-designing a crisis response plan can be counterproductive when a patient is overwhelmed by anxiety (Peplau 1997). Then, a focus on 'care' can be prioritised to enable stabilisation by facilitating rest, safety, and helping patients to alleviate their distressing emotions. Similarly, nurses perceive that some patients are not open or receptive to a process of healing. They refer to patients who are not oriented on 'staying alive' or do not have 'a spark of hope' (Chapters 4 and 8). Moreover, as part of the fluctuating suicidal process, one must consider that patients might deal temporarily with experiences of loss of control or pre-occupation with suicide plans (Kleiman et al. 2017, Lees et al. 2014). Likewise, individuals with suicidal ideation can disconnect from others as suicide risk rises (Van Orden et al. 2010), and may be ambivalent towards receiving help or even reject 'the very nurturance that might save their lives' (Maris et al. 2000, p. 43). Thus, these insights should be taken into account when interpreting the interaction between caring and healing, as presented above.

Furthermore, when interpreting the interaction between caring and healing, one should also consider that nurses who focus on caring are not necessarily focused on healing processes, or proficient in supporting such processes. While a large number of nurses express an orientation toward caring, such as by listening and showing compassion (Chapter 3), they often limitedly orient on helping patients to learn, generate self-understanding, and resolve their own mental health problems (Peplau 1997). Similarly in Forchuk and Reynolds' study (2000), patients valued nurses who were available, friendly, genuine, and good listeners, but simultaneously, they often missed a nurse who helped them to help themselves in the process of finding solutions to their problems.

9.2. Factors mediating the nature of interactions between nurses and persons with suicidal ideation

This dissertation provides insights into factors that potentially mediate the nature of interactions between nurses and persons with suicidal ideation. Here, mediating factors are discussed at the micro, meso, and macro levels based on the findings of this dissertation and the associated literature. It is important to reason beyond this multilevel structure because the mediating factors need to be interpreted within a dynamic interaction.

9.2.1. Micro level: factors related to nurses, patients, and what occurs between them

Among the insights across individual studies, it appears that the **nurses' professional identity** is a mediating factor for their interactions with patients who experience suicidal ideation. This professional identity can be considered based on the main approaches discussed previously. From this perspective, it would appear that the professional identity of some nurses is based more on interpersonal engagement with patients. Such engagement is oriented on acknowledging, connecting, and collaborating with patients as unique and self-determining individuals. Other nurses struggle to realise such a professional identity. Instead, their professional identity is focused on the task-oriented and instrumental processes of checking, controlling, and directing patients as 'risk objects' that need to be managed.

Additionally, nurses' professional identity can be considered from the perspective of the nurturing potential of nurse-patient interactions, as noted previously. Then, nurses' professional identity is, to a variable extent, based around enabling caring and/or healing processes. From this standpoint, it is seen that many nurses have a limited (or a professionally imposed) orientation on healing processes, such as helping patients develop insight into their suicidal ideation. Moreover, some nurses appear to overlook the very basics of caring (e.g. Chapter 6).

On the one hand, these findings expand on the knowledge that nurses often do not realise a professional identity that is based on therapeutic engagement (Lees et al. 2014, McAndrew et al. 2014). On the other hand, the findings confirm the many opportunities that nurses have to develop a professional identity grounded within the crux of their practice: the primacy of everyday care and the nurse–patient relationship, with emphasis placed on being with patients 'in the here and now', meeting individual needs, collaborating with, and nurturing patients' recovery (Gunasekara et al. 2014, Hurley 2009, Santangelo et al. 2018).

Interrelated with the nurses' professional identity, **nurses' reactions and beliefs** can mediate the nature of nurse–patient interactions. The potential impact of nurses' reactions is

a central focus of Chapter 4, where interactions with patients were conceptualised as a minefield which indicates some of the high demands and intense emotions that nurses can experience in practice. Nurses note that interacting with patients can evoke intense feelings of anxiety and responsibility, which could reinforce a reaction to control and protect patients. Consequently they increase their observations and restraint of the patients (Chapter 4) or, more subtly, encourage patients to move from their room to the dayroom where they can be better observed. The nurses' tendency to control and protect patients is also crucially related to their fear of blame and litigation concerning possible adverse outcomes, including (attempted) suicide. This sense of fear triggers nurses to uphold self-protective strategies, such as conforming to protocols and documenting their actions (Chapter 4).

While nurses' reactions can influence their approach to patients, the opposite may also be true. According to Cutcliffe and Stevenson (2008, p. 947), caring for persons with suicidal ideation makes huge demands on the well-being of the carer, especially if one actively engages with the person rather than observing from a distance. From this viewpoint, the findings suggest that nurses who interpersonally engage with patients may be more susceptible to emotional reactions than those who keep their distance and are task-oriented. In fact, nurses often remain distant and task-oriented as a strategy to avoid overwhelming emotions in a deeply confrontational context (Talseth & Gilje 2011).

In addition, the findings suggest that **nurses' beliefs mediate the nature of their interactions with patients**. For example, in Chapter 6, patients indicate that some nurses do not ask them about suicide or they advise them that talking too often about suicide increases its likelihood. This may reflect a common belief among healthcare professionals that discussing suicide may increase suicidal ideation, despite evidence that it is more likely to reduce it and promote mental health (Dazzi et al. 2014). Similarly, in Chapter 4, some nurses indicate that they do not talk too frequently about suicidal ideation or 'dig too deep' into the patients' history of suicidal ideation. For some nurses, this might reflect a lack of engagement in enabling patients to give voice to themselves and their suicidality, while for others, it might reflect a careful consideration that intense conversations and exploring feelings can be counterproductive when a patient is overwhelmed by anxiety (Peplau 1997).

Furthermore, certain beliefs are reflected in the **nurses' effort to adapt their approach** toward assessing and evaluating suicidal ideation to their personal style and connectedness with patients (Chapter 8). Some nurses refrain from using 'formal' assessment instruments because they believe it hampers their interpersonal connection with patients (Chapter 8). Similarly, Meerwijk and colleagues (2010) found that some nurses believe that suicide risk assessments are unnecessary if patients do not express suicidal ideation. Overall, as noted previously, the nurses' beliefs regarding the discussion and assessment of suicide warrant attention. While nurses' beliefs reflect valid perspectives, such as the danger of checklist-

style approaches, they may also induce adverse consequences if they limit the potential of nurses to respond to a patient's suicidal ideation (Chapter 8). Considering this, it may be that nurses' efforts to adapt their approach toward assessing and evaluating suicidal ideation may reflect a sensitivity to provide individualised care and attune to a patient's perspective. However, at least for some nurses, such adaptation is steered based on the nurse's own needs. This is noted in Chapter 5 where some nurses indicate that they prefer not to have direct talks about suicide because of their own discomfort to do so. This can be problematic when it overshadows the patients' need for expressing their suicidal ideation.

Interrelated with nurses' professional identity, reactions, and beliefs, **nurses' qualities and skills** can mediate the nature of nurse–patient interactions. This doctoral study found that reflection and self-awareness are among the most crucial qualities and skills to develop and sustain an interpersonal engagement with patients. The findings underline that a lack of reflection and self-awareness about one's actions and emotions can disturb nurses' clinical judgement and make them take control over patients (Chapter 8). Moreover, a lack of this capacity is associated with blurred professional boundaries (e.g. becoming too intimate), burnout, and compassion fatigue (Edwards et al. 2006, Hagen et al. 2016). Conversely, self-awareness and reflection represent a capacity that enables nurses to become aware of the reactions (e.g. anxiety) that patients evoke in them and to regulate these reactions when responding to patients. This capacity helps them to use containment interventions judiciously and to stay oriented on 'bridging difficult moments together' (Chapters 4 and 8).

Reflection and self-awareness of one's own emotions, prejudices, and needs is important to preserve an attitude of acceptance and tolerance when listening and responding to individuals with suicidal ideation (Cutcliffe & Barker 2002, Morrissey & Higgins 2019). In this respect, some patients refer to nurses who condemn their suicidality through expressions of anger and blame, which can increase their feelings of hopelessness (Chapter 6). The Safewards model (Bowers 2014) underscores the need for nurses to regulate their emotions and reactions, indicating that nurses' anxiety or frustration can hinder an attuned response to patients, which may provoke further anxiety and loss of self-esteem. Moreover, this model suggests that unattuned responses of nurses can evoke conflicting behaviours in patients which, in turn, triggers nurses to take containment measures.

The present dissertation also deepens the insight that the capacity for self-reflection and self-awareness can enable nurses to **develop a sense of expertise even with limited working experience** (Lees et al. 2014). The study on patient participation (Chapter 3) states that younger nurses are less inclined to share power and responsibility with patients concerning their safety. This finding might be explained by young nurses' immature skills to: collaborate with patients, judge the relative importance of different aspects in a given situation, or convey tolerance towards patients' emotional expressions (Cutcliffe & Barker 2002). Moreover,

younger nurses might have a tendency to adhere to ward routines in a complex environment and be less prepared than older nurses to cope with patients' dangerous behaviours and their own feelings of insecurity (Benner 1982). All these elements can hamper the nurses' flexibility, which they need to include and attune to a patient's perspective. However, the qualitative studies propose that a linear association between a nurse's age and engagement provides a limited perspective as it overlooks other elements, such as nurses' reflection. This was exemplified in the insight that the capacity to be reflective was sometimes more prominent in young nurses who focused on acknowledging, connecting, and collaborating with patients as individuals, but largely absent in some older nurses, who interacted with patients in a more checking, controlling and directing way (Chapters 4-5).

Closely related to reflection and self-awareness, the findings suggest that **nurses' clinical reasoning** can mediate nurse–patient interaction. Clinical reasoning is a complex cognitive process of gathering and analysing patient information, arriving at an understanding of the patient's problem or situation, and providing a congruent response (Simmons 2010). Researchers in mental health nursing often consider how clinical reasoning can enable therapeutic nurse-patient interactions (Cleary et al. 2012, Delaney et al. 2017). They call for a person-centred reasoning process, in which the combination of listening, understanding, and responding can enable therapeutic interaction. Indeed, although listening to patients and conveying openness is essential for therapeutic interaction, it will not lead to congruent responses without appropriate understanding and meaning-making (Cleary et al. 2012, Delaney et al. 2017). This is especially the case in the context of suicidality, where complex processes, such as a patient's hopelessness or ambivalence about dying are difficult to understand (Sellin et al. 2017).

Against this background, the findings suggest that **nurses' clinical reasoning is often guided by a focus on suicide risk categorisation**. Indeed, nurses often follow a process of gathering information about suicide risk, assigning a risk level to patients, and using surveillance and protective measures accordingly. Here, it must be emphasised that knowledge and attentiveness regarding suicide risk and protective factors is essential to clinical reasoning in nursing. However, the findings indicate that nurses who indiscriminately focus on suicide risk categorisation and 'checking of factors' are ill-equipped to listen to and understand patients and might even reduce patients to risk objects that need to be managed (e.g. Chapters 6 and 8).

Additionally, in line with Carlén and Bengtsson (2007), this dissertation suggests that **nurses have a tendency to label patients**, for instance as psychiatric diagnosis, 'mask wearer', or 'determined patient' (e.g. Chapter 5). When nurses approach patients based on such 'identity labels' this may trigger the patients' feelings of being stigmatised (Chapter 6). Within this understanding, Carlén and Bengtsson (2007) found that when nurses are able to reflect on

their everyday work, they can transcend the use of stigmatising labels. Instead they can become more inclined and able to recognise the patients' suffering in terms related to feelings of meaninglessness, hopelessness, or loss of control.

This capacity for reflection may partly explain why the **clinical reasoning among some nurses seems to reflect a more person-centred perspective**. For example in Chapter 8, nurses allow patients to express their feelings, thoughts, and experiences, and this appears to enable their potential to get to know patients as individuals, and to develop an understanding of the nature (e.g. hopelessness) and function of patients' suicidal expressions. This potential for understanding is enhanced when nurses use their intuitive and emotional sensitivity in a way that enables them to look beyond a patient's behaviour and to interpret and understand their—sometimes chaotic and conflicting—messages (Chapter 4).

The findings also highlight the influence of **interpersonal qualities and skills**. For example, the perspectives of some nurses reflect the ability to convey closeness and support (e.g. show compassion, validate emotions), respect and approach a patient as a person, and demonstrate acceptance and understanding towards patients. Such skills and qualities are central in the realisation of effective interpersonal practice (Cleary et al. 2012) and seem to represent the capacity of nurses to inspire hope in patients (Chapter 6). Additionally, in Chapter 3, nurses who perceive themselves as more competent to share power and responsibility with patients feel more able to facilitate patient participation. This sharing of power and responsibility is a crucial skill in the context of suicide risk, where nurses are easily inclined to take over control of patients (Chapters 4–5), thereby potentially leaving patients disempowered in decision-making about their care, treatment, and aspects of daily living (Chapter 6).

Additionally, **nurses' non-verbal and verbal communication skills** appear to mediate their interaction with patients, including their ability to listen, ask, and discuss suicide, and be transparent (Chapters 6-8). Moreover, the findings suggest that many nurses are ill-equipped to have therapeutic conversations with patients who experience suicidal ideation. For example, the skill to provide input during a conversation that helps patients to generate self-understanding is often not demonstrated by nurses—or not present (Chapter 8). Furthermore, the studies point to the importance of sharing information with patients, undertaking assessments, and understanding a person's suicidal ideation. These aspects of interaction reflect the need for nurses to have specific knowledge, for instance knowledge about risk and protective factors. However, the findings suggest that nurses may use their knowledge as part of a directive approach (such as to impose input for a safety plan) instead of using their knowledge in a way that leads to meaningful and individualised interventions (Chapter 4).

In addition, some nurses emphasise their technical skills. This is clear in the perspective of nurses who use a checking approach, indicating a focus on how to pose standardised questions during assessments or how to improve their surveillance of patients (Chapter 5). However, **technical expertise in carrying out procedures is not a desirable emphasis** in mental health nursing, where self, interactions, and relationships are therapeutic means to affect favourable change and improve health outcomes (Cleary et al. 2012, Peplau 1997). Indeed, such emphasis informs checklist-style approaches and ignores the need for nurse–patient relationships that center interpersonal skills and genuine collaboration with patients (Cutcliffe & McKenna 2018). Nursing care for patients would then be more focused on ways of 'doing' as opposed to 'being', and this is counterproductive in a context where it is essential to approach patients as individuals and validate and support their emotions (Cleary et al. 2012).

Rather, the findings show that nurses need an ability to identify opportunities to engage with patients in meaningful ways without appearing to be checking or controlling patients as risk objects. To this end, some nurses seem to have the interpersonal qualities and skills to make efforts to acknowledge and connect with patients as individuals, even during standardised assessments and observations (Chapter 5). This accords with Cleary and colleagues (2012, p. 72) who refer to 'sophisticated communication' as an ability of nurses to conduct the technical aspects of care as an opportunity to elevate the quality of their relationship with patients.

The findings suggest that **individuals with suicidal ideation can have certain characteristics** that mediate the nature of their interactions with nurses. Both nurse and patient perspectives show that patients' lack of trust and open communication about suicide (e.g. as a result of feeling shame) influence their interaction. Trust is found to be a dynamic process, one that can develop and strengthen during interaction, or be compromised (Chapters 4-8). In particular, trust is perceived as a prerequisite for a safe atmosphere for open and genuine communication about suicide. Moreover, trust is something that could be shared or unshared with patients. Indeed, from a nurse perspective, trust is conceptualised as the tipping point in balancing a patient's protection with their freedom and autonomy. Furthermore, the potential for trust to be compromised is highlighted, especially in 'counter-reactions of patients', such as when feeling forced to disclose suicidal ideation or being subject to controlling procedures (Chapter 8). According to Dinc and Gastmans' literature review (2013), patients will not easily develop trust with nurses who remain distant and adhere strictly to procedures. This nuance is important because some nurses frame trust as part of an instrumental tie that enables them to manage suicide risk (e.g. gather information). However, their articulation of trust differed from trust as a relational process, which centres

on reciprocity, interpersonal connections, and mutual understanding (Dinc and Gastmans 2013).

Nurses perceived that **some patients are not open or honest about their suicidal ideation** and that this interferes with their potential to develop an accurate and meaningful picture of patients (Chapter 4). Moreover, nurses referred to the difficulty of collaborating with patients who are preoccupied with suicidal plans, lack insight into their suicidal ideation, or express chaotic messages. According to Lees and colleagues (2014), patients with suicidal ideation can have difficulty expressing their needs and accessing and sharing their experiences. While it is reasonable that patients' characteristics interfere with nurses' clinical work, such perceptions may also, as noted previously, reflect a tendency of nurses to categorise patients and to interact with them as part of formal procedures (Chapters 5-6). Then, patients' lack of open communication quickly induces a controlling approach in nurses, instead of stimulating greater efforts to connect with patients and try to understand the nature of a patient's silence or withdrawal (Chapter 4).

The systematic review in Chapter 6 reflects the understanding within leading theories of suicide that **individuals with suicidal ideation can deal with constricting perceptions** such as, 'I am a burden' or 'nobody cares about me' (Van Orden et al. 2010). The findings suggest that a patient's feelings of burdensomeness can mediate the nature of nurse–patient interaction because it induces patients' withdrawal or conformance (Van Orden et al. 2010). This aligns with the expression of a nurse in Chapter 4: *"If we indicate to patients that we are going to the seclusion room, then few patients say they'd 'rather not'".* Thus, while patients can express counter-reactions in response to coercive practices, they might also submit themselves to these coercive practices or follow the nurses' instructions. Such reflections are also crucial in the context of patient participation (Chapters 2-3), where a patient's willingness, perspectives, and competences toward participation in their care and treatment should be considered (Longtin et al. 2010).

Furthermore, it is indicated from the nurses' perspective that certain **aspects of psychiatric diagnoses** can present challenges for interaction, including communication and relatedness difficulties (e.g. distrust). For example, in Chapter 4, one nurse indicates: *'in their psychosis they can feel threatened or live in their own world. This makes it difficult to make contact with them and make agreements'.* The relevance of such perception is underlined by the research of Seikkula and colleagues (2011), indicating that people in psychotic crises might avoid contact because they perceive others as being dangerous. Additionally, studies refer to **borderline personality disorders in patients with suicidal ideation**. These studies indicate that certain personality traits (e.g. anger, frustration) can present difficulties for patients to feel safe, trust themselves and others, as well as to cope constructively with oneself, which is associated with suicide attempts (Holm & Severinsson 2011, Stringer et al.

2013). However, while certain personality traits of patients (such as frustration) may influence nurse-patient interaction, nurses should not approach these patients 'as different', but nurture their hidden strengths, and address their need to feel safe, trusted, and validated (Holm & Severinsson 2011).

Thus, the presumed influence of psychiatric diagnosis and their interpretation merits attention. Indeed, Lees and colleagues (2014) suggest that **nurses overuse labels such as 'borderline personality disorder'**, sometimes even as a reason not to engage interpersonally with patients. Moreover, nurses can stigmatise patients by approaching them with an emphasis on diagnosis or judge them as 'another suicide attempt' (Chapter 6). Thus, this reiterates the point that reflection, self-awareness, and clinical reasoning are crucial skills in proving nursing care for patients with suicidal ideation.

9.2.2. Meso level: organisational factors

The findings also revealed factors at the hospital and ward level that mediate the nature of nurses' interactions with persons who experience suicidal ideation.

First, the studies suggest that **the availability of resources plays a key role** in nurse–patient interaction. A large number of nurses perceived high work demands (e.g. administration), multiple patient assignments, and staffing shortage as conditions that hinder their ability to interact, talk with, and listen to patients. These conditions are also represented in the PaCT-PSY, where a perceived lack of time—or the idea that patient participation leads to a loss of time—are potential barriers to patient participation (Chapter 2). Some nurses also indicated that time constraints require them to take protective actions more often to preserve safety (Chapter 4). This finding aligns with the literature review of van der Merwe and colleagues (2009), indicating that nurses use seclusion more frequently during staffing shortages.

Similarly, from a patient perspective, it appears that **nurses are often busy and do not have time to spend** with them (Chapter 6). This perception of the 'busy nurse' sometimes increased their threshold for help-seeking. This aspect warrants attention in caring for patients with suicidal ideation, who often already feel ambivalent towards help-seeking due to perceived burdensomeness (Van Orden et al. 2010). Additionally, while time constraints are a pressing issue in nursing (Sharac et al. 2010), one should also consider that nurses might not spend their available time on meaningful interaction or might distance themselves from patients (Talseth and Gilje 2011). Furthermore, in line with Peplau's theory of interpersonal relations (1997), nurses should be aware that contacts with patients do not have to last long in order to have the potential to be therapeutic or non-therapeutic. Indeed, even very brief

contacts, such as (not) greeting a patient can have a major impact on a patient's mental state (e.g. their self-perception) (Chapter 6). That said, the dissertation supports the argument that available time and adequate staffing can support consistent and regular nurse–patient interactions, and these are essential for enabling therapeutic progress in patients (Forchuk and Reynolds 2000).

Opportunities for debriefing, intervision, and supervision are pivotal for nurses to regulate their emotions, reflect on their practice and decision-making (e.g. considering positive risk-taking), and learn from their experiences (Morrissey and Higgins 2019). Conversely, the absence of support systems, such as supervision and emotional debriefings, are likely to produce high stress levels in nurses, which can lead to compassion fatigue (Edwards et al. 2006), and jeopardise their inclination to acknowledge, connect, and collaborate with the patient as a unique and self-determining individual (Hagen et al. 2016, Lees et al. 2014). Nonetheless, it should be noted that, while the availability of support systems is crucial, nurses themselves need to actively initiate and participate in debriefings and supervision to promote their professional support and development (Awenat et al. 2017).

The nurses' perspectives show that **certain dynamics of teamwork and support** mediate the nature of nurse–patient interaction. For example, nurses were more willing to enable a patient's participation in safety issues when they perceived higher support and approval from their colleagues and managers to engage in patient participation (Chapter 3). Such findings represent a key factor in nursing, namely that the perception of being supported, valued, and respected by a team is one of the main psychological rewards for nurses (Lu et al. 2012). This was also seen in Chapter 8, where team support enabled nurses to feel validated, express and regulate their emotions, share responsibilities, and deal with uncertainties around their interactions with patients. However, there were also nurses who referred to a lack of team support, such as when their concerns were not heard or their professionalism was questioned (Chapter 8). In line with Morrissey and Higgins' study (2019), nurses may perceive themselves within a context where there is no place for their emotions and opinions. However, this prevents them from processing their feelings and reflecting on their responses to patients in a safe and supportive environment.

Additionally, **certain team dynamics seemed to represent a restricted nursing role**. For example, some nurses referred to team agreements that they as nurses should not engage with patients in conversations about hopelessness or traumatic experiences. Moreover, some nurses tended to quickly shift responsibility for decisions involving risk to psychiatrists or refer patients to psychologists for a therapeutic conversation (Chapter 4). While these team-related micro-processes were not fully explored in the scope of this dissertation, they point to deeper dynamics that mediate nurse–patient interaction.

One common issue in the literature is that nurses fill subordinate positions in teams, especially in those teams with power structures in multidisciplinary interaction (Barker and Buchanan-Barker 2011). Power structures represent a particular threat to nurses' professional identity, as they may present nursing as inferior, lacking in knowledge, and having restricted potential (Terry 2020). The latter is emphasised in teams where nurses lack empowerment and autonomy, such as when therapeutic conversations with patients are preserved for psychologists or psychiatrists. Such dynamics partly explain why, as highlighted in this dissertation, some nurses have no therapeutic perspective in conversations and everyday interactions with patients. Nurses can even break off conversations or refrain from listening to feelings of hopelessness that patients want to share, thereby leaving patients' needs unmet (Chapters 4-6).

Conversely, where nurses seem to have a more autonomous and empowered role in the team, they can create a nurturing space for patients, for instance, by prioritising human contact and using their conversation skills to stimulate discussion about a patient's feelings and reflection on their coping strategies (Chapters 4-6). Moreover, nurses could adopt a role from which they truly collaborate with patients and advocate for their interests in the multidisciplinary team. This is different than a role from which nurses (have to) quickly refer patients to team members who hold a superior position (Chapter 8).

Organisational culture also appears to be a factor that mediates the nature of nurse–patient interaction. One issue addressed here is the **possible association between the model of care and nurses' professional identity**. Across several studies, it was noted that many nurses appear to follow a medical and custodial-oriented model of care, in which persons are approached by their suicide risk, which needs to be managed and controlled. When nursing is based on such a model, nurses' primary task is to implement risk-aversive strategies to keep patients and themselves safe. In this case, nurses might do nothing more than observing patients, upholding rules, and performing tasks, while being identified as 'risk agents', 'controlling practitioners', or 'guardians who keep watch' (Cutcliffe and Barker 2002, Morrissey and Higgins 2019). Patients underscored this perspective, reporting that they felt powerless when being subject to procedural control and surveillance performed by nurses, or when nurses emphasised power differentials through (non) verbal expressions (Chapter 6).

Nuance should be considered in the association between the model of care and nurses' professional identity. According to Cutcliffe and McKenna (2018), it is possible that even when nurses have the skills and qualities to engage interpersonally with patients, the organisational culture discourages their application. Conversely, Sercu and colleagues (2015) indicate that working on a ward with a dominant medical model does not necessarily mean that nurses accept a reductionist approach to their patients. Indeed, some nurses in the present dissertation criticised the overemphasis on defensive and procedural practices.

They wanted to follow a more person-centred and collaborative model of care, where there is more emphasis on acknowledging patients as people, inviting them to dialogue, and attending to their needs for emotional care and connection (Chapter 8). It was observed that nurses with such interpersonal orientation ameliorate some of the negative influences of the environment, for instance, when nurses' interpersonal engagement remediates a patient's anxiety (Chapter 6).

The studies also suggest that the **type of ward and service delivery** can mediate the nature of nurse–patient interaction. In Chapter 3, nurses on closed wards were less willing than those on open wards to share power and responsibility with patients concerning their safety. This finding was partly explained by the restrictive nature of the closed wards, which was also evident in interviews with nurses in these wards who often referred to the availability and use of surveillance policies and containment-oriented methods. In this respect, Pettit and colleagues' (2017) study suggests that in services with access to seclusion, staff perceive seclusion as more acceptable and report greater use of it. However, the qualitative evidence in this dissertation calls for the consideration of nuances. Nurses on either open or closed wards did not express fundamentally different accents in their interactions with patients. While some nurses in closed wards appeared to work in more controlling ways, this cannot be generalised, as there were also those equally or more inclined towards acknowledging, connecting, and collaborating with patients than nurses on open wards. Moreover, aspects of control and power should not be considered as merely something structural; they are also present in subtle persuasive ways or directing communication, or surveilling patients while 'just sitting outside' (Chapters 4 and 6).

Further considering differences across services, patients suggested that nurses in emergency services had little focus on engaging interpersonally with them, for example, by listening to and trying to understand their experiences. However, the systematic review included limited evidence in this context and the lack of nurse perspectives prohibited conclusive statements about how nurse–patient interaction unfolds in emergency services (Chapter 6). Also, one could argue that **overemphasis on viewing nurse–patient interaction through an organisational lens** may overlook the unique meaning of an individual's suicidality, and how, from their perspective, this can be addressed (Chapter 6). For example, some policymakers, and hospital or ward leaders have the misconception that interpersonal and collaborative interactions are not feasible or do not have much value in high-security wards. However, even in forensic psychiatry, a focus on caring contact, presence, and genuine collaboration are essential and contribute to outcomes, such as remediating the negative impact of involuntary care (Akther et al. 2019), assisting patients with the detection of early warning signs (Fluttert et al. 2008), and reducing a patient's criminal recidivism (Schaftenaar et al. 2018).

9.2.3. Macro level: broader healthcare and social factors

This section ends with a cursory overview of **broader healthcare and social factors** that potentially mediate the nature of nurse–patient interaction. While such macro factors were not explicitly studied in this dissertation, they should be considered as they can affect the way in which nursing care is constructed, experienced, or expected to be performed.

One common element worldwide is the **shift in mental healthcare from hospital-based to community-based care**. According to Thornicroft and colleagues (2016), policymakers should work towards a balanced and comprehensive mental health system that includes both community- and hospital-based care. Against this backdrop, it is noteworthy to mention that the reduction of psychiatric hospital beds is debated in the context of suicide. Some researchers point to a possible increase of suicide due to deinstitutionalisation (Allison et al. 2018), while others argue that replacing hospital beds with well-developed community services does not (Barbui et al. 2018) and may even reduce suicide rates (Pirkola et al. 2009). With regard to this debate, both this dissertation and previous studies suggest that psychiatric hospitals can be environments that nurture recovery for patients with suicidal ideation, provided that they meet patients' needs for person-centeredness, connectedness, and emotional and physical safety, and encourage the vital importance of therapeutic relationships (Berg et al. 2017).

In Belgium, progress in establishing community-based services has been slow, but it is expected that this evolution will continue (Mistiaen et al. 2019). This could influence nurse–patient interaction in psychiatric hospitals, as **nurses might increasingly be required to promote contextual and family-oriented interventions** to support patient recovery (Deproost 2018). Then, nurses may focus more on helping patients to attain discharge readiness (Berg et al. 2017) and nurturing a patient's relationships across healthcare services and within their natural network (Forchuk et al. 2020). Simultaneously, nurses will become increasingly employed in community-based settings. In this context, they may experience new opportunities and challenges in developing a professional identity. Community nurses could develop a professional identity around essential aspects raised in this dissertation, such as meeting a person's needs in daily life, developing an interpersonal relatonship, and creating a nurturing space in which people can learn to cope with their suicidality, and (re)establish close ties with other people and life itself (Chapter 6). However, it is also true that, compared to hospital-based nurses, community nursing practice sometimes equally reflects task orientation and mechanisms to control patients (e.g. securing adherence to medication) (Hannigan 2014). Moreover, in the community, nurses'

professional identity is often threatened by shared caseloads, leading to blurred roles and an overemphasis on coordination (Crawford et al. 2008).

A particular evolution, globally and in Belgium, is that policymakers in mental healthcare are **increasingly focused on routine outcome monitoring and measuring the quality of care** (Kendrick et al. 2016, Kilbourne et al. 2018). In Flanders, mental healthcare systems are intensely involved in implementing quality indicators (Superior Health Council 2016b) and meeting accreditation norms that incorporate an evaluation of interventions to detect and manage suicide risk (The Joint Commission 2016). Here, it is noteworthy to mention that the main motivation expressed by hospital directors to participate in the CoNuPaS study (Chapter 7) was that it suited the hospital's intention to 'meet accreditation norms'.

The **focus on 'measuring mental healthcare'** through outcome monitoring, quality indicators, and accreditation norms provides opportunities to improve the quality of mental healthcare and is widely accepted by policymakers and payers in this context (Kilbourne et al. 2018, van Os et al. 2017). However, it has also attracted criticism in that it might foster 'bureaucratic healthcare cultures' in which enumeration, productivity, and benchmarking are prioritised, instead of interpersonal relationships, nurse-patient contact, and patients' personal experiences, and their needs and right to self-determination (Happell 2008, McCrae 2014, van Os et al. 2017).

Indeed, this dissertation suggests that **overemphasis on outcomes, indicators, and accreditations can be problematic**. For example, while the conceptual foundation developed in this dissertation presents a basis on which to inform quality indicator development, the same conceptual foundation highlights that such effort is complex and potentially counterproductive. For example, incorporating processes such as 'talking about suicide with patients' into a quality indicator makes sense when considering its vital importance in patient care (Dazzi et al. 2014). However, reflecting core insights in this dissertation, such effort carries the risk that talking about suicide is reduced to a mechanistic effort to gather information, thereby overlooking the fundamental interpersonal nature (e.g. trust, genuine interaction, emotional attunement) of talking about suicide (Hom et al. 2017).

Regarding nursing practice, careful attention is required so that the focus on outcomes, indicators, and accreditations does not present *new wine in old bottles* so to speak. Indeed, this focus is similar to the **historical movement towards classifications of functional health patterns and nursing diagnoses** (NANDA 2001). This encouraged nursing to focus on symptom management and task completion in practice, thereby overshadowing the view of nursing as an interpersonal process with its origins in caring and nurse-patient relationships (Delaney et al. 2017, Peplau 1997, Watson 1979). Similarly, historical and current movements in healthcare that overlook nursing as an interpersonal process might

partly explain the insight that some nurses are more oriented on checking, controlling, and directing the patient as a 'risk object' that needs to be managed.

Interrelated with the 'lack of resources' mentioned earlier, **workload pressures and shortage of nurses** are globally recognised factors that affect the quality of healthcare (Rafferty et al. 2019). Moreover, nurse staffing cuts might adversely affect patient outcomes, such as preventable hospital deaths (Aiken et al. 2014). Simultaneously, a nuanced perspective is necessary when considering the mediating effect of workload and staffing shortage on nurse–patient interaction. The present findings suggest that more nurses or more time for nurses does not necessarily lead to them spending more time with patients or focusing their presence on them. In other words, nurses would not automatically be more involved in high-quality person-centred and collaborative care (Feo & Kitson 2016). In this respect, it is interesting to consider the reasons for the questionable effect of fixed time periods for nurse–patient interaction, such as Protected Engagement Time, on patient outcomes (McCrae 2014).

Furthermore, within the context of this dissertation, it is important to consider factors that potentially mediate the nature of nurse–patient interaction at a societal level. Literature highlights the **social stigma around suicidality and mental health problems**. This stigma prevents people with suicidal ideation from seeking help in mental health services (Reynders et al. 2014), and it was one of the barriers for patients to approach, trust, and discuss suicide with nurses (Chapter 6). Furthermore, social stigma reflects the perception that people with suicidal ideation are incapable of being responsible and competent to manage their suicidality. This perception may lead to **societal pressure to control suicide risk**, and subsequently, trigger a cascade of influences: national suicide prevention strategies reflect a risk-dominated paradigm (Heller 2015); psychiatric hospitals provide a necessary containing system (Roberts 2005); risk assessment and management become a system of surveillance (Szmukler & Rose 2013), and nurses are left with a socially mandated protection role (Slemon et al. 2017).

Of course, such cascade of influences based on societal stigma is an inadequate representation of the nature and dynamics of nurse-patient interactions. For example, it does injustice to the genuine, interpersonal interactions that some nurses establish with patients (e.g. Chapter 5). Simultaneously, nurses are not necessarily a passive subject in respect of how they deal with social stigma. In fact, the literature suggests that countering stigma, for instance by relating to patients as a fellow human being, might present a driving force for nurses to work in mental healthcare (Sercu et al. 2015).

Nevertheless, the societal perception towards suicide risk may partly explain why **nurses often act from a risk-avoidant position when responding to possible suicide risk**, instead of considering a positive risk-taking approach that mobilises a person's strengths and

abilities (Higgins et al. 2016, Slemon et al. 2017). This was for instance seen in patients' perceptions of nurses who denied their request to leave the hospital ward or removed their personal belongings (Chapter 6). According to Higgins and colleagues (2016), while positive risk-taking aligns with promoting patients' autonomy and recovery, there is a challenge in reconciling this approach with the societal pressure to control suicide risk both inside and outside the ward. From a societal perspective, positive risk-taking appears to reflect a 'trial and error approach', which cannot be permitted. Simultaneously, such societal perspective can perpetuate hospital cultures in which nurses fear blame and litigation in relation to potential suicide and find it easier to justify an intervention to prevent suicide. However, such cultures are also associated with environments in which nurses' interventions reflect a narrow view on preventing suicide and overlook other risks that might encourage suicidal ideation, such as stigma and social exclusion (Higgins et al. 2016, Van Orden et al. 2010).

Actual social circumstances can mediate the nature of nurse–patient interactions today and in the future. Regarding **the coronavirus pandemic (Covid-19)**, researchers have already considered its impact on the mental health and suicide risk of people, including both patients and mental health professionals, and how recovery might be supported (Reger et al. 2020, Usher et al. 2020). A long period of social distancing is occurring to overcome the coronavirus pandemic, leading to a disruption of human contact and a search for alternative, often digital ways of support (Reger et al. 2020, Usher et al. 2020).

What is infrequently considered is the impact that the coronavirus pandemic will have on the nature of interpersonal face-to-face interactions between mental health professionals and individuals with suicidal ideation. Following the present dissertation, it can be hypothesised that the current period of social distancing will mediate the subtle ways through which professionals convey connection and hope to persons with suicidal ideation (e.g. through physical contact, handshake), the behaviours they prioritise (e.g. hand hygiene; Chapter 3), and how all this is received by patients.

Potential long-lasting effects of the coronavirus pandemic on the interaction between mental health professionals and patients with suicidal ideation are not necessarily negative. For example, the shared social distancing experience might in fact encourage a capacity of professionals to better acknowledge and connect with patients as fellow human beings. Moreover, it can encourage professionals to be sensitive and attentive towards feelings of loneliness and social isolation, which are common among people with suicidal ideation (Van Orden et al. 2010).

9.3. Methodological considerations

The studies in this dissertation have methodological limitations that have been described and discussed in the previous Chapters. Therefore, what follows is an overview of concurrent methodological considerations that pertain to several of the studies.

A major strength of this dissertation is that it includes **seven studies with a range of research designs and methods.** It comprises three qualitative studies based on grounded theory, one systematic international review, one quantitative cross-sectional multilevel study, and two studies on the development and psychometric evaluation of two distinct instruments (PaCT-PSY and CoNuPaS). The use of both quantitative and qualitative approaches enabled the researchers to address the complex research objectives, particularly by enhancing the conceptual understanding of the interactions between nurses and individuals with suicidal ideation, and facilitating data about mediating factors.

The conceptual insights in this dissertation mainly emerged in the context of **nursing care in inpatient mental health settings**. Such insights are highly relevant in Belgium, where the rate of psychiatric hospitalisation is among the highest in the world, and the duration of admissions continues to be long (Mistiaen et al. 2019). Indeed, the data obtained with the CoNuPaS indicated that 73.7% of the participants (n = 297/405) were hospitalised for more than one month in the same ward (Chapter 7). This context enabled research on working alliances where nurses engage with patients over an extended period of time (Chapter 8). However, findings in such context might be less applicable in countries such as the USA and Italy, where the proportion of psychiatric beds is much lower and the duration of admissions is much shorter (Allison et al. 2018, Barbui et al. 2018).

Additionally, while the focus on psychiatric hospitals supported this study's congruency and conceptual density, this specific context has limitations when considering **a continuity of care perspective** (Aerts et al. 2017). The main focus on inpatient care overlooks the current reform in Belgium towards community-based care and mental health service networks (Lorant et al. 2016). An additional focus on community services from a continuity of care perspective would have been appropriate, as this could have rendered new knowledge about how nurses deliver follow-up care for persons with suicidal ideation, and how nurses provide community care and support a person's community living. Moreover, few insights have been gained concerning critical periods for prevention and treatment, including discharge and service transition (Chung et al. 2017). For example, in the qualitative studies (Chapters 4, 5, and 8), nurses were attentive to the intermittent ward leave of patients, but expressed few accounts pertaining to preparing patients for discharge or nurturing a patient's relationships with other professionals across healthcare services (Forchuk et al. 2020). While this may indicate that these aspects are not a priority for nurses, it might be partly explained from a methodological perspective.

It should be noted that **none of the studies used a longitudinal design**. They were either cross-sectional quantitative studies or qualitative studies based on individual semi-structured interviews. This limited the potential of the dissertation to explore how interactions and relationships develop over time and to uncover aspects pertaining to continuity of care. Additionally, it is noteworthy that issues of discharge and service transition were not often questioned in the interviews, as nurses did not bring up these topics spontaneously. Moreover, although the PaCT-PSY can render data about how nurses facilitate patient participation in relation to discharge, this was not a focus in the multilevel study (Chapter 3).

Issues of trustworthiness, including issues pertaining to myself as the author of this dissertation (J.V.), must be considered in relation to the qualitative approaches used in the individual studies and the systematic review. General openness was important in collecting and analysing the data so that relevant variations in perceptions and experiences could emerge and be reconstructed (Holloway and Wheeler 2010). Reflexivity was crucial as I co-constructed the data collection and analysis, and I was deeply involved in trying to understand the participants' perspectives (Malterud 2001). I critically reflected on how my preconceived ideas (e.g. as a nurse and researcher) influenced the research process and vice versa. I conducted the analyses and other research steps in close collaboration with several researchers and under the supervision of an experienced qualitative researcher. The prioritisation of researcher triangulation helped me develop my interview and analytical skills, reflect on and monitor my subjectivity and preconceived ideas, and gain new insights by supplementing and contesting different perspectives and interpretations (Morse 2015).

Within the data analysis based on grounded theory, **the constant comparison method was particularly important** to seek variations in the data, understand differences between content and meaning in the nurses' narratives, and uncover implicit processes on how nurses approach patients (Hallberg 2006). As noted previously, the main approaches in nursing practice (e.g. connecting versus controlling) were not always explicitly present in the interviews. Nurses often used similar phrases, such as, 'being present', 'inviting patients', 'talking about suicide', and 'making agreements'. Then, the constant comparison of data enabled the researchers to examine the subtext of these phrases, and subsequently, to notice that they differed in their meaning and underlying mechanisms. This detailed and considerate approach enabled the emergence of a framework of concepts to guide nurses in moving from an overemphasis on controlling patients, to a focus on engaging on a personal level with patients and enhancing their nurturing potential.

Analysing the large amounts of rich data was challenging and made me feel uncertain, especially in relation to complex phenomena such as suicidality and nurse-patient interaction. Throughout the analyses, it was important to refrain from forcing the process, and simultaneously, to trust the process of emergence. Ensuring that the concept generation was

grounded in nurses' perspectives was only possible with self-discipline, tolerance of uncertainty, and debriefings and discussions with other researchers. Such a considerate approach was crucial because otherwise there was a risk that constructs, such as the working alliance (Chapter 8), would not have emerged from the nurse perspective but would have been conceptualised based on pre-existing evidence or indiscriminately imported from psychotherapy (Priebe and McCabe 2006).

The **transferability of the qualitative evidence was supported** by recruiting participants from various psychiatric hospitals and ward types across Flanders. Moreover, transferability was enabled by prioritising a range of quality measures (e.g. researcher triangulation) and by achieving a level of conceptualisation that captures nurses' perspectives and their main concerns in clinical practice. Additionally, the systematic review resulted in a synthesis of qualitative evidence from studies in a range of Western cultures. Following these considerations, it can be asserted that the dissertation's findings might be similarly experienced by patients and nurses in psychiatric hospitals in other Western cultures. This statement of transferability is supported by evidence that patients' views of their relationships with nurses can cross some cultural boundaries (Forchuk and Reynolds 2000).

However, from a sociocultural perspective, it is also important to consider that the findings in **the individual studies mainly pertain to Dutch-speaking nurses and patients**, and that the ethnic and cultural backgrounds of the people who participated (or did not participate) were not identified. Consequently, it was not possible to examine whether non-Dutch speaking nurses and patients, from potentially other cultural backgrounds, have similar or different perceptions of their interactions. This is a limitation as cultural differences can present challenges in nurse-patient interactions, such as language difficulties or nurses misunderstanding of patients' care needs and expectations. Moreover, cultural issues are associated with the meaning and acceptability of suicide, and this can influence how people interact in this context (Hjelmeland 2011).

The development of two Likert-scale instruments, the PaCT-PSY and the CoNuPaS, and the cross-sectional study (Chapter 3) addresses priorities in national and international mental healthcare by focusing on facilitating patient participation and making contact with patients experiencing suicidal ideation (Aerts et al. 2017, WHO 2017). **The instruments were developed and psychometrically evaluated by rigorous processes and multiple tests**. The availably of validated instruments to examine clinician-patient interaction can help to expand on knowledge of the perspectives and needs of patients and clinicians regarding their interaction, and the influencing factors. Moreover, the PaCT-PSY and the CoNuPaS can provide data that render the value of interpersonal and collaborative patient interaction visible to nurses and other clinicians, policy-makers, and educators. More specifically, these instruments can highlight the interpersonal, communicative, and collaborative skills (e.g.

shared decision-making, initiating conversations about suicide) required by professionals when interacting with patients who have mental health problems and/or experience suicidal ideation.

Simultaneously, arguments can be made about **how to justify a focus on obtaining numerical data** about such complex, interpersonal, and contextually dependent phenomena, and how to preserve their authenticity and deeper meaning (Sitzman and Watson 2019). Based on the qualitative evidence in this dissertation, the researchers acknowledge that some deeper subjective aspects of nurse-patient interaction cannot be captured by numerical data. Moreover, the conceptual insights suggest that different or 'covert' mechanisms can underlie the same objective score (Hjelmeland 2010). As asserted in Chapter 7, in relation to the use of instruments such as the PaCT-PSY and the CoNuPaS, it is important to locate the data obtained with these instruments back to their conceptual foundation and the context where the data acquire their meaning. Without making these deeper reflections, the risk exists that phenomena, such as building dialogue with patients and talking about suicide, are reduced to instrumental acts to increase control, and this is contradictory to interpersonally informed approaches (e.g. Chapter 8).

To end this section, it is important to consider the methodological considerations pertaining to follow-up studies. Several studies were conducted in the broader context of this dissertation, including two qualitative studies based on the principles of grounded theory. First, a study on the **perspective of patients with suicidal ideation** was conducted to understand patients' perceptions of making contact with nurses in psychiatric hospitals (Vandewalle et al. 2020b). Second, a study was conducted from the **perspective of family members** of hospitalised patients with suicidal ideation to enhance understanding of their interaction with each other, as well as the family members' experiences and expectations of inpatient mental health services (Vandewalle et al. 2020a). This study was initiated based on the insight that nurses' involvement with family members of patients is limited. The qualitative studies render local and critical insights pertaining to basic principles in approaching individuals with suicidal ideation, including 'making contact' and 'involving relatives' (Aerts et al. 2017).

Additionally, a **cross-sectional questionnaire study with the CoNuPaS** (Chapter 7) is under way. This study will address the lack of large-scale research into patients' perspectives of their contact with nurses in psychiatric wards. This study can provide information on multilevel factors, such as age, severity of suicidal ideation, and type of psychiatric hospital (ward) that influence patients' perceptions of their contact with nurses. Furthermore, a new **cross-sectional study with the PaCT-PSY** (Chapter 2) is being prepared. This instrument will be completed again by professionals in psychiatric hospitals as part of the Federal programme to improve patient participation in the quality of care and patient safety (Federal

Government Belgium 2020). This research will offer opportunities to assess the evolution of patient participation cultures across psychiatric hospitals. Moreover, it can offer opportunities to further develop and refine the instrument. To this end, reflections emerged during this doctoral study on how to improve the PaCT-PSY. It might be relevant to include more items concerning emotional safety in addition to physical safety, and to add items concerning patient participation in the context of suicide prevention and suicidal ideation treatment, including aspects of safety and crisis response planning (Bryan et al. 2017, Stanley and Brown 2012).

9.4. Recommendations for clinical practice, policy, education, and further research

Several recommendations for clinical practice, policy, education, and further research are addressed and described based on the dissertation's findings and methodological approaches, as well as the limitations. In particular, the recommendations reflect the need to foster a person-centred and collaborative paradigm in nursing practice (Barker and Buchanan-Barker 2011, Gabrielsson et al. 2015). Such paradigm is established through the formation and fostering of interpersonal interactions and relationships. It requires interpersonal nursing; meaning nursing focused on respecting patients' uniqueness and right to self-determination, demonstrating compassion and understanding, attending to patient's needs and narratives, and enabling empowerment through genuine collaboration (Barker and Buchanan-Barker 2011, Gabrielsson et al. 2015). Fostering a person-centred and collaborative paradigm can underpin a practice in which nurses make meaningful and life-saving contributions based on interpersonal and collaborative interactions with patients who experience suicidal ideation. This should be a driving force for policymakers, leaders, educators, and researchers, and most importantly, for nurses themselves. The recommendations presented below should be interpreted from an integrative perspective so that they fully contribute to the scientific underpinning and professionalisation of nursing.

9.4.1. Recommendations for clinical practice and policy

The first point to consider is the need to pay more attention to **leadership as a core strategy of fostering a less restrictive, more person-centred, and collaborative care culture** (Beckett et al. 2013, Duxbury et al. 2019). Hospital and ward leaders (e.g. directors, nurse managers, and head nurses) need to articulate a vision and implement policies that promote interpersonal interactions and relationships, where the focal point of care and

treatment is the experience of individuals with mental health problems and their relatives (Barker and Buchanan-Barker 2011). Such a person-centred vision and culture can be informed by principles and practices of the recovery model, including patient participation, genuine collaboration, personal growth, and social inclusion (Heller 2015, Slade et al. 2014).

Additionally, the rudiments of trauma-informed care are very valuable in the context of providing nursing care for individuals with suicidal ideation, where **relational and emotional care should be prioritised** (Hagen et al. 2017, Muskett 2014). Utilising a trauma-informed lens, leaders can cultivate cultures in which employees avoid emotionally unsafe and disempowering practices, and instead nurture patient recovery by prioritising interpersonal and collaborative care processes, including connectedness and shared decision-making (Muskett 2014). Simultaneously, in such cultures, employees are encouraged to be sensitive and responsive to their own needs and experiences, including the emotional impact of caring, and their risk of vicarious trauma, burnout, and compassion fatigue (Sweeney et al. 2018). This is important given that nurses' emotional competencies are central to providing sensitively attuned care. However, nurses also referred to the possibility of becoming emotionally exhausted because of their interaction with patients with suicidal ideation (e.g. Chapter 8).

In such a context, **nurses need adequate resources and support systems**. Policymakers and leaders should enable nurses' time spend in direct care by ensuring adequate staffing and reasonable workloads. This can reduce the daily pressure on nurses as well as enable the consistency in nurse-patient interaction, and thereby potentially foster therapeutic relationships (Forchuk and Reynolds 2000, Seed et al. 2010, Sharac et al. 2010). Additionally, hospital leaders and ward leaders (e.g. head nurses) in particular, must provide tailored support for nurses by acknowledging them as people, and by including and being attuned to their needs and concerns. They are in a good position to encourage a culture of individual and team support by facilitating opportunities for debriefing, intervision (a team-based coaching and learning method), and supervision. This culture should represent a safe space in which nurses can express, discuss, and regulate their actions, attitudes, beliefs, and emotions. This, in turn, would allow nurses to detect and resolve issues that interfere with their ability to engage interpersonally with patients who experience suicidal ideation (Hagen et al. 2016, Lees et al. 2014).

Opportunities for debriefing, intervision, and supervision are also recommended strategies to curtail a culture in which **fear of blame and litigation prevails** (Awenat et al. 2017). This is a core concern for nurses in relation to potential suicide (attempts) (Chapter 4). Essentially, this sense of fear induces a kind of nursing practice that is grounded in organisational and professional needs (e.g. it serves defensive and self-protective strategies), instead of being concerned with meeting the individual needs of patients through interpersonal engagement

(Morrissey and Higgins 2019). Strategies to reduce fear of blame and litigation must allow nurses time to reflect on their own functioning, feel empowered, and take opportunities for support in developing resilience and self-care. Simultaneously, critical incidents, such as suicide (or attempted suicide), should be reviewed not to blame people, but to nurture trust in professional judgements, and provide support and learning opportunities for everyone involved (Awenat et al. 2017, Slemon et al. 2017).

The processes underlying fear of blame and litigation (e.g. self-protection) suggest that **patient safety is sometimes understood solely in terms of professional responsibility and accountability**. However, such understanding encourages an emphasis on controlling and managing suicide risk through paternalistic interventions (Slemon et al. 2017). This contradicts the focus on patient participation in issues of patient safety (Chapters 2-3) and raises critical questions regarding a professional's responsibility and accountability. Should we then also blame professionals for using counterproductive custodial-oriented approaches or for developing poor relationships with patients (e.g. with low levels of empathy), which might also lead to suicide death (Burgess et al. 2000)? It is time to redefine professional responsibility and accountability in a way that is more closely related to and values interpersonal and relationship-based care for patients with suicidal ideation. Indeed, within a recovery philosophy, fully accountable and responsible nurses strive for a judicious use of protective interventions and consider their relationship with patients as essential (Rio et al. 2020). Moreover, they facilitate meaningful patient participation by sharing decisions and responsibilities and considering positive risk-taking opportunities, but without letting go of their responsibility to assist patients during periods of acute suicidality (Manuel and Crowe 2014, Morrissey and Higgins 2019).

Unfortunately, all too often, **nurses themselves do not value, overlook, or underestimate the benefits of establishing interpersonal and collaborative interactions** with patients. Rather, they conform to defensive practices to 'keep the ward safe', follow the 'group norm', or appear satisfied to settle for a subordinate role within systems dominated by a medical model (Barker and Buchanan-Barker 2011, Seed et al. 2010). These nurses might even represent a so-called 'unresponsive organisational culture', and this is a barrier to developing person-centred care (Beckett et al. 2013). Conversely, the development of a person-centred care culture can appeal to and enable self-responsibility in nurses. This type of culture flourishes in hospitals and wards with less structural hierarchy, and where there are more clinical leadership roles. In such hospitals, policymaking is based on a vision of care, and leaders enable nurses' professional development through principles such as, participation, learning, autonomy, and empowerment (Beckett et al. 2013). These principles should underpin opportunities for debriefing, intervision, and supervision. Moreover, such opportunities must be provided within a framework that fosters interpersonal, relational, and

emotional care, instead of merely focusing on tasks or mandatory procedures (Awenat et al. 2017, Berg et al. 2017).

In Belgium, **advanced practice nurse roles for master-educated nurses** have been formally recognised (Rafferty et al. 2019). Within this context, the role of nurse specialists is being defined and their implementation is considered pivotal for the scientific development of the nursing workforce (Deproost 2018). Nurse specialists can ensure quality care for people with multifaceted care needs (including people with suicidal ideation) by delivering complex relationship-based care and implementing evidence-based interventions (Hanrahan et al. 2012, Perraud et al. 2006). Based on this dissertation, nurse specialists might play a crucial role in ensuring the development and integrity of a person-centred and collaborative care culture. For instance, they can coach nurses to realise more fully an integrative perspective between interpersonal engagement and a skilled involvement in suicide risk assessment and management. This is important as nurses might use evidence-based interventions, such as safety and crisis response planning, as a professional instrument to manage suicide risk, rather than as an instrument that represents a process of co-production to support a patient's self-management (Chapter 4).

Implementing and developing a patient participation culture in the hospital is of paramount importance. Hospital and ward leaders and nurses themselves should recognise their central role in promoting such a culture (Chapters 2–3). Patient participation must be considered and promoted in different modalities and at all levels in the organisation. Foremost, it is essential that patients can lead their own recovery process by participating in their care and treatment (Sellin et al. 2017). This is necessary as patients all too often think of themselves as being in a system where they have no voice and choice (Chapter 6), or nurses coerce patients into believing and accepting their own viewpoints regarding safety interventions (Chapters 4 and 8). Additionally, the perspectives and lived experiences of patients should be incorporated into the ways in which suicide risk assessment and management practices are performed (Berg et al. 2017). This calls for the design of complex interventions, as the conceptual understandings in the present dissertation indicate a complex integration of interpersonal and clinical care processes (Chapter 8). From a methodological perspective, such complex interventions can be supported by co-design trajectories with an emphasis on patient participation (Castro et al. 2018, van Meijel et al. 2004).

Interrelated with implementing and developing a patient participation culture, **the involvement of peer workers in mental healthcare** is emerging internationally and also in Flanders (Vandewalle and Debyser et al. 2016, 2017). Peer workers can make an important contribution to suicide prevention and suicidal ideation treatment, in particular by supporting peers by forming 'natural' connections and a hope-inspiring engagement (Huisman and

Bergen 2018, Pfeiffer et al. 2019). Moreover, their perspectives and lived experiences are central to organisational cultures that are recovery-oriented, and that work towards services that are accessible (e.g. by reducing stigma), tailored to personal needs, and promote inclusive communities (Slade et al. 2014). Peer workers should be involved in a manner that allows them to make an authentic and meaningful contribution, construct a positive identity, and experience support to manage and promote their own well-being (Vandewalle and Debyser et al. 2016, 2017).

Policymakers should acknowledge the evidence that suicide risk assessment instruments lack sensitivity and specificity to predict suicide and that **suicide risk categorisation approaches (e.g. high- and low-risk groups) are not a suitable basis for clinical decision-making** in inpatient settings (Belsher et al. 2019, Carter et al. 2017). Moreover, as noted previously, suicide risk categorisation approaches inform a way of clinical reasoning in practice in which nurses *check, control,* and *direct* patients as risk objects that need to be managed. Against this background, the need for nurses who make contact with patients as individuals, look beyond a patient's behaviour, and develop skills and qualities in being sensitively vigilant and attentive (e.g. for suicide cues, patient's needs and positive signs) is highlighted (Chapters 4-8).

The need for patients to interact with nurses who care for and acknowledge them as unique individuals (Chapter 6) highlights that **providing nursing care for individuals with suicidal ideation is, in essence, an interpersonal endeavour**. Nurses should be proactive in talking with patients about suicidal ideation. This should not be done with a narrow view on preventing suicide, but with a focus on validating the patients' emotions, exploring needs, allowing patients to give voice to themselves and their suicidality, and negotiating a collaborative approach. In this way, nurses can enable a nurturing space in which patients can learn to cope with their suicidality, and (re)establish close ties with other people, services, and life itself (Chapter 6).

However, with regard to the latter, **nurses seemed to pay little attention to the involvement of relatives**, despite the vital role of relatives in patients' recovery (Sellin et al. 2017), and in suicide prevention and suicidal ideation treatment (Aerts et al. 2017). However, the systematic review (Chapter 6) called for a considerate approach, highlighting that not all people with suicidal ideation have 'close ties' with their relatives, and instead, these interactions might be characterised by shame, lack of support, or abusive relationships. In this context of complex relationships, one concrete strategy to enable the involvement of relatives can be to support nurses in safety and crisis response planning, with an emphasis on partnership with patients and their relatives (Bryan et al. 2017, Stanley and Brown 2012). This emphasis on partnership and strengths-based approaches is crucial because the literature points to the risk that family members might be only involved as a 'source of

information' (Vandewalle et al. 2020a) or as an 'extension of the surveillance network', wherein they are expected to stay with and observe the patient (Morrissey and Higgins 2019). However, when family members are pulled into such professional- and custodial-oriented roles, this undermines their caring and nurturing presence as a family member.

In line with the advice of the Belgian Superior Health Council (2016a), **coercive interventions such as seclusion must be avoided in mental healthcare** as much as possible. They can only be used as a last resort and should be performed in a safe and respectful way. However, in line with the recent qualitative literature review of Hawsawi and colleagues (2020), this dissertation highlights that practices, such as door-locking and seclusion, continue to be used, and can have a negative impact on patients (e.g. feeling overpowered, punished), and the nurse-patient interaction (e.g. distrust, disruption of open communication and connection). More awareness is needed for 'second order risks' in persons with suicidal ideation (Higgins et al. 2016). This means that coercive interventions are used to prevent risk, but they actually result in increased risks to patients by increasing emotional harm, feelings of hopelessness, and social isolation (Beck et al. 1990, Van Orden et al. 2010). Such insights are significant and should prompt a critical review of restrictive hospital and ward rules and routines, and a critical reflection on their effect and indication.

Alternatives for restraint and seclusion are highly recommended, as the need to reduce restraint and seclusion is clear, but it must not result in hospital wards that become, or feel, unsafe for patients or nurses (Wilson et al. 2017). Within this understanding, the present dissertation suggests that nurses can benefit from guidance on using evidence-based strategies, such as safety and crisis response planning (Bryan et al. 2017, Stanley and Brown 2012). Specific nursing guidelines that promote a collaborative perspective in risk assessment and safety planning are necessary (e.g. Higgins et al. 2015). When becoming proficient in such collaborative practices, nurses will be better able to support early recognition of warning signs, proactive planning of preventive actions through shared decision-making, and supporting patients' self-management (Fluttert et al. 2008, Kontio et al. 2012).

Additionally, the **principle of de-escalation is relevant in mental healthcare** and in providing nursing care for patients with suicidal ideation (Price and Baker 2012). The literature suggests that an interpersonal engagement with emphasis on empathy, listening, and providing comfort may in itself have a de-escalating effect on patients who are in crisis (Kontio et al. 2012). Nurses could expand this potential by becoming proficient in de-escalating strategies, such as using a calm voice and intonation, be aware of body language, and mitigate a reaction for protection and control (Bowers 2014, Price and Baker 2012). Such de-escalating strategies are essential in a context where nurses should carefully reflect

on how they present themselves in relation to caring for patients who are highly vulnerable and sensitive to the nurses' attitudes and responses (Chapter 6).

In line with deinstitutionalisation, policymakers and hospital leaders must **encourage the development of chains of care in suicide prevention and the treatment of suicidal ideation** (Aerts et al. 2017). This will require strategic decisions on how and where to position nurses in the chain of care. In this respect, mental health nurses could make a valuable contribution to low-threshold community services. They can become involved in community-based teams to support people in the context of their daily lives, or work closely with general practitioners. From a low-threshold position, nurses can expand their role in suicide prevention and the treatment of suicidal ideation. They can provide evidence-based psychosocial interventions, including brief contact interventions (Fleischmann et al. 2008), and coproduce safety and crisis response plans with individuals who experience suicidal ideation (Bryan et al. 2017, Stanley and Brown 2012). This focus on accessible (self-help) interventions is important in Flanders, where experiences of shame and stigma often prevent people with suicidal ideation from accessing mental health services and encourage them to use psychotropic medication (Reynders et al. 2014). This might also partly explain the high use of psychotropic medication in the Flemish population more broadly (approximately 16% in 2013; Mistiaen et al. 2019, p. 61).

9.4.2. Recommendations for nursing education

In line with the core strategies of the Flemish Suicide Prevention Action Plan (Department of Welfare, Public Health and Family 2012), it is important to consider the education of nurses who interact with individuals who experience suicidal ideation. In essence, **nurses must have adequate basic education and follow-up training** in order to support their ongoing professional development. While education and training opportunities are important, nurses themselves should seek and acknowledge the value of such opportunities.

From a quality of care perspective, **nurse educators should review nursing curricula** to ensure that they are based on a person-centred and collaborative paradigm. The aim should be to enable the broad implementation of nurses who represent basic attitudes, such as demonstrating compassion and acceptance, as well as interpersonal, reflective, and collaborative skills. Education and training programmes that embrace this perspective are crucial for the future of mental health nursing, as they can inculcate in nurses a professional identity oriented to person-centred and collaborative care. In Belgium, the diploma degree and bachelor's degree in nursing (Rafferty et al. 2019) provide opportunities to incorporate the core insights of this dissertation, such as patients' need to give voice to themselves and

the lack of an integrative perspective between interpersonal engagement and suicide prevention practices.

Regarding the bachelor's degree in nursing specifically, it is hoped that the new 'generic' four-year curriculum does not emphasise nursing as a mere technical and coordinating endeavour (e.g. undertaking assessments). This could lead to an erosion of nurses' interpersonal and communicative skills (Cutcliffe and McKenna 2018), thereby leaving them ill-prepared for approaching individuals in open and sensitive ways, such as when discussing suicide (Bolster et al. 2015). Alternatively, the new bachelor in nursing programme offers opportunities to include a **person-centred vision for nursing that promotes a holistic orientation on physical, psychological, and social aspects** of a person's illness and recovery experiences in everyday life (Deproost 2018). Furthermore, universities that offer a master's degree in nursing have a responsibility to enable quality mental health nursing by providing advanced programmes centred on relationship-based care within a recovery-orientation and support the development of competent nurse specialists (Doyle et al. 2018, Hanrahan et al. 2012).

Basic education programmes and workplace training should transcend a medical and technical orientation as well as a narrow view of suicide prevention (Michel and Jobes 2011, Tee and Üzar Özçetin 2016). Rather, education and training should incorporate an **integrative offer that aims to support nurses' interpersonal skills and qualities, communication skills, as well as their knowledge and technical skills.** For example, the dissertation suggests that education and training programmes can combine content towards enhancing:

- Nurses' interpersonal skills and qualities: acknowledging patients as individuals, validating patients' emotions (e.g. compassion);
- Nurses' communication skills: non-verbal skills, and listening and talking skills to attend to a patient's narrative, enable shared decision-making, and de-escalate crises situations (e.g. talk in a soft tone); moreover, nurses can benefit from skills to discuss suicide, and build conversations that help patients develop insight into their suicidal ideation;
- Nurses' knowledge and technical skills: suicide-related warning signs, risk and protective factors, and the use of evidence-based collaborative strategies (e.g. safety planning); additionally, nurses can benefit from understanding processes involved in nurse-patient interaction, the suicidal process, and the lived experience of suicidal ideation (e.g. perceived burdensomeness).

An integrative offer in nursing education that supports skills, knowledge, and attitudes like those presented above, is important for promoting person-centeredness and recovery-

orientation in practice. This accords with the perspectives of patients that suggest that **nurses with a repertoire of diverse skills and qualities** have the most to offer. For instance, patients indicate that they can develop a sense of trust and security when they interact with nurses who are competent in helping them to talk about and reflect on their suicidality and coping strategies, and able to tolerate, accept, and understand their feelings (Chapter 6).

To enhance the nurse's repertoire of skills and qualities, the literature emphasises the value of **using a mixture of experiential and interactive learning formats**, including clinical placements, audio taping encounters, role-playing, and narrative-based virtual patient simulation (Guise et al. 2012, Tee and Üzar Özçetin 2016). Education and training programmes should acknowledge that, as noted previously, nurses' reflective skills and self-awareness represent a crucial factor for sensitively attuned nurse-patient interactions. Therefore, small group formats can be facilitated that allow (student) nurses to work on their personal development, reflect on their attitudes, develop critical thinking skills, and get in touch with their own prejudices, needs, and fears (e.g. issues of self-protection) (Deproost 2018, Scheckel and Nelson 2014).

More specifically, educative e-learning modules are a user-friendly approach to enable nurses to become more proficient in making contact with patients who experience suicidal ideation, including aspects related to talking about suicide (Aerts et al. 2017). Furthermore, specific training formats based on the relational foundations of nursing care, such as those present in the working alliance, can be considered (Chapter 8). For example, Kar Ray and colleagues (2020) developed a working alliance-based suicide prevention training framework. This framework centres empathy, proactive detection, and reflection on clinical decisions and positive risk-taking. Considering the dissertation's results, such relationship-based frameworks can make an essential contribution to suicide prevention approaches, which are all too often confined to behavioural control and physical restriction (Fitzpatrick and River 2018). Indeed, suicide risk assessment and management training must be given with a focus on interpersonal engagement with patients (Michel and Jobes 2011).

Furthermore, to promote a person-centred and collaborative paradigm in nursing practice, the literature suggests that the **involvement of individuals with lived experiences of suicidal ideation** in education and training might positively impact the attitudes of (student) nurses, the values they pursue, their reflection and self-awareness, and their ability to connect with patients as individuals (Byrne et al. 2013, Happell et al. 2019, Tee and Üzar Özçetin 2016). More specifically, this dissertation suggests that incorporating individuals' lived experiences in nursing education might provide an essential perspective from which to consider how to provide nursing care, including how patients want to participate in their care

and treatment, how they want to have conversations about suicide, and how they want interventions for risk assessment and management to be used (e.g. safety planning).

The two instruments included in this dissertation, the **PaCT-PSY and the CoNuPaS, can highlight diverse and specific areas of nurse-patient interaction that require attention** in education and training. For example, policymakers can focus on the collaborative behaviours of nurses and other mental health professionals to facilitate patient participation (e.g. sharing information, dialogue, and sharing responsibilities) (Chapter 2), or they can focus on the needs of patients in relation to being enabled by nurses to express their suicidal ideation and explore their needs (Chapter 7).

A central insight of this dissertation is that **nurses often do not fully realise their espoused nurturing potential** (encompassing caring and healing processes) (Deproost 2018). Nurses are not always aware of the importance to reflect on how they present themselves to persons with suicidal ideation (Chapter 6). Moreover, they often have little focus on assisting patients to resolve their mental health problems (Peplau 1997). Indeed, nurses are often focused on giving advice and distracting patients, rather than investigating patients' difficulties in daily living (e.g. feeling hopeless). Moreover, some nurses are focused on categorising the expressions of patients and controlling suicide risk, and this precludes them from understanding and responding to patients in a sensitive and attuned way. This diminishes nurturing potential, or as expressed in previous studies, reflects an 'untapped therapeutic potential' in mental health nursing (Cameron et al. 2005, Lees et al. 2014).

Education and training programmes can **enhance nurses' psychotherapeutic skills and awareness of therapeutic processes**. Such programmes can provide nurses with concepts and principles that enable them to gain a deeper understanding of themselves and the possible meanings of patients' suicidal expressions (Morrissey and Higgins 2019). Particularly, mentalisation-informed programmes may improve nurses' capacity to become aware of, reflect on, and understand their own and others' mental states (e.g. needs, feelings, beliefs) (Bateman and Fonagy 2012). This capacity is pivotal for the interpersonal process (Delaney et al. 2017), including the potential to be and remain connected and attuned to patients (Chapter 8). Moreover, this can inform a way of clinical reasoning in nursing, which is based on interpersonal and person-centred treatment, instead of a narrow diagnostic and suicide risk categorisation.

While education and training are important in promoting interpersonal nursing and nurses' contribution to suicide prevention, the **relative contribution of education and training** should be acknowledged. Indeed, there is only moderate evidence to support the effectiveness of suicide prevention education programmes for nurses (Ferguson et al. 2018). This can be partly explained by the notion that certain qualities and skills underpinning effective interpersonal practices, such as compassion, empathy, and emphasising shared

humanity are difficult to teach. While well-considered education and training programmes can support nurses' potential to develop interpersonal qualities and skills (Tee and Üzar Özçetin 2016), at least some of this potential or the lack of this potential is underpinned by a person's personality before one becomes a nurse (Cleary et al. 2012). Additionally, the contribution of education may be relative when student nurses are educated in person-centred approaches, but become quickly socialised in hospitals where impersonal, custody and containment-focused nursing are the norm (Cutcliffe and McKenna 2018). Thus, this reiterates our point that recommendations for clinical practice, education, and research are best interpreted from an integrative perspective.

9.4.3. Recommendations for further research

In terms of further research, a first point to consider is that this dissertation is noteworthy for its focus on the **integration of elements of interpersonal engagement with aspects of suicide risk assessment and management.** For example, it was highlighted that some nurses observe patients without interpersonal engagement or involve in safety planning with few intentions to collaborate with patients. Conversely, nurses can foster an interpersonal engagement with patients, but simultaneously, refrain from evaluating suicide risk on a regular basis (Chapter 8). Researchers focusing on these topics might be inspired by the qualitative approaches in this dissertation with an emphasis on 'uncovering underlying processes'. Such approaches can enrich the insight on how suicide prevention practices can be more meaningfully embedded within a person-centred and collaborative paradigm.

This focus on 'embeddedness' is relevant to researchers in many healthcare domains. In nursing, the fundamentals of care framework is receiving increasing attention (Kitson et al. 2013). Central to this framework is the patient-nurse relationship, which underpins and mediates the integration of physical and psychosocial care dimensions. Based on this framework, researchers increasingly highlight the lack of an integrative perspective in nursing practice, where, for instance, bathing a patient is seen simply as an act to attain cleanliness rather than an opportunity to connect with patients and to provide person-centred care (Feo and Kitson 2016). Similarly, in the present dissertation, nurses seemed to have limited attention for providing physical care and involving the relatives of patients. Within this view, further research in the context of psychiatric hospitals might consider the fundamentals of care framework as a source of inspiration to examine the physical, psychological, and social aspects relevant to nursing care for patients with suicidal ideation (Kitson et al. 2013).

Furthermore, quantitative and qualitative studies can apply a **longitudinal process-oriented framework consisting of data collection at different moments in time**. Such research

can provide new insights into how nurse-patient interactions and relationships (e.g. working alliance) develop over time, how they affect patient and nurse experiences, and how they facilitate or impede micro-processes in a person's clinical, personal, and social recovery (Leamy et al. 2011, Lloyd et al. 2008). Within this context, studies from a nurse and patient perspective can, for instance, focus on the process of supporting or restricting ward leave of patients. Such understanding is important, as nurses in psychiatric hospitals are often involved in coordinating ward leave, but there is limited evidence on the underlying processes of 'therapeutic leave' and positive risk-taking approaches more broadly (Barlow and Dickens 2018). Without a deeper understanding of such risk-related processes in everyday practice, nurses might continue to approach patients in reductive ways, even in contexts where a recovery model is promoted (Higgins et al. 2016).

Future research could apply the **suicidal process as the focal point of research**, and then explore how this process is related to a person's interactions and relationships with mental health professionals. This could enrich insights in this dissertation, including the insight that when patients gain a sense of being cared for and acknowledged as a person, this may counter their perceptions of isolation and burdensomeness (Chapter 6). Similarly, innovative research in the domain of interpersonal neurobiology can enable the scientific underpinning of how processes in interpersonal nurse-patient interaction can help patients lead a more meaningful life. To this end, researchers have started to integrate concepts of interpersonal neurobiology with fundamental concepts of mental health nursing, including care, connection, narrative, and anxiety (Delaney et al. 2017, Wheeler 2011). This interaction is based on the understanding that interpersonal experiences (e.g. emotional attunement) play a significant role in forging key connections in the brain (Siegel 2012). This is potentially a promising avenue for providing insights and a language that fosters a person-centred and collaborative paradigm in nursing practice, and in suicide prevention and treatment of suicidal ideation.

From the perspective of person-centred care, an issue that raised the author's interest during the course of his doctoral study is the potential to **converge studies with either a focus on suicide or euthanasia**. In Belgium, psychological suffering stemming from mental health problems is acknowledged as a valid legal basis for euthanasia (Thienpont et al. 2015). In this context, further qualitative research could explore how patients, relatives, and professionals perceive and give meaning to suicide and euthanasia. Converging and contrasting data from such research might enrich the nuanced understanding of interactional aspects, such as talking about death, forming person-to-person connections, and the impact of caring for all individuals involved. Moreover, the dissertation's findings reflect the strong focus of nurses on protecting life and preventing death. However, Ho (2014) asserts that other views should not be neglected, such as an individual's right to body ownership and an individual's perception that suicide may be the best—and even a rational—solution. Against

this background, studies integrating perspectives on suicide and euthanasia may create a space for deepening the understanding of nuances within concepts, such as professional power and patient autonomy, that are possibly overlooked in the field of suicidology.

Further research could explore whether the observed dynamics in nurse-patient interactions are specific to nursing, or whether additional concepts and processes play a role in the **interaction between patients and other mental healthcare professionals**. Furthermore, acknowledging that professional disciplines do not 'operate in a silo' (Grant and Lusk 2015), research should further explore team dynamics, including issues of teamwork, team support, and team hierarchy. For example, a study that examines the perspectives of different disciplines can enhance the understanding of how the nurses' engagements intersect with those of other professionals (e.g. psychiatrists) within the multidisciplinary process of care and treatment.

Further research should **transcend the psychiatric hospital context and give more attention to principles of continuity of care** (Aerts et al. 2017). Acknowledging the international shift toward community-based mental healthcare, critical research is needed on nurse-patient interactions in a community- and home-based context. In this respect, the open dialogue approach is receiving international attention (Freeman et al. 2019, Seikkula et al. 2011). Open dialogue is a social network approach to mental healthcare that focuses on early contact in crisis situations, and connecting with and empowering a patient's support system. In this approach, meetings are facilitated between patients, their relatives, and mental healthcare professionals in which there is space to share experiences and decision-making around resources, treatment planning, and goals (Seikkula et al. 2011). Based on the present dissertation, the author believes that it could be worthwhile to study the open dialogue approach in the context of suicidality, where interpersonal communication, involvement of relatives, and co-produced safety planning are of paramount importance.

Further research should focus on populations beyond those considered in this doctoral study. More attention should be given to **children, youth, and older adults with suicidal ideation**, and nurses working on wards where these populations are admitted. This is important in Belgium, where suicide, suicide attempts, and suicidal ideation occur in youth populations (Gisle et al. 2020), and the suicide rate among older men is considered high (van Landschoot et al. 2018). Moreover, a life span perspective is recommended, because the onset of suicidal ideation and behaviour during childhood might persist into adulthood (Van Orden et al. 2010).

Additionally, one can argue that this dissertation as well as guidelines for suicide prevention (e.g. Aerts et al. 2017) particularly promote a practice where verbal interaction, such as discussing suicide and therapeutic communication, is of central importance. However, a narrow focus on verbal and therapeutic aspects of interaction may not suit those people with

suicidal ideation who have reduced verbal, intellectual, or learning capacities. This can be a topic of further study.

Following this dissertation, it might be worthwhile to associate the previously discussed nurturing dimensions in nursing (i.e. caring and healing) and the main nursing approaches (e.g. connecting versus controlling) with **nurse recruitment, job satisfaction, and retention**. These are pressing issues in nursing, where up to 30% of nurses report of their intention to leave the hospital within the next year as a result of job dissatisfaction (Aiken et al. 2013). Further research can examine the hypothesis that the opportunity for nurses to work in accordance with a person-centred and collaborative paradigm that nurtures recovery promotes nurse recruitment, job satisfaction, and retention. Considering this, Seed and colleagues (2010) found that psychiatric hospital nurses' job satisfaction was higher in those nurses who involved more in providing individualised patient care and developing therapeutic relationships. They concluded that promoting an orientation on individualised care and therapeutic relationships will **revitalise nursing practice**, thereby supporting nurse retention and recruitment. Similarly, in their hospital study, Ray and colleagues (2011) found that a practice change from using formal observations toward an approach of active engagement and individualised patient care increased the professionals' job satisfaction. However, such associations do not yet have a strong scientific underpinning, and, as shown in this dissertation, will most likely be subject to a range of mediating factors (e.g. nurse autonomy, supervision, and emotional support).

Future research should further the understanding of how **upcoming innovative technologies and online interventions in suicide prevention and treatment of suicidal ideation** interact with face-to-face human contact, and how this interaction should be negotiated and understood. In Belgium and other countries, technologies such as social media, online self-help, and smartphone applications (e.g. BackUp and On Track Again in Flanders) appear to be promising tools to support people seeking help and coping with suicidal crises (De Jaegere et al. 2019, Pauwels et al. 2017, Torok et al. 2020). Given that nurses play a crucial role in supporting patients' help-seeking and self-management, they are in a good position to support the use and implementation of innovative technology. As with every intervention, technology-focused interventions should be embedded within the context of interpersonal engagement. Indeed, the use of technology should not overshadow the provision and vital importance of human contact for individuals with suicidal ideation. Unfortunately, in some inpatient mental health settings, the use of technology, including microphone and video surveillance, informs a practice wherein nurses *check*, *control*, and *direct* patients from their nursing station, and wherein patients are no longer personally known, related to, or understood by nurses (Appenzeller et al. 2019, Cutcliffe and McKenna 2018). More subtly, technology-focused interventions can disempower patients when they

become part of a surveillance network, such as when nurses impose the expectation on patients to phone them during weekend leave (Chapter 4).

To conclude, the author of the dissertation would like to assert that studying the interactional and relational aspects of nursing care in the domain of suicidality is very complex. This complexity should should neither be feared nor simplified. Rather, it should be embraced and studied in order to enhance the understanding of the nature and value of a person-centred and collaborative paradigm in providing nursing care, and in suicide prevention and suicidal ideation treatment. This perspective is vital and, therefore, should be recognised in the third Flemish Suicide Prevention Action Plan (Department of Welfare, Public Health and Family 2012).

REFERENCES

Aerts, S., Dumon, E., Van Heeringen, K. & Portzky, G. (2017). *Detectie en behandeling van suïcidaal gedrag: multidisciplinaire richtlijn voor hulpverleners in de gezondheidszorg*. Brussel: Politeia.

Aiken, L. H., Sloane, D. M., Bruyneel, L., Van den Heede, K., & Sermeus, W. (2013). Nurses' reports of working conditions and hospital quality of care in 12 countries in Europe. *International Journal of Nursing Studies, 50*, 143-153. https://doi.org/10.1016/j.ijnurstu.2012.11.009

Aiken, L. H., Sloane, D. M., Bruyneel, L., Van den Heede, K., Griffiths, P., Busse, R., . . . Sermeus, W. (2014). Nurse staffing and education and hospital mortality in nine European countries: a retrospective observational study. *The Lancet*, 383, 1824-1830. doi.org/10.1016/S0140-6736(13)62631-8

Akther, S. F., Molyneaux, E., Stuart, R., Johnson, S., Simpson, A., & Oram, S. (2019). Patients' experiences of assessment and detention under mental health legislation: systematic review and qualitative meta-synthesis. *BJPsych open*, *5*. https://doi.org/10.1192/bjo.2019.19

Allison, S., Bastiampillai, T., Licinio, J., Fuller, D. A., Bidargaddi, N. & Sharfstein, S. S. (2017). When should governments increase the supply of psychiatric beds? *Molecular Psychiatry*, 23, 796-800. doi.org/10.1038/mp.2017.139

Appenzeller, Y. E., Appelbaum, P. S., & Trachsel, M. (2019). Ethical and Practical Issues in Video Surveillance of Psychiatric Units. *Psychiatric Services*. doi.org/10.1176/appi.ps.201900397

Awenat, Y., Peters, S., Shaw-Nunez, E., Gooding, P., Pratt, D. and Haddock, G. (2017). Staff experiences and perceptions of working with in-patients who are suicidal: qualitative analysis. *The Britisch Journal of Psychiatry*, 211, 103-108. https://doi.org/10.1192/bjp.bp.116.191817

Barbui, C., Papola, D. & Saraceno, B. (2018). Forty years without mental hospitals in Italy. *International Journal of Mental Health Systems*, 12. https://doi.org/10.1186/s13033-018-0223-1

Barker P. (2003). The Tidal Model: psychiatric colonization, recovery and the paradigm shift in mental health care. *International Journal of Mental Health Nursing*, 12, 96-102. doi.org/10.1046/j.1440-0979.2003.00275.x

Barker, P. & Buchanan-Barker, P. (2011). Myth of mental health nursing and the challenge of recovery. *International Journal of Mental Health Nursing*, 20, 337-344. doi.org/10.1111/j.1447-0349.2010.00734.x

Barlow, E. -M., & Dickens, G. L. (2018). Systematic review of therapeutic leave in inpatient mental health services. *Archives Of Psychiatric Nursing*, *32*, 638-649. doi.org/ 10.1016/j.apnu.2018.02.010

Bateman, A. W., and Fonagy, P. (2012). *Handbook of mentalizing in mental health practice.* Washington DC: American Psychiatric Publishing.

Beck, A., Brown, G., Berchick, R., Stewart, B., Steer, B. (1990). Relationship between hopelessness and ultimate suicide: a replication with psychiatric outpatients. *American Journal of Psychiatry*, 147, 190-195. doi.org/10.1176/ajp.147.2.190

Beckett, P., Field, J., Molloy, L., Yu, N., Holmes, D., & Pile, E. (2013). Practice what you preach: developing person-centred culture in inpatient mental health settings through strengths-based, transformational leadership. *Issues in Mental Health Nursing, 34*, 595-601. doi.org/10.3109/01612840.2013.790524

Belsher, B. E., Smolenski, D. J., Pruitt, L. D. et al. (2019). Prediction Models for Suicide Attempts and Deaths: A Systematic Review and Simulation. *JAMA Psychiatry*, 76, 642-651. doi.org/10.1001/jamapsychiatry.2019.0174

Benner, P. (1982). From novice to expert. *American Journal of Nursing*, 82, 402-407.

Berg, S.H., Rørtveit, K., & Aase, K. (2017). Suicidal patients' experiences regarding their safety during psychiatric in-patient care: a systematic review of qualitative studies. *BMC Health Services Research*, 17, 73. doi.org/10.1186/s12913-017-2023-8

Björkdahl A., Palmstierna T., & Hansebo G. (2010). The bulldozer and the ballet dancer: aspects of nurses' caring approaches in acute psychiatric intensive care. *Journal of Psychiatric and Mental Health Nursing*, 17, 510–518.

Bolster, C., Holliday, C., Oneal, G. and Shaw, M. (2015). Suicide Assessment and Nurses: What Does the Evidence Show? *The Online Journal of Issues in Nursing*, 20. doi.org/10.3912/OJIN.Vol20No01Man02

Bowers, L. (2014). Safewards: a new model of conflict and containment on psychiatric wards. *Journal of Psychiatric and Mental Health Nursing*, 21, 499-508. doi.org/10.1111/jpm.12129

Bryan, C. J., Mintz, J., Clemans, T. A. et al. D. (2017). Effect of crisis response planning vs. contracts for safety on suicide risk in U.S. Army Soldiers: A randomized clinical trial. *Journal of Affective Disorders*, 212, 64-72. doi.org/10.1016/j.jad.2017.01.028

Burgess, P., Pirkis, J., Morton, J. & Croke, E. (2000). Lessons from a comprehensive clinical audit of users of psychiatric services who committed suicide. *Psychiatric Services*, 51, 1555-1560. doi.org/10.1176/appi.ps.51.12.1555

Byrne, L., Happell, B., Welch, T. & Moxham, L. J. (2013). 'Things you can't learn from books': teaching recovery from a lived experience perspective. *International Journal of Mental Health Nursing*, 22, 195-204. doi.org/10.1111/j.1447-0349.2012.00875.x

Cameron, D., Kapur, R. & Campbell, P. (2005). Releasing the therapeutic potential of the psychiatric nurse: a human relations perspective of the nurse–patient relationship. *Journal of Psychiatric and Mental Health Nursing*, 12, 64-74. doi.org/10.1111/j.1365-2850.2004.00796.x

Carlén, P. and Bengtsson, A. (2007). Suicidal patients as experienced by psychiatric nurses in inpatient care. *International Journal of Mental Health Nursing*, 16(4), 257-265. doi.org/10.1111/j.1447-0349.2007.00475.x

Carter, G., Milner, A., McGill, K., Pirkis, J., Kapur, N. & Spittal, M. J. (2017). Predicting suicidal behaviours using clinical instruments: systematic review and meta-analysis of positive predictive values for risk scales. *British Journal of Psychiatry*, 210, 387-395. doi.org/10.1192/bjp.bp.116.182717

Castro, E. M., Malfait, S., Van Regenmortel, T., Van Hecke, A., Sermeus, W., & Vanhaecht, K. (2018). Co-design for implementing patient participation in hospital services: A discussion paper. *Patient Education and Counseling,* 101, 1302-1305. https://doi.org/10.1016/j.pec.2018.03.019

Chung, D.T., Ryan, C.J., Hadzi-Pavlovic, D., Singh, S.P., Stanton, C. and Large, M.M. (2017). Suicide Rates After Discharge From Psychiatric Facilities: A Systematic Review and Meta-analysis. *JAMA Psychiatry*, 74, 694-702. doi.org/10.1001/jamapsychiatry.2017.1044

Cleary, M., Hunt, G. E., Horsfall, J. & Deacon, M. (2012). Nurse-patient interaction in acute adult inpatient mental health units: a review and synthesis of qualitative studies. *Issues in Mental Health Nursing*, 33, 66-79. doi.org/10.3109/01612840.2011.622428

Crawford, P., Brown, B., & Majomi, P. (2008). Professional identity in community mental health nursing: A thematic analysis. *International Journal of Nursing Studies 45*, 1055-1063. doi.org/10.1016/j.ijnurstu.2007.05.005

Cutcliffe, J. R., & Barker, P. (2002). Considering the care of the suicidal patient and the case for 'engagement and inspiring hope' or 'observations'. *Journal of Psychiatric and Mental Health Nursing*, *9*, 611-621. doi.org/10.1046/j.1365-2850.2002.00515.x

Cutcliffe, J.R. and Happell, B. (2009). Psychiatry, mental health nurses, and invisible power: Exploring a perturbed relationship within contemporary mental health care. *International Journal of Mental Health Nursing*, 18, 116-125. doi.org/10.1111/j.1447-0349.2008.00591.x

Cutcliffe, J. R., & McKenna, H. (2018). Psychiatric/mental health nursing in the 21st century: It's 'déjà vu' all over again!. *International Journal of Nursing Studies*, 81, A3–A5. https ://doi.org/10.1016/j.ijnurstu.2018.03.004

Cutcliffe, J.R. and Stevenson, C. (2008). Feeling our way in the dark: the psychiatric nursing care of suicidal people--a literature review. *International Journal of Nursing Studies*, 45, 942-953. doi.org/10.1016/j.ijnurstu.2007.02.002

Cutcliffe, J.R., Stevenson, C., Jackson, S. and Smith, P. (2006). A modified grounded theory study of how psychiatric nurses work with suicidal people. *International Journal of Nursing Studies*, 43, 791-802. doi.org/10.1016/j.ijnurstu.2005.09.001

Dazzi, T., Gribble, R., Wessely, S., & Fear, N. T. (2014). Does asking about suicide and related behaviours induce suicidal ideation? What is the evidence? *Psychological Medicine*, *44*, 3361-3363. doi.org/10.1017/S0033291714001299

De Hert, M., Correll, C. U., Bobes, J., Cetkovich-Bakmas, M., Cohen, D., Asai, I., . . . Leucht, S. (2011). Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care. *World Psychiatry, 10*, 52-77. doi.org/10.1002/j.2051-5545.2011.tb00014.x

De Jaegere, E., van Landschoot, R., van Heeringen, K., van Spijker, B. A. J., Kerkhof, A., Mokkenstorm, J. K., & Portzky, G. (2019). The online treatment of suicidal ideation: A randomised controlled trial of an unguided web-based intervention. *Behaviour Research and Therapy, 119*. doi.org/10.1016/j.brat.2019.05.003

Delaney, K. R., Shattell, M. & Johnson, M. E. (2017). Capturing the Interpersonal Process of Psychiatric Nurses: A Model for Engagement. *Archives of Psychiatric Nursing*, 31, 634-640. doi.org/10.1016/j.apnu.2017.08.003

Department of Welfare, Public Health and Family (2012). Voorstel voor de gezondheidsdoelstelling: preventie van zelfdoding & een Vlaams actieplan voor de preventie van zelfdoding 2012-2020. Retrieved from: www.zorg-en gezondheid.be/sites/default/files/atoms/files/Vlaams%20Actieplan%20Suïcidepreventie %202012-2020.pdf

Deproost, E. (1995). Psychiatrische verpleegkunde: al te verpleegkundig? *Psychiatrie en Verpleging*, 2, 55-65.

Deproost, E. (2018). Verpleegkunde in een nieuwe geestelijke gezondheidszorg: uitdagingen en een visie voor de toekomst. *Psychiatrie en Verpleging*. Afscheidsnummer, 24-51.

Dinc, L., & Gastmans, C. (2013). Trust in nurse-patient relationships: a literature review. *Nursing Ethics*, 20, 501-516. doi.org/10.1177/0969733012468463

Doyle, L., Ellilä, H., Jormfeldt, H., Lahti, M., Higgins, A., Keogh, B., Meade, O., Sitvast, J., Skärsäter, I., Stickley, T. and Kilkku, N. (2018), Preparing master-level mental health nurses to work within a wellness paradigm: Findings from the eMenthe project. *International Journal of Mental Health Nursing*, 27, 823-832. doi.org/10.1111/inm.12370

Duxbury, J., Baker, J., Downe et al. (2019). Minimising the use of physical restraint in acute mental health services: The outcome of a restraint reduction programme ('REsTRAIN YOURSELF'). *International Journal of Nursing Studies*, 95, 40-48. doi.org/10.1016/j.ijnurstu.2019.03.016

Edwards, D., Burnard, P., Hannigan, B., Cooper, L., Adams, J., Juggessur, T., Fothergil, A. and Coyle, D. (2006). Clinical supervision and burnout: the influence of clinical supervision for community mental health nurses. *Journal of Clinical Nursing*, 15, 1007-1015. doi.org/10.1111/j.1365-2702.2006.01370.x

Federal Government Belgium (2020). Patiëntenparticipatiecultuur op microniveau in algemene en psychiatrische ziekenhuizen. Retrieved from: https://www.health.belgium.be/sites/default/files/ugent_23.01.2020.pdf

Felton, A., Repper, J., Avis, M. (2018). The construction of people with mental health problems as risk objects: Findings of a case study inquiry. *Journal of Psychiatric and Mental Health Nursing*, 25, 558-568. doi.org/10.1111/jpm.12501

Feo, R. and Kitson, A. (2016). Promoting patient-centred fundamental care in acute healthcare systems. *International Journal of Nursing Studies, 57*, 1-11. doi.org/10.1016/j.ijnurstu.2016.01.006

Ferguson, M. S., Reis, J. A., Rabbetts, L., Ashby, H.-J., Bayes, M., McCracken, T., Ross, C., & Procter, N. G. (2018). The effectiveness of suicide prevention education programs for nurses: A systematic review. *Crisis: The Journal of Crisis Intervention and Suicide Prevention, 39*, 96–109. doi.org/10.1027/0227-5910/a000479

Fitzpatrick, S. J. & River, J. (2018). Beyond the Medical Model: Future Directions for Suicide Intervention Services. *International Journal of Health Services*, 48, 189-203. doi.org/10.1177/0020731417716086

Fleischmann, A., Bertolote, J. M., Wasserman, D. et al. (2008). Effectiveness of brief intervention and contact for suicide attempters: a randomized controlled trial in five countries. *Bulletin of the World Health Organization*, 86, 703-709. doi.org/10.2471/BLT.07.046995

Fluttert, F., Van Meijel, B., Webster, C., Nijman, H., Bartels, A., & Grypdonck, M. (2008). Risk management by early recognition of warning signs in patients in forensic psychiatric care. *Archives of Psychiatric Nursing, 22*, 208-216. doi.org/10.1016/j.apnu.2007.06.012

Forchuk, C., Martin, M.-L., Sherman, D. et al. (2020). Healthcare professionals' perceptions of the implementation of the transitional discharge model for community integration of psychiatric clients. *International Journal of Mental Health Nursing*, 1-10 doi.org/10.1111/inm.12687

Forchuk, C. & Reynolds, W. (2000). Clients' reflections on relationships with nurses: comparisons from Canada and Scotland. *Journal of Psychiatric and Mental Health Nursing*, 8, 45-51. doi.org/10.1046/j.1365-2850.2001.00344.x

Freeman, A. M., Tribe, R. H., Stott, J. C. H., & Pilling, S. (2019). Open Dialogue: A Review of the Evidence. *Psychiatric Services*, 70, 46-59. doi.org/10.1176/appi.ps.201800236

Gabrielsson, S., Sävenstedt, S., & Zingmark, K. (2015). Person-centred care: clarifying the concept in the context of inpatient psychiatry. *Scandinavian Journal of Caring Sciences, 29*, 555-562. doi.org/10.1111/scs.12189

Gisle L, Drieskens S, Demarest S, Van der Heyden J. (2020). Geestelijke gezondheid: gezondheidsenquête 2018. Brussel, België: Sciensano, Rapportnummer: D/2020/14.440/4. Retrieved from: https://www.gezondheidsenquete.be

Guise, V., Chambers, M., Välimäki, M. (2012). What can virtual patient simulation offer mental health nursing education? *Journal of Psychiatric and Mental Health Nursing*, 19, 410-418. doi.org/10.1111/j.1365-2850.2011.01797.x

Gunasekara, I., Pentland, T., Rodgers, T. & Patterson, S. (2014). What makes an excellent mental health nurse? A pragmatic inquiry initiated and conducted by people with lived experience of service use. *International Journal of Mental Health Nursing*, 23, 101-109. doi.org/10.1111/inm.12027

Grant, C. L., & Lusk, J. L. (2015). A multidisciplinary approach to therapeutic risk management of the suicidal patient. *Journal of multidisciplinary healthcare*, *8*, 291–298. doi.org/10.2147/JMDH.S50529

Hagen, J., Hjelmeland, H., & Knizek, B. L. (2017). Relational principles in the care of suicidal inpatients: Experiences of therapists and mental health nurses. *Issues in Mental Health Nursing*, *38*, 99-106. doi.org/10.1080/01612840.2016.1246631

Hagen, J., Knizek, B. L., & Hjelmeland, H. (2016). Mental health nurses' experiences of caring for suicidal patients in psychiatric wards: An emotional endeavor. *Archives of Psychiatric Nursing*, *31*, 31-37. doi.org/10.1016/j.apnu.2016.07.018

Hallberg, L. R.-M. (2006). The 'core category' of grounded theory: making constant comparisons. *International Journal of Qualitative Studies on Health and Well-Being*, 1, 141-148. doi.org/10.1080/17482620600858399

Hannigan, B. (2014). "There's a lot of tasks that can be done by any": Findings from an ethnographic study into work and organisation in UK community crisis resolution and home treatment services. *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine*,18, 406–421.

Hanrahan, N. P., Delaney, K. R., & Stuart, G. W. (2012). Blueprint for development of the advanced practice psychiatric nurse workforce. *Nursing Outlook, 60*, 91-104. doi.org/10.1016/j.outlook.2011.04.007

Happell, B. (2008). Meaningful information or a bureaucratic exercise? Exploring the value of routine outcome measurement in mental health. *Issues in Mental Health Nursing, 29*, 1098-1114. doi.org/10.1080/01612840802319852

Happell, B., Platania-Phung, C., Scholz, B., et al. (2019), Changing attitudes: The impact of Expert by Experience involvement in Mental Health Nursing Education: An international survey study. *International Journal of Mental Health Nursing*, 28, 480-491. doi.org/10.1111/inm.12551

Hawsawi, T., Power, T., Zugai, J. and Jackson, D. (2020), Nurses' and consumers' shared experiences of seclusion and restraint: A qualitative literature review. *International Journal of Mental Health Nursing*. doi.org/10.1111/inm.12716

Heller, N.R. (2015). Risk, Hope and Recovery: Converging Paradigms for Mental Health Approaches with Suicidal Patients. *The British Journal of Social Work*, 45, 1788-1803. doi.org/10.1093/bjsw/bcu007

Higgins, A., Doyle, L., Downes, C. et al. (2016). There is more to risk and safety planning than dramatic risks: Mental health nurses' risk assessment and safety-management practice. *International Journal of Mental Health Nursing*, 25, 159-170. doi.org/10.1111/inm.12180

Higgins, A. Morrissey, J. Doyle, L. Bailey, J. Gill, A. (2015). Best Practice Principles for Risk Assessment and Safety Planning for Nurses working in Mental Health Services. Dublin: Health Service Executive. Retrieved from: https://nursing-midwifery.tcd.ie/assets/publications/pdf/best-principles-risk-assessment.pdf

Hjelmeland, H., & Knizek, B. L. (2010). Why we need qualitative research in suicidology. *Suicide and Life-Threatening Behavior*, *40*, 74–80. https :// doi.org/10.1521/suli.2010.40.1.74

Hjelmeland, H. (2011). Cultural context is crucial in suicide research and prevention. *Crisis*, 32, 61-64. doi.org/10.1027/0227-5910/a000097

Ho, A. O. (2014). Suicide: Rationality and responsibility for Life. *The Canadian Journal of Psychiatry*, *59*, 141–147. doi.org/10.1177/070674371405900305

Holloway, I., Wheeler, S. (2010). Qualitative research in nursing and healthcare. Oxford: Wiley-Blackwell.

Holm, A. L. & Severinsson, E. (2011). Struggling to recover by changing suicidal behaviour: narratives from women with borderline personality disorder. *International Journal of Mental Health Nursing*, 20, 165-173. doi.org/10.1111/j.1447-0349.2010.00713.x

Hom, M.A., Stanley, I.H., Podlogar, M.C. & Joiner, T.E. (2017), "Are You Having Thoughts of Suicide?" Examining Experiences With Disclosing and Denying Suicidal Ideation. *Journal of Clinical Psychology*, 73, 1382-1392. doi.org/10.1002/jclp.22440

Huisman, A. & van Bergen, D. D. (2019). Peer specialists in suicide prevention: Possibilities and pitfalls. *Psychological Services*, 16, 372-380. doi.org/10.1037/ser0000255

Hurley, J. (2009), A qualitative study of mental health nurse identities: Many roles, one profession. *International Journal of Mental Health Nursing*, 18, 383-390. doi.org/10.1111/j.1447-0349.2009.00625.x

Jobes, D. A. (2012). The Collaborative Assessment and Management of Suicidality (CAMS): an evolving evidence-based clinical approach to suicidal risk. *Suicide and Life-Threatening Behavior*, *42*, 640-653. doi.org/10.1111/j.1943-278X.2012.00119.x

Kar Ray, M., Wyder, M., Crompton, D., Kousoulis, A.A., Arensman, E., Hafizi, S., Van Bortel, T. & Lombardo, C. (2020). PROTECT: Relational safety based suicide prevention training frameworks. *International Journal of Mental Health Nursing*. doi.org/10.1111/inm.12685

Kendrick, T., El-Gohary, M., Stuart, B., Gilbody, S., Churchill, R., Aiken, L., . . . Moore, M. (2016). Routine use of patient reported outcome measures (PROMs) for improving treatment of common mental health disorders in adults. *Cochrane Database Syst Rev, 7*, Cd011119. doi.org/10.1002/14651858.CD011119.pub2

Kilbourne, A.M., Beck, K., Spaeth-Rublee, et al. (2018). Measuring and improving the quality of mental health care: a global perspective. *World Psychiatry*, 17, 30-38. doi.org/10.1002/wps.20482

Kitson, A., Conroy, T., Kuluski, K., Locock, L., & Lyons, R. (2013). Reclaiming and redefining the fundamentals of care: Nursing's response to meeting patients' basic human needs. Adelaide, South Australia: School of Nursing, the University of Adelaide. Retrieved from https://digital.library.adelaide.edu.au/dspace/bitstream/2440/75843/1/hdl_75843.pdf

Kontio, R., Joffe, G., Putkonen, H. et al. (2012). Seclusion and restraint in psychiatry: patients' experiences and practical suggestions on how to improve practices and use alternatives. *Perspectives in Psychiatric Care*, 48, 16-24. doi.org/10.1111/j.1744-6163.2010.00301.x

Leamy, M., Bird, V., Le Boutillier, C., Williams, J. and Slade, M. (2011). Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. *The British Journal of Psychiatry*, 199(6), 445-452. doi.org/10.1192/bjp.bp.110.083733

Lees, D., Procter, N. and Fassett, D. (2014). Therapeutic engagement between patients in suicidal crisis and mental health nurses. *International Journal of Mental Health Nursing*, 23, 306-315. doi.org/10.1111/inm.12061

Lindgren, B.-M., Ringnér, A., Molin, J. and Graneheim, U.H. (2019). Patients' experiences of isolation in psychiatric inpatient care: Insights from a meta-ethnographic study. *International Journal of Mental Health Nurses*, 28, 7-21. doi.org/10.1111/inm.12519

Littlewood, D. L., Kyle, S. D., Carter, L. A., Peters, S., Pratt, D., & Gooding, P. (2019). Short sleep duration and poor sleep quality predict next-day suicidal ideation: an ecological momentary assessment study. *Psychological medicine*, *49*, 403–411. https://doi.org/10.1017/S0033291718001009

Lloyd, C., Waghorn, G. & Williams, P. L. (2008). Conceptualising Recovery in Mental Health Rehabilitation. *British Journal of Occupational Therapy*, 71, 321-328. doi.org/10.1177/030802260807100804

Longtin, Y., Sax, H., Leape, L., Sheridan, S., Donaldson, L. & Pittet, D. (2010). Patient Participation: Current Knowledge and applicabiliy to Patient Safety. *Mayo Clinical Proceedings*, 85, 53-62. doi.org/10.4065/mcp.2009.0248

Lorant, V., Grard, A., Van Audenhove, C., Helmer, E., Vanderhaegen, J. and Nicaise, P. (2016). Assessment of the priority target group of mental health service networks within a nation-wide reform of adult psychiatry in Belgium. *BMC Health Services Research*, 16. doi.org/10.1186/s12913-016-1434-2

Lu, H., Barriball, K. L., Zhang, X., & While, A. E. (2012). Job satisfaction among hospital nurses revisited: A systematic review. *International Journal of Nursing Studies*, 49, 1017-1038. doi.org/10.1016/j.ijnurstu.2011.11.009

Kleiman, E. M., Turner, B. J., Fedor, S., Beale, E. E., Huffman, J. C. & Nock, M. K. (2017). Examination of real-time fluctuations in suicidal ideation and its risk factors: Results from two ecological momentary assessment studies. *Journal of Abnormal Psychology*, 126, 726-738. doi.org/10.1037/abn0000273

Malterud, K. (2001). Qualitative research: standards, challenges, and guidelines. *Lancet*, 358, 483-488. doi.org/10.1016/s0140-6736(01)05627-6

Manuel, J. & Crowe, M. (2014). Clinical responsibility, accountability, and risk aversion in mental health nursing: A descriptive, qualitative study. *International Journal of Mental Health Nursing*, 23, 336-343. doi.org/10.1111/inm.12063

Maris, R, Berman, A & Silverman, M. (2000). *'The theoretical component in suicidology'*, in Maris, R., Berman, A. & Silverman, M. (eds) Comprehensive textbook of suicidology, pp. 26-61, Guilford: New York.

Martela, F. & Steger, M. F. (2016). The three meanings of meaning in life: Distinguishing coherence, purpose, and significance. *The Journal of Positive Psychology*, 11, 531-545, doi.org/10.1080/17439760.2015.1137623

McAndrew, S., Chambers, M., Nolan, F., Thomas, B., & Watts, P. (2014). Measuring the evidence: reviewing the literature of the measurement of therapeutic engagement in

acute mental health inpatient wards. *International Journal of Mental Health Nursing*, *23*, 212-220. doi.org/10.1111/inm.12044

McCrae, N. (2014). Protected engagement time in mental health inpatient units. *Nursing management 21*, 28-31. doi.org/10.7748/nm2014.03.21.1.28.e1179

McMyler, C. and Pryjmachuk S. (2008). Do 'no-suicide' contracts work?. *Journal of Psychiatric and Mental Health Nursing*, 15, 512-522. doi.org/10.1111/j.1365-2850.2008.01286.x

Meerwijk, E.L., van Meijel, B., van den Bout, J., Kerkhof, A., de Vogel, W. and Grypdonck, M. (2010). Development and evaluation of a guideline for nursing care of suicidal patients with schizophrenia. *Perspectives in Psychiatric Care*, 46, 65-73. doi.org/10.1111/j.1744-6163.2009.00239.x

Michel, K. & Jobes, D. A. (2011). *Building a therapeutic alliance with the suicidal patient*. Washington DC: American Psychological Association.

Mistiaen, P., Cornelis. J., Detollenaere, J., Devriese, S., Farfan-Portet, M. I. & Ricour, C. (22 October 2019). Organisation of mental health care for adults in Belgium. Brussels: Belgian Health Care Knowledge Centre. Retrieved from: https://kce.fgov.be/content/about-copyrights-for-kce-publications

Morrissey, J. & Higgins, A. (2019). "Attenuating Anxieties": A grounded theory study of mental health nurses' responses to patients with suicidal behaviour. *Journal of Clinical Nursing*, 28, 947-958. doi.org/10.1111/jocn.14717

Morse, J. M. (2015). Critical analysis of strategies for determining rigor in qualitative inquiry. *Qualitative Health Research*, 25, 1212–1222. doi.org/10.1177/1049732315588501

Muskett, C. (2014). Trauma-informed care in inpatient mental health settings: a review of the literature. *International Journal of Mental Health Nursing*, 23, 51-59. doi.org/10.1111/inm.12012

NANDA (2001). Nursing Diagnoses: Definitions & Classification 2001-2002. North American Nursing Diagnosis Association, Philadelphia.

Pauwels, K., Aerts, S., Muijzers, E., De Jaegere, E., van Heeringen, K., & Portzky, G. (2017). BackUp: Development and evaluation of a smart-phone application for coping with suicidal crises. *PloS one*, *12*. doi.org/10.1371/journal.pone.0178144

Peplau, H.E. (1997). Peplau's Theory of Interpersonal Relations. *Nursing Science Quarterly*, 10, 162-167. doi.org/10.1177/089431849701000407

Perraud, S., Delaney, K.R., Carlson-Sabelli, L., Johnson, M.E., Shephard, R. and Paun, O. (2006), Advanced Practice Psychiatric Mental Health Nursing, Finding Our Core: The Therapeutic Relationship in 21st Century. *Perspectives in Psychiatric Care*, 42, 215-226. doi.org/10.1111/j.1744-6163.2006.00097.x

Pettit, S. A., Bowers, L., Tulloch, A., Cullen, A. E., Moylan, L. B., et al. (2017). Acceptability and use of coercive methods across differing service configurations with and without seclusion and/or psychiatric intensive care units. *Journal of Advanced Nursing*, *73*, 966–976. doi.org/10.1111/jan.13197

Pfeiffer, P. N., King, C., Ilgen, M., Ganoczy, D., Clive, R., et al. (2019). Development and pilot study of a suicide prevention intervention delivered by peer support specialists. *Psychological Services, 16*, 360–371. doi.org/10.1037/ser0000257

Pirkola, S., Sund, R., Sailas, E., & Wahlbeck, K. (2009). Community mental-health services and suicide rate in Finland: a nationwide small-area analysis. *Lancet, 373*, 147-153. doi.org/10.1016/s0140-6736(08)61848-6

Price, O., Baker, J. (2012). Key components of de-escalation techniques: a thematic synthesis. *International Journal of Mental Health Nursing*, 21, 310-319.

Priebe, S. & McCabe, R. (2006), The therapeutic relationship in psychiatric settings. *Acta Psychiatrica Scandinavica*, 113, 69–72. doi.org/10.1111/j.1600-0447.2005.00721.x

Rafferty A-M, Busse R, Zander-Jentsch B, Sermeus B. and Bruyneel L. (2019). *Strengthening health systems through nursing: Evidence from 14 European countries.* Copenhagen: World Health Organization. Available from: https://www.ncbi.nlm.nih.gov/books/NBK545725/

Ray, R., Perkins, E. and Meijer, B. (2011). The Evolution of Practice Changes in the Use of Special Observations. *Archives of Psychiatric Nursing*, 25, 90-100. doi.org/10.1016/j.apnu.2010.07.007

Reger, M.A., Stanley, I. H., Joiner, T.E. (2020). Suicide Mortality and Coronavirus Disease 2019—A Perfect Storm? *JAMA Psychiatry.* doi.org/10.1001/jamapsychiatry

Reynders, A., Kerkhof, A. J., Molenberghs, G. & Van Audenhove, C. (2014). Attitudes and stigma in relation to help-seeking intentions for psychological problems in low and high suicide rate regions. *Social Psychiatry and Psychiatric Epidemiology*, 49, 231-239. doi.org/10.1007/s00127-013-0745-4

Rio, J.H.M., Fuller, J., Taylor, K. and Muir-Cochrane, E. (2020), A lack of therapeutic engagement and consumer input in acute inpatient care planning limits fully accountable mental health nursing practice. *International Journal of Mental Health Nursing*, 29, 290-298. doi.org/10.1111/inm.12684

Roberts, M. (2005), The production of the psychiatric subject: power, knowledge and Michel Foucault. *Nursing Philosophy*, 6, 33-42. doi.org/10.1111/j.1466-769X.2004.00196.x

Santangelo, P., Procter, N. & Fassett, D. (2018). Mental health nursing: Daring to be different, special and leading recovery-focused care? *International Journal of Mental Health Nursing*, 27, 258-266. doi.org/10.1111/inm.12316

Schaftenaar, P., van Outheusden, I., Stams, G.-J., & Baart, A. (2018). Relational caring and contact after treatment. An evaluation study on criminal recidivism. *International Journal of Law and Psychiatry, 60*, 45-50. doi.org/10.1016/j.ijlp.2018.07.011

Scheckel, M. M., & Nelson, K. A. (2014). An interpretive study of nursing students' experiences of caring for suicidal persons. *Journal of Professional Nursing, 30*, 426-435. doi.org/10.1016/j.profnurs.2014.03.003

Seed, M. S., Torkelson, D. J. & Alnatour R. (2010). The Role of the Inpatient Psychiatric Nurse and Its Effect on Job Satisfaction. *Issues in Mental Health Nursing*, 31, 160-170, doi.org/10.3109/01612840903168729

Seikkula, J., Alakare, B., & Aaltonen, J. (2011). The Comprehensive Open-Dialogue Approach in Western Lapland: II. Long-term stability of acute psychosis outcomes in advanced community care. *Psychosis*, 3, 192-204. doi.org/10.1080/17522439.2011.595819

Sellin, L., Asp, M., Wallsten, T. and Wiklund Gustin, L. (2017). Reconnecting with oneself while struggling between life and death: The phenomenon of recovery as experienced by persons at risk of suicide. *International Journal of Mental Health Nursing*, 26, 200-207. doi.org/10.1111/inm.12249

Sercu, C., Ayala, R. A., & Bracke, P. (2015). How does stigma influence mental health nursing identities? An ethnographic study of the meaning of stigma for nursing role identities in two Belgian psychiatric hospitals*. International Journal of Nursing Studies*, 52, 307-316. doi.org/10.1016/j.ijnurstu.2014.07.017

Sharac, J., McCrone, P., Sabes-Figuera, R., Csipke, E., Wood, A. & Wykes, T. (2010). Nurse and patient activities and interaction on psychiatric inpatients wards: A literature review. *International Journal of Nursing Studies*, 47, 909-917. doi.org/10.1016/j.ijnurstu.2010.03.012

Siegel, D. J. (2012). *The developing mind: How relationships and the brain interact to shape who we are* (2nd ed.). New York: Guilford Press.

Simmons, B. (2010), Clinical reasoning: concept analysis. *Journal of Advanced Nursing*, 66, 1151-1158. doi.org/10.1111/j.1365-2648.2010.05262.x

Sitzman, K. & Watson, J. (2019). *Assessing and Measuring Caring in Nursing and Health Sciences: Watson's Caring Science Guide*, (3th ed.). New York: Springer Publishing.

Slade, M., Amering, M., Farkas, M. et al. (2014). Uses and abuses of recovery: implementing recovery-oriented practices in mental health systems. *World Psychiatry*, 13, 12-20. doi.org/10.1002/wps.20084

Slemon, A., Jenkins, E. and Bungay, V. (2017). Safety in psychiatric inpatient care: The impact of risk management culture on mental health nursing practice. *Nursing Inquiry*, 24. doi.org/10.1111/nin.12199

Stanley, B. and Brown, G.K. (2012). Safety Planning Intervention: A Brief Intervention to Mitigate Suicide Risk. *Cognitive and Behavioral Practice*, 19, 256-264. doi.org/ 10.1016/j.cbpra.2011.01.001

Stringer, B., van Meijel, B., Eikelenboom, M., Koekkoek, B., Licht, C. M., Kerkhof, A. J., . . . Beekman, A. T. (2013). Recurrent suicide attempts in patients with depressive and anxiety disorders: the role of borderline personality traits. *Journal of Affective Disorders*, 151, 23-30. doi.org/10.1016/j.jad.2013.02.038

Stuart, S.R., Tansey, L. & Quayle, E. (2017). What we talk about when we talk about recovery: a systematic review and best-fit framework synthesis of qualitative literature. *Journal of Mental Health*, 26, 291-304. doi.org/10.1080/09638237.2016.1222056

Superior Health Council (2016a). *Omgaan met conflict, conflictbeheersing en dwanginterventies in de geestelijke gezondheidszorg*. Geraadpleegd via: https://www.health.belgium.be/sites/default/files/uploads/fields/fpshealth_theme_file/hgr_advies_9193_dwanginterventie.pdf

Superior Health Council (2016b). *Towards a generic framework for the development of quality indicators in mental health care in Belgium*. Retrieved from: https://www.health.belgium.be/sites/default/files/uploads/fields/fpshealth_theme_file/shc_9204_advisory_quality.pdf

Sweeney, A., Filson, B., Kennedy, A., Collinson, L., & Gillard, S. (2018). A paradigm shift: relationships in trauma-informed mental health services. *BJPsych advances*, *24*, 319–333. doi.org/10.1192/bja.2018.29

Szmukler, G., & Rose, N. (2013). Risk assessment in mental health care: values and costs. *Behavioral Sciences & the Law, 31*, 125-140. doi.org/10.1002/bsl.2046

Talseth, A. G. & Gilje, F. L. (2011). Nurses' responses to suicide and suicidal patients: a critical interpretive synthesis. *Journal of Clinical Nursing*, 20, 1651-1667. doi.org/10.1111/j.1365-2702.2010.03490.x

Tee, S., & Üzar Özçetin, Y. S. (2016). Promoting positive perceptions and person centred care toward people with mental health problems using co-design with nursing students. *Nurse Education Today, 44*, 116-120. doi.org/10.1016/j.nedt.2016.05.024

Terry, J. (2020), 'In the middle': A qualitative study of talk about mental health nursing roles and work*. International Journal of Mental Health Nursing*. doi.org/10.1111/inm.12676

The Joint Commission (2016). Sentinel Event Alert 56: Detecting and treating suicide ideation in all settings. Retrieved from: https://www.jointcommission.org/sea_issue_56.

Thienpont, L., Verhofstadt, M., Van Loon, T., Distelmans, W., Audenaert, K., & De Deyn, P. P. (2015). Euthanasia requests, procedures and outcomes for 100 Belgian patients

suffering from psychiatric disorders: a retrospective, descriptive study. *BMJ Open, 5*, e007454. doi.org/10.1136/bmjopen-2014-007454

Thornicroft, G., Deb, T. & Henderson, C. (2016). Community mental health care worldwide: current status and further developments. *World Psychiatry*, 15, 276-286. doi.org/10.1002/wps.20349

Torok, M., Han, J., Baker, S., Werner-Seidler, A., Wong, I., Larsen, M. E., & Christensen, H. (2020). Suicide prevention using self-guided digital interventions: a systematic review and meta-analysis of randomised controlled trials. *The Lancet Digital Health*, 2, 25-36. doi.org/10.1016/S2589-7500(19)30199-2

Usher, K., Durkin, J. and Bhullar, N. (2020), The COVID-19 pandemic and mental health impacts*. International Journal of Mental Health Nursing*. doi.org/10.1111/inm.12726

Vancampfort, D., Hallgren, M., Firth, J., Rosenbaum, S., Schuch, F. B., Mugisha, J., . . . Stubbs, B. (2018). Physical activity and suicidal ideation: A systematic review and meta-analysis. *Journal of Affective Disorders, 225*, 438-448. doi.org/10.1016/j.jad.2017.08.070

van der Merwe, M., Bowers, L., Jones, J., Simpson, A. & Haglund, K. (2009). Locked doors in acute inpatient psychiatry: A literature review. *Journal of Psychiatric and Mental Health Nursing*, 16, 293-299. doi.org/10.1111/j.1365-2850.2008.01378.x

Vandewalle, J., Debyser, B., Beeckman, D. et al. (2017). "Constructing a positive identity": A qualitative study of the driving forces of peer workers in mental health care systems. *International Journal of Mental Health Nursing*, 27, 378-389. doi.org/10.1111/inm.12332.

Vandewalle, J., Debyser, B., Beeckman, D., Vandecasteele, T., Van Hecke, A., Verhaeghe, S. (2016). Peer workers' perceptions and experiences on barriers to implementation of peer worker roles in mental health services: A literature review. *International Journal of Nursing Studies*. doi.org/10.1016/j.ijnurstu.2016.04.018

Vandewalle, J., Debyser, B., Deproost. E., Verhaeghe, S. (2020a). 'Looking through the lens of uncertainty': Qualitative study of family members' expectations regarding inpatient mental health services for adults with suicidal ideation. *International Journal of Mental Health Nursing.* Manuscript under review.

Vandewalle, J., Van Hoe, C., …, Verhaeghe, S. (2020b). Dynamics of trust in the relationship between patients with suicidal ideation and mental health nurses: Qualitative study of patients' perspectives. Manuscript being finalised.

van Landschoot, R., van Heeringen, K., Portzky, G. (2018). Epidemiologisch rapport. De Vlaamse suïcidecijfers in een national en international context. Retrieved from: https://www.vlesp.be/assets/pdf/epidemiologisch-rapport-2018-nl-114841.pdf

van Meijel, B., Gamel, C., van Swieten-Duijfjes, B., & Grypdonck, M. H. (2004). The development of evidence-based nursing interventions: methodological considerations. *Journal of Advanced Nursing, 48*, 84-92. doi.org/10.1111/j.1365-2648.2004.03171.x

Van Orden, K. A., Witte, T. K., Cukrowicz, K. C., Braithwaite, S., Selby, E. A. & Joiner, T. E. (2010). The Interpersonal Theory of Suicide. *Psychological Review*, 117, 575-600. doi.org/10.1037/a0018697

Van Os, J., Berkelaar, J., Hafkenscheid, E.A. (2017). Benchmarken: doodlopende weg onder het mom van 'ROM'. *Tijdschrift voor Psychiatrie,* 59, 247-250.

Vatne, M. & Naden, D. (2018). Experiences that inspire hope: Perspectives of suicidal patients. *Nursing Ethics*, 25, 444-457. doi.org/10.1177/0969733016658794

Verbeke, E., Vanheule, S., Cauwe, J., Truijens, F. & Froyen, B. (2019). Coercion and power in psychiatry: A qualitative study with ex-patients. *Social Science & Medicine*, 223, 89-96. doi.org/10.1016/j.socscimed.2019.01.031

Wand, T., Buchanan-Hagen, S., Derrick, K. and Harris, M. (2020), Are current mental health assessment formats consistent with contemporary thinking and practice?. *International Journal of Mental Health Nursing*, 29: 171-176. doi.org/10.1111/inm.12656

Watson, J. (1979). *Nursing: The philosophy and science of caring.* Boston: Little, Brown.

Wheeler, K. (2011). A relationship-based model for psychiatric nursing practice. *Perspectives in Psychiatric Care, 47*, 151-159. doi.org/10.1111/j.1744-6163.2010.00285.x

Wilson, C., Rouse, L., Rae, S. and Kar Ray, M. (2017). Is restraint a 'necessary evil' in mental health care? Mental health inpatients' and staff members' experience of physical restraint. *International Journal of Mental Health Nursing*, 26, 500-512. doi.org/10.1111/inm.12382

World Health Organization (WHO). (2017). *Patient Safety, Making health care safer*. Geneva: World Health Organisation. Retrieved from https://apps.who.int/iris/bitstream/handle/10665/255507/WHO-HIS-SDS-2017.11-eng.pdf?sequence=1

Zugai, J. S., Stein-Parbury, J. & Roche, M. (2015). Therapeutic alliance in mental health nursing: an evolutionary concept analysis. *Issues in Mental Health Nursing*, 36, 249-257. doi.org/10.3109/01612840.2014.969795

Summary (English)

This doctoral study emerged from a national and international context in which the occurrence and burden of suicide, suicide attempts, and suicidal ideation are high. Within this context, inpatient mental healthcare offers important opportunities for suicide prevention and the treatment of suicidal ideation. Contemporary evolutions in mental healthcare underscore the importance of encouraging a recovery philosophy, including transformations towards more patient participation and person-centred care and treatment. However, contradictions are reported, particularly in psychiatric hospitals, where dominant medical ideologies, surveillance systems, and containment-oriented measures overshadow – and impede – the potential of realising person-centred and collaborative approaches in suicide prevention and treatment of suicidal ideation.

Within inpatient mental healthcare, nurses often make contact with patients who experience suicidal ideation, and provide most of the direct care in the multidisciplinary team context. Nurses are deemed to play an important role in and make an essential contribution to preventing suicide and promoting the recovery of patients with suicidal ideation. However, there is limited evidence to provide a scientific foundation for this role and contribution. In fact, the evidence available indicates that nurses can demonstrate negative attitudes when interacting with patients who express suicidal ideation and that they experience such interaction as complex and demanding.

Nurses might, for instance, refrain from discussing suicide with patients. Additionally, patients report that the care they receive from nurses is often based on defensive procedures and medical interventions, and that these may overshadow their need for interpersonal and emotional care. Such insights underline tensions between nursing's espoused interpersonal therapeutic ideals and what actually happens in their practice. To resolve such tensions, critical research is needed to better understand the interactions between nurses and people with suicidal ideation. Such research could make an essential addition to the knowledge base of suicide prevention and treatment of suicidal ideation, which is largely restricted to risk factor studies, epidemiology, and formal experiments.

This dissertation includes seven studies. Chapters 2 and 3 present two studies on patient participation in the context of patient safety, which is a priority for the World Health Organization. The studies examined the patient participation culture in hospitals and, at a micro level, explored mental health professionals' involvement (including nurses) in facilitating patient participation.

Chapter 2 includes a three-stage study to develop and psychometrically evaluate the patient participation culture tool for psychiatric wards (PaCT-PSY). The study resulted in a validated

60-item tool comprising thirteen components. This tool has the capacity to examine the patient participation culture in psychiatric wards by creating an inventory of factors that influence professionals' willingness to share power and responsibility with patients concerning patient safety issues.

Chapter 3 presents a cross-sectional study based on data gathered with the PaCT-PSY. The sample comprised 705 nurses employed in 173 psychiatric wards within 37 hospitals. A multilevel analysis was used to examine the factors that influence the nurses' willingness to share power and responsibility with patients concerning patient safety issues. The findings indicated that women, young nurses, and nurses employed in closed wards were less inclined to share power and responsibility with patients concerning patient safety issues. In contrast, nurses' involvement in facilitating patient participation was encouraged by their perception of having relevant competences (such as collaborative skills) and being supported by their colleagues and the hospital managers to facilitate patient participation.

Chapters 4 and 5 focus on the interactions between nurses and patients with suicidal ideation in psychiatric wards, from the perspective of nurses. Two qualitative studies based on semi-structured interviews were conducted to gain insight into the meanings of nurses' experiences and to understand the concepts and processes underpinning nurse-patient interactions. The studies were based on grounded theory principles, including detailed analyses and constant data comparisons.

The objective of the study in Chapter 4 was to understand the nurses' actions and aims in their interactions with patients with suicidal ideation. The study revealed the core element: 'promoting and preserving safety and a life-oriented perspective'. This core element provides crucial insights into how nurses manage the risk of suicide, including how they use suicide prevention protocols and make agreements with patients about safety. Nurses also tried to guide patients away from suicidal ideation, which involved a focus on creating conditions for patients to (re)gain hope and to prevent hopelessness. Furthermore, nurses' interactions with patients experiencing suicidal ideation were vocalised as a 'minefield'. This reflects the emotional demands that nurses can experience as well as the tensions they can perceive, such as when balancing a patient's autonomy, safety, and the possibility of overprotecting patients.

Subsequently, the objective of the study in Chapter 5 was to understand how nurses make contact with patients who experience suicidal ideation. The study indicated that nurses 'create conditions for open and genuine communication' while maintaining a focus on 'developing an accurate and meaningful picture of patients'. These interconnected core elements represent nurses' attention to interpersonal processes such as building trust as well as their predominant focus on assessing suicide risk. The study uncovered micro-elements of contact, including subtle ways by which nurses create a safe atmosphere to talk about

suicide and how this communication might give nurses an essential perspective from which to assess and document suicidal ideation. Based on a detailed analysis of these 'subtle ways', the understanding emerged that some nurses were guided more by an orientation on checking and controlling suicide risk while others were guide more by an orientation on acknowledging and connecting with the patient as a person.

Chapters 6 and 7 focus on interactions with nurses from the perspective of persons with suicidal ideation. The previous studies with nurses indicated that nurses are not necessarily proficient in developing interpersonal and collaborative interactions. This called for research from the patient's perspective to gain a fuller understanding of the reciprocal nature of nurse-patient interaction.

Therefore, Chapter 6 includes a systematic review that aimed to synthesise the perceptions of individuals with suicidal ideation and behaviour regarding their interactions with nurses. Both qualitative and quantitative studies within inpatient, community mental health, and emergency services contexts were reviewed. The systematic review included 26 studies based on electronic database searching and hand searching. Most studies used qualitative approaches and focused on inpatient mental healthcare in Western countries. The thematic analysis showed that individuals with suicidal ideation and behaviour want to interact with nurses who care for and acknowledge them as unique individuals. They stressed the value of nurses who meet their basic needs, connect with them, and accept and understand what they are going through. Moreover, it was indicated that nurses can enable individuals to give voice to themselves and their suicidality, thereby creating a nurturing space in which they can learn to cope with their suicidality, and (re)establish close ties with other people, healthcare services, and life itself.

From a methodological perspective, it was indicated that evidence from the perspective of patients regarding their contact with nurses is largely restricted to qualitative research and that there are no valid instruments to quantitatively examine patient-nurse contact. Therefore, the systematic review and a qualitative study (Chapters 5–6) provided the point of departure for the study in Chapter 7 with the aim of developing and psychometrically evaluating a questionnaire: the contact with nurses from the perspective of patients with suicidal ideation (CoNuPaS). The CoNuPaS was evaluated by rigorous processes and multiple tests, including a Delphi procedure with experts and a factor analysis based on a sample of 405 adult patients with self-reported suicidal ideation in the past year. The CoNuPaS comprises 23 items and two subsections to examine patients' perceptions of how they experience contact with nurses (CoNuPaS-experience) and what they find important in that contact (CoNuPaS-importance). The subsections comprise four components: encountering a space to express suicidal thoughts and explore needs, being recognised as a unique and self-determining individual, encountering nurses' availability/information-sharing/transparency on

expectations, and trusting nurses in communication about suicidality. The CoNuPaS demonstrated good psychometric properties. The availability and thoughtful use of this questionnaire is central to an improved understanding of nurses' contributions to suicide prevention and the treatment of suicidal ideation.

Chapter 8 focuses on creating a better understanding of the relationships that nurses develop with patients experiencing suicidal ideation in psychiatric wards. Similar to the studies in Chapters 5 and 6, the study used a qualitative grounded theory design with semi-structured interviews. By examining the underlying dynamics, concepts, and processes of nurse-patient relationships from the nurse perspective, the working alliance emerged as a construct that offers an adequate representation of how nursing care for patients with suicidal ideation can be understood. The working alliance is an interpersonal and collaborative relational process, which is underpinned by the core variable 'seeking connectedness and attunement with the person at risk of suicide'. The core variable underpins three clusters: investing in the foundations of the working alliance, nourishing the clinical dimension of the working alliance, and realising an impact with the working alliance. This study, however, highlighted that an interpersonal orientation is largely absent in the perspective of some nurses. Indeed, they form relationships with patients that are more accurately conceptualised as an 'instrumental tie'. Efforts such as talking about suicide and making agreements then represent a mechanism to control patients and enhance patient compliance, rather than a way to connect with patients and attune to their perspective. This study makes a valuable contribution to nursing research, practice, and education by highlighting the importance and tensions for nurses to assess, evaluate, and respond to patients' suicidal ideation, in harmony with a commitment to connect with patients and attune to their perspective.

This dissertation ends with a general discussion (Chapter 9). First, it connects nurses' and patients' perspectives of their interactions and relationships. Critical reflections are made about the nature and role of the 'two main approaches' in nursing care. From a conceptual perspective, it was found that some nurses were more oriented towards acknowledging, connecting, and collaborating with patients as unique and self-determining individuals, while other nurses were more oriented to checking, controlling, and directing patients as 'risk objects' that need to be managed. Another central finding was the lack of an integrative perspective in nursing practice between interpersonal aspects and the assessment and management of suicide risk. In particular, the need for embedding suicide prevention efforts into a foundation of interpersonal engagement was highlighted.

The discussion proceeds with a focus on the 'nurturing potential' of nurse-patient interactions. This includes nurses' orientation on 'nurturing as caring' and 'nurturing as healing' (e.g. supporting a patient's change, growth, and development). Using this distinction enables the understanding that some nurses overlook the very basics of caring (such as

showing compassion and treating patients with respect) and that many nurses have a limited (or a professionally imposed) orientation on healing processes. Regarding the latter, nurses have, for example, a limited orientation towards having conversations with patients that help patients gain insight into their suicidal ideation. Moreover, they may use safety and crisis response planning as a professionally-oriented strategy to control patients, rather than as an attempt to engage patients in shared decision-making and support their self-management.

Subsequently, the discussion considers factors that mediate the nature of nurse-patient interaction at the micro-, meso-, and macro-level. Important factors involve the influence of the nurses' professional identity and emotional reactions, the influence of the organisational culture, and the increasing focus in healthcare on meeting quality indicators and accreditation norms. The discussion also provides methodological considerations, such as the lack of attention for community-based services in this dissertation. The discussion ends with recommendations for clinical practice and policy, education, and further research, with a particular focus on fostering a person-centred and collaborative paradigm in nursing care.

Overall, this doctoral dissertation enhances the understanding of the rudiments of interpersonal interactions and relationships in the context of nursing care for individuals with suicidal ideation. This understanding can inform reform in suicide prevention and the treatment of suicidal ideation, and support a context wherein patients can participate in their care and treatment, and access nurses who interact with them as unique individuals in sensitive and competent ways. While studying the interactional and relational aspects of nursing care in the domain of suicidality is very complex, this complexity should neither be feared nor simplified, but embraced and further studied to enhance the understanding—and support the implementation—of a person-centred and collaborative paradigm. Nursing care for individuals with suicidal ideation needs to be an interpersonal endeavour, one characterised by meaningful contact, connecting with patients as unique individuals, and engaging in collaborative and therapeutic interactions.

Samenvatting (Nederlands)

Dit doctoraatsonderzoek werd uitgewerkt naar aanleiding van de aanzienlijke impact, op nationaal en internationaal niveau, van suïcide, suïcidepogingen en suïcidale ideatie (het nadenken over, overwegen of plannen van suïcide). De intramurale geestelijke gezondheidszorg biedt belangrijke kansen voor suïcidepreventie en de behandeling van suïcidale ideatie. Evoluties in de geestelijke gezondheidszorg onderstrepen daarbij het belang van een herstelvisie (*recovery*), met een nadruk op patiëntenparticipatie en op samenwerking en persoonsgerichte zorg en behandeling. Dergelijke evolutie wordt echter vaak niet of slechts moeizaam gerealiseerd in de intramurale geestelijke gezondheidszorg. Dit is bijvoorbeeld het geval in psychiatrische ziekenhuizen waar een dominant medisch model en een nadruk op observatie- en bewakingsgerichte procedures een barrière vormen voor een persoons- en samenwerkingsgerichte benadering bij suïcidepreventie en de behandeling van suïcidale ideatie.

Binnen de intramurale geestelijke gezondheidszorg hebben verpleegkundigen een belangrijke plaats in de zorg voor patiënten met suïcidale ideatie. Verpleegkundigen hebben regelmatig contact met patiënten en in een multidisciplinaire teamcontext verlenen zij de meeste dagelijkse en directe zorg. Verpleegkundigen worden geacht een belangrijke rol en bijdrage te hebben in de preventie van suïcide en het bevorderen van het herstel van patiënten met suïcidale ideatie. Er is echter beperkte evidentie voorhanden om deze rol en bijdrage wetenschappelijk te onderbouwen. De beschikbare inzichten tonen aan dat verpleegkundigen een negatieve houding kunnen hebben wanneer zij contact maken met patiënten. Ook geven verpleegkundigen aan dat ze dit contact als complex en lastig kunnen ervaren (bijvoorbeeld: verpleegkundigen laten soms na om suïcide te bespreken met patiënten).

Bovendien ervaren patiënten dat de 'zorg' van verpleegkundigen vaak gebaseerd is op defensieve procedures en medische interventies en dat verpleegkundigen daarmee niet tegemoetkomen aan hun nood aan relationele en emotionele zorg. Deze ervaringen van patiënten onderstrepen een spanningsveld tussen de interpersoonlijke fundamenten van de verpleegkunde en wat er in hun praktijk echt gebeurt. Om dergelijke spanningsvelden op een gefundeerde manier op te lossen, is kritisch onderzoek nodig om de interactie tussen verpleegkundigen en personen met suïcidale ideatie beter te begrijpen. Dergelijk onderzoek heeft een essentiële plaats in de kwaliteitsvolle en *evidence-based* praktijkvoering van suïcidepreventie en de behandeling van suïcidale ideatie. Onderzoek in deze context is immers vooralsnog hoofdzakelijk beperkt tot studies over risicofactoren, epidemiologie en formele experimenten.

Dit proefschrift omvat zeven studies. Hoofdstukken 2 en 3 bevatten twee studies over patiëntenparticipatie in het kader van patiëntveiligheid. Deze focus is van groot belang voor de Wereldgezondheidsorganisatie. Onderzoek toont namelijk aan dat gezondheidszorg veiliger is als de patiënt actief betrokken wordt in de besluitvorming op verschillende niveaus.
Hoofdstuk 2 bevat een driefasige studie om de *patient participation culture tool for psychiatric wards* (PaCT-PSY) te ontwikkelen en psychometrisch te evalueren. De studie resulteerde in een gevalideerde tool met 60 items, bestaande uit 13 componenten om de patiëntenparticipatiecultuur op psychiatrische afdelingen te onderzoeken. Dit gebeurt via het verkennen van de factoren die van invloed zijn op de bereidheid van professionals om patiënten actief te engageren in de besluitvorming over patiëntveiligheid. Om tot deze gedeelde besluitvorming te komen dienen professionals macht en verantwoordelijkheid te delen met patiënten. Met andere woorden, professionals dienen afstand te nemen van een paternalistische rol waarin patiënten worden verwacht zich te onderwerpen aan de begeleiding of behandeling die hen wordt opgelegd.
Hoofdstuk 3 gaat vervolgens in op een cross-sectionele studie gebaseerd op de gegevens verzameld met de PaCT-PSY. De steekproef omvatte 705 verpleegkundigen werkzaam op 173 psychiatrische afdelingen in 37 ziekenhuizen. Een *multi-level* analyse (een statische methode) werd gebruikt om de factoren te onderzoeken die van invloed zijn op de bereidheid van verpleegkundigen om macht en verantwoordelijkheid met patiënten te delen over aspecten van patiëntveiligheid (o.a. het omgaan met lichamelijke veiligheid, agressie, en suïciderisico). Enerzijds toonden de resultaten aan dat vrouwen, jongere verpleegkundigen en verpleegkundigen werkzaam op gesloten afdelingen minder geneigd zijn om macht en verantwoordelijkheid te delen met patiënten over aspecten van patiëntveiligheid. Anderzijds waren verpleegkundigen meer geëngageerd in het faciliteren van patiëntenparticipatie wanneer zij percipieerden dat zij daarvoor relevante competenties hadden (bijvoorbeeld vaardigheden om patiënten te engageren in gedeelde besluitvorming) en ondersteund werden door hun collega's en het ziekenhuismanagement. Deze studie heeft belangrijke implicaties voor de rol van leidinggevenden en meer bepaald de kwantiteit en kwaliteit van klinisch leiderschap in organisaties.
In Hoofdstukken 4 en 5 wordt ingegaan op de interacties tussen verpleegkundigen en patiënten met suïcidale ideatie op psychiatrische afdelingen, vanuit het perspectief van verpleegkundigen. Twee kwalitatieve studies werden gevoerd op basis van semi-gestructureerde interviews. Dit gebeurde om inzicht te krijgen in de betekenis van de ervaringen van verpleegkundigen en om de concepten en processen te begrijpen die de interactie tussen verpleegkundigen en patiënten onderbouwen. De studies waren gebaseerd op principes van *grounded theory* (een benadering in kwalitatief onderzoek) met onder meer aandacht voor detailanalyses en de methode van constante vergelijking.

De doelstelling van de studie in Hoofdstuk 4 was om de acties en doelen van verpleegkundigen te begrijpen binnen hun interactie met patiënten. De studie onthulde het kernelement 'het bevorderen en behouden van veiligheid en een levensgericht perspectief'. Dit kernelement reflecteerde cruciale inzichten in hoe verpleegkundigen omgaan met suïciderisico's; onder meer hoe zij suïcidepreventie protocollen hanteren en hoe zij afspraken maken met patiënten over veiligheid. Tevens investeerden verpleegkundigen in het creëren van voorwaarden voor patiënten om hoop te (her)winnen en hopeloosheid te voorkomen (bijvoorbeeld door te zorgen voor afleiding). Verder toonde de studie aan dat verpleegkundigen hun interacties met patiënten kunnen ervaren als 'een mijnenveld'. Dit weerspiegelde de emotionele impact die verpleegkundigen kunnen ervaren, hun vrees om schuldig en aansprakelijk te worden bevonden bij een suïcide(poging), alsook een spanningsveld tussen het bieden van veiligheid en mogelijke overbescherming van de patiënt (met mogelijk een negatieve impact voor de autonomie van de patiënt).

Vervolgens beoogde de studie in Hoofdstuk 5 meer inzicht te verkrijgen in hoe verpleegkundigen contact maken met patiënten die suïcidale ideatie ervaren. Uit deze studie bleek dat verpleegkundigen 'voorwaarden scheppen voor open en oprechte communicatie' (o.a. over suïcide), terwijl ze alert en waakzaam zijn voor 'het ontwikkelen van een accuraat en betekenisvol beeld van patiënten'. Deze kernelementen weerspiegelden de aandacht van verpleegkundigen voor interpersoonlijke processen zoals het opbouwen van vertrouwen én hun focus op het beoordelen en evalueren van suïciderisico's. De studie bracht micro-elementen in het contact aan het licht, waaronder de subtiele wijze waarop verpleegkundigen een veilige sfeer creëren om over suïcide te praten. Ook biedt de studie inzicht in hoe open communicatie met de patiënt verpleegkundigen een essentieel perspectief kan bieden om de suïcidaliteit van patiënten te beoordelen. Op basis van de detailanalyse ontwikkelde zich het inzicht dat verpleegkundigen eerder meer gericht kunnen zijn op het controleren en beheersen van suïciderisico's of eerder op het erkennen van de patiënt als persoon en het maken van een connectie.

In Hoofdstukken 6 en 7 werd ingegaan op de interactie met verpleegkundigen vanuit het perspectief van personen met suïcidale ideatie. De studies met verpleegkundigen toonden aan dat verpleegkundigen niet altijd onderlegd zijn in—of een prioriteit maken van—interpersoonlijke en samenwerking gerichte interacties. Daarom was verder onderzoek vanuit het perspectief van patiënten nodig om de interactie tussen verpleegkundigen en patiënten beter te begrijpen. Hoofdstuk 6 bevat een systematische literatuurstudie die tot doel had een synthese te maken van de percepties van personen met suicidale ideatie en gedragingen over hun interacties met verpleegkundigen. Zowel kwalitatieve als kwantitatieve studies binnen intramurale en gemeenschapsgerichte geestelijke gezondheidszorg en spoeddiensten werden beoordeeld. De systematische review includeerde 26 studies die

werden geïdentificeerd via elektronische databanken en het doorzoeken van referentielijsten van literatuurstudies. De meeste studies gebruikten een benadering gebaseerd op kwalitatief onderzoek en waren gericht op intramurale geestelijke gezondheidszorg in westerse landen.
De thematische analyse toonde aan dat personen met suicidale ideatie en gedragingen contact willen maken met verpleegkundigen die voor hen zorgen en hen erkennen als een uniek individu; verpleegkundigen die in hun basisbehoeften voorzien, met hen een connectie aangaan, en een accepterende en begripvolle houding hebben ten aanzien van wat zij doormaken (o.a. hun emoties). Verder gaven de participanten aan dat verpleegkundigen hen een stem kunnen geven en hen kunnen ondersteunen om woorden te geven aan hun suïcidaliteit. Op die manier kunnen verpleegkundigen een ontwikkelingsgericht milieu creëren waarin patiënten kunnen leren omgaan met hun suïcidaliteit. Dergelijk milieu biedt ook kansen voor patiënten om hun connectie met andere mensen (o.a. hun familie), hulpverlening en het leven te versterken of te herstellen. Vanuit methodologisch oogpunt maakte de systematische literatuurstudie ook duidelijk dat de evidentie vanuit het perspectief van patiënten over het contact met verpleegkundigen beperkt is tot kwalitatief onderzoek.
Daarom vormden de systematische review en de kwalitatieve studie (Hoofdstukken 5 en 6) het uitgangspunt voor het onderzoek in Hoofdstuk 7. Dit onderzoek had het doel om een vragenlijst te ontwikkelen en psychometrisch te evalueren: *the contact with nurses from the perspective of patients with suicidal ideation* (CoNuPaS). Deze studie was baanbrekend, aangezien er geen valide instrumenten waren om het contact tussen patiënten met suïcidale ideatie en verpleegkundigen op een kwantitatieve wijze te onderzoeken. De CoNuPaS werd geëvalueerd via meerdere tests, waaronder een Delphi-procedure met expertpanel en een factoranalyse op basis van een steekproef van 405 volwassen patiënten die rapporteerden suicidale ideatie te hebben ervaren in het afgelopen jaar. De CoNuPaS omvat 23 items en twee subsecties over de perceptie van patiënten met betrekking tot hun ervaringen in het contact met verpleegkundigen (*CoNuPaS-experience*) en wat zij belangrijk vinden in dat contact (*CoNuPaS-importance*).
De subsecties bestaan uit vier componenten: ervaren van een milieu waar suïcide bespreekbaar is met de verpleegkundige en waar noden worden geëxploreerd; zich erkend voelen als een uniek individu met ruimte voor zelfbepaling; de beschikbaarheid/informatie-uitwisseling/transparantie over verwachtingen vanwege verpleegkundigen; en verpleegkundigen vertrouwen in de communicatie over suïcidaliteit. De CoNuPaS heeft sterke psychometrische eigenschappen. De beschikbaarheid en het bedachtzame gebruik van deze vragenlijst hebben een centrale plaats in het bevorderen van de bijdrage van verpleegkundigen aan suïcidepreventie en de behandeling van suïcidale ideatie. Meer bepaald kan de CoNuPaS gegevens genereren over de verpleegkundige praktijk met als doel een betere aansluiting te creëren tussen het contact dat patiënten ervaren met

verpleegkundigen en wat patiënten belangrijk vinden in dit contact wanneer zij suïcidale ideatie ervaren.

Hoofdstuk 8 richt zich op het creëren van inzicht in de relaties die verpleegkundigen ontwikkelen met patiënten die suïcidale ideatie ervaren. Net als bij de studies in Hoofdstukken 4 en 5, gebruikte de studie een kwalitatief onderzoeksdesign met semigestructureerde interviews gebaseerd op *grounded theory*. Door de onderliggende dynamieken, concepten en processen van verpleegkundige-patiëntrelaties vanuit verpleegkundig perspectief te onderzoeken, kwam de werkalliantie (*working alliance*) naar voren als het construct dat weerspiegelt hoe de verpleegkundige zorg voor patiënten met suïcidale ideatie kan worden begrepen. De werkalliantie is een relationeel proces gericht op interpersoonlijke interactie en samenwerking. Dit proces wordt onderbouwd door de kernvariabele: 'het zoeken van connectie en afstemming met de persoon die het risico loopt op suïcide'. Deze kernvariabele fundeert drie clusters: investeren in de fundamenten van de werkalliantie (o.a. vertrouwen), het inspireren van de klinische dimensie van de werkalliantie (o.a. evalueren van risico's) en het realiseren van een impact met de werkalliantie (o.a. toenemende openheid in het contact). Deze studie levert een essentiële bijdrage aan de verpleegkundige praktijk, opleiding en onderzoek. Meer bepaald benadrukt de studie het belang van het inschatten, evalueren en aanpakken van suïciderisico in harmonie met een betekenisvol contact met patiënten waarin connectie en afstemming centraal staan. Tegelijkertijd toont de studie aan dat verpleegkundigen hierbij spanningen ervaren en vaak niet gericht zijn op het ontwikkelen van een interpersoonlijke en samenwerkingsgerichte relatie met patiënten. Immers, het inzicht kwam tot stand dat sommige verpleegkundigen zich richten op het ontwikkelen van een instrumentele band (*instrumental tie*) met patiënten eerder dan een werkalliantie.

Het proefschrift eindigt met een algemene discussie. Ten eerste worden de perspectieven van verpleegkundigen en patiënten met elkaar in verband gebracht. Er wordt kritisch gereflecteerd over de eigenheid en de rol van 'twee hoofdbenaderingen' in de verpleegkundige praktijk. Vanuit conceptueel perspectief groeide het inzicht dat sommige verpleegkundigen meer gericht zijn op het erkennen van - het maken van een connectie met - en het samenwerken met - de patiënt als een uniek en zelfbepalend individu. Andere verpleegkundigen zijn meer gericht op het checken, controleren en sturen van de patiënt als een 'risico-object' dat moet worden beheerst. Een andere centrale bevinding was het gebrek aan een geïntegreerd perspectief in de verpleegkundige praktijk tussen interpersoonlijke aspecten in de zorg en de inschatting, evaluatie en omgang met suïciderisico's. Er werd met name gewezen op de noodzaak om interventies voor suïcidepreventie beter in te bedden in een milieu waarin interpersoonlijk engagement centraal staat. De discussie legt verder de nadruk op het *nurturing* potentieel van interacties tussen verpleegkundigen en patiënten.

Hier gaat het over hoe verpleegkundigen het herstel van patiënten met suïcidale ideatie kunnen ondersteunen. Daarvoor hebben verpleegkundigen enerzijds een oriëntatie nodig op 'zorg' (o.a. empathie, vertrouwen en veiligheid), en anderzijds op 'het ondersteunen van positieve verandering, groei en ontwikkeling' bij de patiënt. Dit laatste kunnen verpleegkundigen o.a. realiseren door gesprekken te hebben met patiënten die hen helpen bij het reguleren van hun emoties en het verwerven van inzicht in hun suïcidale ideatie. Door dit onderscheid te maken zien we dat veel verpleegkundigen niet of nauwelijks gericht zijn op het ondersteunen van positieve verandering, groei en ontwikkeling van patiënten en dat sommige verpleegkundigen zelfs geen aandacht hebben voor de basisprincipes van zorg verlenen.

Vervolgens gaat de discussie in op factoren op micro-, meso- en macroniveau die de eigenheid van de interactie tussen verpleegkundigen en patiënten beïnvloeden. Belangrijke factoren zijn onder meer de professionele identiteit van verpleegkundigen, de emotionele reacties van verpleegkundigen (zoals angst, schuldgevoel na een suïcide), de invloed van de organisatiecultuur (o.a. de aanwezigheid van een dominant medisch model) en de toenemende focus in de gezondheidszorg op kwaliteitsindicatoren en accreditatienormen. De discussie gaat ook in op methodologische overwegingen, zoals de gebrekkige aandacht in dit proefschrift voor gemeenschapsgerichte zorg. De discussie eindigt met aanbevelingen voor de klinische praktijk en beleid, onderwijs en verder onderzoek. Daarin gaat bijzondere aandacht uit naar het bevorderen van een persoons- en samenwerking gerichte benadering in de verpleegkundige zorg.

De bevindingen in dit proefschrift vergroten het inzicht in de interpersoonlijke interacties en relaties in de context van verpleegkundige zorg voor personen met suïcidale ideatie. Dit inzicht is cruciaal om hervormingen in suïcidepreventie en de behandeling van suïcidale ideatie te ondersteunen. Bovendien bieden de inzichten uit het proefschrift een conceptueel kader voor het ontwikkelen van een context waarin patiënten kunnen participeren in hun zorg en behandeling, en toegang krijgen tot verpleegkundigen die hen als unieke individuen benaderen, op een sensitieve en competente wijze.

Onderzoek over relationele aspecten in de verpleegkundige zorg in het domein van suïcidaliteit is erg complex. Deze complexiteit moet echter niet worden gevreesd of vereenvoudigd maar moet worden omarmd en verder bestudeerd. Enkel zo kan een persoons- en samenwerkingsgerichte benadering in de verpleegkundige zorg ten volle worden gerealiseerd. Verpleegkundige zorg voor personen met suïcidale ideatie is namelijk in essentie een interpersoonlijk proces. Dergelijk proces wordt fundamenteel gekenmerkt door het maken van een betekenvol contact, het vormen van een connectie met een uniek individu én aandacht voor samenwerking en het realiseren van therapeutische interacties.

Hulp nodig?

Denk je aan zelfmoord en heb je nood aan een gesprek, dan kan je terecht bij de Zelfmoordlijn op het nummer 1813 of via www.zelfmoord1813.be

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Joeri Vandewalle, september 2020

Curriculum Vitae

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Opleidingen

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2017 – 2019	European Academy of Nursing Science Summer Schools (4 weken in totaal) Malmö 2017, Gent 2018, Lissabon 2019; Certificaat behaald
2017	CIEL Bretagne (Ecole de langue Français) 2 semaines cours de langue, Brest, France; Certificaat behaald
2016	Easy School of Languages Advanced General English Course (CEFR-C1) 2-weeks language course, Valletta, Malta; Certificaat behaald
2015	British Study Centres 3-weeks English language course, Brighton & Hove, UK; Certificaat behaald
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2010 – 2013	Bachelor verpleegkunde/ keuzetraject psychiatrie Bachelorproef: 'Stigmatisering: een drempel op weg naar volwaardig burgerschap' (18/20); Katholieke Hogeschool Roeselare; Cum laude
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2011	Vakantiewerk: D4 Neurologie - Neurochirurgie Heilig Hart Roeselare-Menen
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Stages

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2011 – 2012	De Wending 3: psychosenzorg, Psychiatrisch ziekenhuis Heilig Hart Ieper Geriatrie 2, Algemeen Ziekenhuis Sint-Rembert Torhout C4: abdominale en vasculaire heelkunde, Heilig Hart Roeselare-Menen
2010 – 2011	SP Neurologisch, Heilig Hart Roeselare-Menen

Publicaties (in Bijlage 1 vindt u meer informatie)

Onder meer 9 artikels als eerste auteur gepubliceerd in peer reviewed internationale verpleegkundige tijdschriften

Presentaties (in Bijlage 2 vindt u meer informatie)

Diverse presentaties gedurende nationale en internationale symposia en congressen

Onderwijs (in Bijlage 3 vindt u meer informatie)

- Verschillende jaren verantwoordelijke van 3 vakken in de Master of Science in de verpleegkunde en de vroedkunde, UGent
- Geven en begeleiden van diverse hoor- en discussiecolleges aan studenten in de Master of Science in de verpleegkunde en de vroedkunde, UGent
- Copromotor van 9 masterproeven

Wetenschappelijke dienstverlening (in Bijlage 1 vindt u meer informatie)

- Participatie in stuur- en werkgroepen in Kliniek Sint-Jozef Pittem en netwerk PRIT/ KWADRAAT
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Talenkennis

• Nederlands	Moedertaal
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• Engels	Certificate Advanced CEFR - C1 (Easy School of Languages, Valletta, Malta, 2016)

Bijlagen

Bijlage 1: Publicaties

2020 Vandewalle, J., Van Hoe, C., …, Verhaeghe, S. (2020). Dynamics of trust in the relationship between patients with suicidal ideation and mental health nurses: Qualitative study of patients' perspectives. Manuscript being finalised.

Vandewalle, J., Debyser, B., Deproost, E., Verhaeghe, S. (2020). 'Looking through the lens of uncertainty': Qualitative study of family members' expectations regarding inpatient mental healthcare for patients with suicidal ideation. Manuscript being finalised.

Vandewalle, J. (2020). Caring for individuals with suicidal ideation: rudiments of interpersonal interactions and relationships in mental health nursing. Doctoral dissertation. Submitted.

Vandewalle, J., Duprez, V., Beeckman, D., Van Hecke, A., Verhaeghe, S. (2020). Contact between patients with suicidal ideation and nurses in mental health wards: development and psychometric evaluation of a questionnaire. *International Journal of Mental Health Nursing*, accepted for publication. Impact factor: 2.433, Ranked: 10/118 in subject category nursing.

Vandewalle, J., Deproost, E., Goossens, P., Verfaillie, J., Debyser, B. Beeckman, D., Van Hecke, A., Verhaeghe, S. (2020). The working alliance with patients experiencing suicidal ideation: a qualitative study of nurses' perspectives. *Journal of Advanced Nursing*. doi.org/10.1111/jan.14500 Impact factor: 2.376, Ranked: 13/118 in subject category nursing.

Vandewalle, J., Van Bos, L., Goossens, P., Beeckman, D., Van Hecke, A., Deproost, E., Verhaeghe, S. (2020). The perspectives of adults with suicidal ideation and behaviour regarding their interactions with nurses in mental health and emergency services: a literature review. *International Journal of Nursing Studies*. doi.org/10.1016/j.ijnurstu.2020.103692. Impact factor: 3.570, Ranked: 1/118 in subject category nursing.

Bijdrage in vakblad Nursing (februari 2020) Artikel: 'Voor mij hoeft het niet meer': do's en don'ts bij suïcidepreventie.

2019 Vandewalle, J., Beeckman, D., Van Hecke, A., Debyser, B., Deproost, E. & Verhaeghe, S. (2019). Contact and communication with patients experiencing suicidal ideation: a qualitative study of nurses' perspectives. *Journal of Advanced Nursing*. doi.org/10.1111/jan.14113. Impact factor: 2.376, Ranked: 13/118 in subject category nursing.

Vandewalle, J., Beeckman, D., Van Hecke, A., Debyser, B., Deproost, E. & Verhaeghe, S. (2019). 'Promoting and preserving safety and a life-oriented perspective': a qualitative study of nurses' interactions with patients experiencing suicidal ideation. *International Journal of Mental Health Nursing*. doi.org/10.1111/inm.12623. Impact factor: 2.433, Ranked: 10/118 in subject category nursing.

2018 Vandewalle, J., Malfait, S., Eeckloo, K., Colman, R., Beeckman, D., Verhaeghe, S., Van Hecke, A. (2018). Patient safety on psychiatric wards: A cross-sectional multilevel study of factors influencing the nurses' willingness to share power and responsibility with patients. *International Journal of Mental Health Nursing*, doi.org/10.1111/inm.12376, Impact factor: 1.869, Ranked: 19/116 in subject category nursing.

Vandewalle, J., Van Hecke, A., Beeckman, D., Deproost, E. & Verhaeghe, S. (2018). Een blik op verpleegkundige zorg voor mensen met suïcidaal gedrag - De eerste resultaten uit een onderzoek bij verpleegkundigen. *Psychiatrie en Verpleging*, 5, 4-13.

Debyser, B., Duprez, V., Beeckman, D., Vandewalle, J., Van Hecke, A., Deproost, E. & Verhaeghe, S. (2018) Mental health nurses and mental health peer workers: Self-perceptions of role-related clinical competences. International *Journal of Mental Health Nursing*, doi.org/10.1111/inm.12406, Impact factor: 1.869, Ranked: 19/116 in subject category nursing.

2017 Malfait, S.*, Vandewalle, J.*, Eeckloo, K., Colman, R., Van Hecke, A. (2017). The development and validation of the Patient Participation Culture Tool for inpatient psychiatric wards (PaCT-PSY). *Archives of Psychiatric Nursing*. Impact factor: 1.201, Ranked: 56/116 in subject category nursing. *Shared First Authorship

Vandewalle, J., Debyser, B., Beeckman, D., Vandecasteele, T., Deproost, E., Van Hecke, A., Verhaeghe, S. (2017). "Constructing a positive identity": A qualitative study of the driving forces of peer workers in mental health care systems. *International Journal of Mental Health Nursing*,

doi.org/10.1111/inm.12332, Impact factor: 1.869, Ranked: 19/116 in subject category nursing.

Patiënten op de teamvergadering: inspiratiegids. Joeri Vandewalle UGent, Lieke Vercruysse en Thomas Dhondt http://www.sintjozefpittem.be/fileadmin/media/pdf/Documenten/inspiratiegids_patient_op_team_FINALE_VERSIE.pdf

2016 Vandewalle, J., Debyser, B., Beeckman, D., Vandecasteele, T., Van Hecke, A., Verhaeghe, S., (2016). Peer workers' perceptions and experiences on barriers to implementation of peer worker roles in mental health services: A literature review. *International Journal of Nursing Studies*, doi.org/10.1016/j.ijnurstu.2016.04.018, Impact factor: 3.755, Ranked: 1/116 in subject category nursing.

Bijlage 2: Presentaties 1) mondeling, 2) poster

2019
- EANS Summer Conference 2019 Lisbon, Portugal, 10-11 July (2)
- CARE4-congress, Leuven, Belgium, 4-6 February 2019 (1 en 2)

2018
- Symposium voor alumni: patiëntenparticipatie in de gezondheidszorg, Gent, 13 december 2018. (1)
- GGZ congres, Antwerpen, 18-19 september 2018
- Afstemmen op (de persoon met) suïcidale ideatie: een blik op de bijdrage van ggz-verpleegkundigen (1)
- 17th European Symposium on Suicide and Suicidal Behaviour (ESSSB17), Ghent, Belgium, 5-8 September 2018. (2)
- Symposium at VIVES University College, Roeselare: "Op zoek naar de authenticiteit in de psychiatrische verpleegkunde: nieuwe uitdagingen" (24 mei 2018). (1)
- Vorming: GGZ verpleegkundigen en GGZ Ervaringswerkers: samen voor de spiegel, 29 januari 2018, VIVES hogeschool Roeselare (1)

2017
- Colloquium of The Federal Public Service (FPS) Health, Food Chain Safety and Environment in Brussels (24 november 2017) "De communicatie beroepsbeoefenaar-patiënt: Welke goede praktijken?"; Patiëntenparticipatie in multidisciplinaire team meetings (1)
- "Patiëntenparticipatie in de zorg: (meer dan) een extraatje?" (24 november 2017) Psychotherapeutisch Centrum Rustenburg, Brugge (1)
- Symposium at University Centre for Nursing and Midwifery, Ghent University (7 November 2017); nursing care for individuals with suicidal ideation (1)

- Conference abstracts, Refocus on Recovery, Nottingham, UK, 18 September (1) Barriers to the implementation of peer worker roles in mental health
- Vorming: ervaringswerkers en verpleegkundigen als tandem: kans of bedreiging? 1 juni 2017, VIVES hogeschool Roeselare (1)
- Zorgsymposium, “Patiëntenparticipatie in de zorg: (meer dan) een extraatje?”, AZ Delta, Roeselare (11 mei 2017) (1)
- Patiëntenparticipatie en patiëntveiligheid op psychiatrische afdelingen: Tijd voor ‘positive risk-taking’?, NVKVV Oostende 22 maart (1)
- De drijfveren van ervaringswerkers in de GGZ”: Implicaties voor een authentieke integratie van ervaringswerkers, NVKVV Oostende 22 maart (1)
- Barriers, enablers and accelerants for the implementation of innovative patient participation practices in general and mental health services CARE4, Abstracts, Antwerpen, 10 februari (1)

2016 Patiëntenparticipatie en patiëntveiligheid op psychiatrische afdelingen: Tijd voor ‘positive risk-taking’? FOD Volksgezondheid, Brussel, 20 september 2016 (1)

2015 “Drijfveren van ervaringsdeskundigen in de geestelijke gezondheidszorg.” Vlaamse hersteldagen te Gent (1 en 2)

2015 “Hoe patiëntenparticipatie vorm krijgt op Volwassenen Kortverblijf”
41ste week van de verpleegkundigen en vroedvrouwen te Oostende (1)

2013 “Psychische kwetsbaarheid, het etiket voorbij”
festival La Folia / cultuurcentrum De Spil te Roeselare (1)

Bijlage 3: Onderwijs

2015 – 2020 Medewerker ‘Methodologie: kwalitatief onderzoek voor de gezondheidszorg’, o.a. schakelprogramma tot de Master of Science in de verpleegkunde en de vroedkunde, Titularis: Prof. dr. S. Verhaeghe, Academiejaren: 2015-2020, vakverantwoordelijke: 2017-2019

Medewerker ‘Kwalitatief onderzoek in de gezondheidszorg voor gevorderden, Master of Science in de verpleegkunde en de vroedkunde, Schakelprogramma tot Master of Science in de Gezondheidsvoorlichting en –Bevordering. Titularis: Prof. dr. S. Verhaeghe

Academiejaren: 2017-2020, vakverantwoordelijke/ lesgever: 2018-2020

Medewerker ‘Visie-ontwikkeling en basisconcepten in verpleegkunde/vroedkunde’, Schakelprogramma tot de Master of Science in de verpleegkunde en de vroedkunde. Titularis: Prof.dr. S. Verhaeghe, academiejaren 2015-2020, vakverantwoordelijke: 2017-2019

	Medewerker ‘Advanced practice in de GGZ-verpleegkunde’, Master of Science in de verpleegkunde en de vroedkunde, Medelesgever: seminaries Hildegard Peplau 2017-2019 Co-promotor 9 masterproeven van studenten Master of Science in de verpleegkunde en de vroedkunde: 2018-2020: Caressa Van Hoe; 2017-2019: Fien Haijen, Evelyn Blanchard, Svea Geeroms, Anne Van Bocxlaer, Jenna Foulon; 2016-2018: Yentl Defour, Jan Verfaillie en Joke De Canck

Bijlage 4: Wetenschappelijke dienstverlening

2017 – …	Sinds 2019: participatie in werkgroep integratie van ervaringswerkers op afdelingen, Kliniek Sint-Jozef, Centrum voor Psychiatrie en Psychotherapie te Pittem Participatie in werkgroep herstelgericht werken én werkgroep klinisch veiligheidsmanagement, Kliniek Sint-Jozef, Centrum voor Psychiatrie en Psychotherapie te Pittem Participatie in werkgroep organisatie EANS Summer Summer School and Summer Conference, Universitair Centrum voor Verpleegkunde en Vroedkunde, Gent (08.2017- 07.2018) Voorbereiding en organisatie symposia Universitair Centrum voor Verpleegkunde en Vroedkunde (UGent) o De interpersoonlijke relatie in de GGZ-verpleegkunde: verdieping en actualisatie (2018) o Patiëntenparticipatie in de GGZ: hefbomen voor patiënten en verpleegkundigen (2018) o Verpleegkundige zorg voor mensen die actief denken aan zelfdoding: match tussen verwachting en dagelijkse praktijk (2017)
2017-2019	Participatie in stuurgroep én werkgroep zorgpad suïcide, PRIT netwerk geestelijke gezondheidszorg midden-West-Vlaanderen Participatie in stuurgroep psychiatrische en GGZ-verpleegkunde, Universitair Centrum voor Verpleegkunde en Vroedkunde, UGent

Naam: Joeri Vandewalle

Datum: 21.09.2020

Handtekening: 

Addenda

Chapter 2

Addendum 1: the PaCT-PSY and factor loadings (English version)

Addendum 2: the PaCT-PSY and factor loadings (Dutch version)

Chapter 6

Addendum 3. Search filter entered in PubMed

Addendum 1: the PaCT-PSY and factor loadings (English version)

	Likert scale	n	mean	SD	Factor 1	2	3	4	5	6	7	8	9	10	11	12	13
Competence **eigenvalue: 2.723**																	
I feel competent to inform the patient	4-point	603	3.45	0.452								.856					
I feel competent to ask advice from or consult the patient	4-point	603	3.45	0.548								.882					
I feel competent to delegate power to the patient concerning topics of the healthcare process	4-point	603	3.25	0.600								.820					
Support **eigenvalue: 4.058**																	
The hospital management facilitates a working environment that supports patient participation	4-point	574	2.74	0.608				.798									
The actions of the hospital management illustrate that patient participation is an important issue	4-point	574	2.47	0.675				.805									
My supervisor has a positive attitude toward patient participation on the ward	4-point	573	3.17	0.598				.774									
My supervisor shows appreciation when I let a patient participate	4-point	573	3.17	0.588				.812									
My supervisor considers suggestions of employees to improve patient participation on the ward	4-point	572	3.14	0.606				.804									
My supervisor shares the results we achieve concerning patient participation	4-point	572	2.53	0.730				.647									
Colleagues support each other in facilitating patient participation in the healthcare process	4-point	572	2.92	0.664				.541									
My supervisor is personally involved in shaping a mission/vision concerning patient participation	4-point	571	3.25	1.033				.584									
Perceived lack of time **eigenvalue: 1.616**																	
Insufficient staffing reduces patient participation	4-point	570	2.63	0.894													.855
Pressure on the ward influences patient participation	4-point	570	2.75	0.782													.841
Patient participation leads to short term loss of time in the individual patient care	4-point	570	1.90	0.634													.457
Information sharing and dialogue: disease and treatment **eigenvalue: 5.029**																	
During the last week I informed patients about the causes of their disease	4-point*	386	2.66	0.830			.791										
During the last week I informed patients about the possible treatment options for their disease	4-point*	419	2.95	0.796			.736										
During the last week I informed patients about the general results the hospital achieved concerning treatment of their illness	4-point*	367	1.90	0.844			.773										
During the last week I informed the patient about the possible consequences of their illness	4-point*	444	2.80	0.807			.737										
During the last week I informed patients about the results of their tests or treatments	4-point*	353	2.93	0.906			.502										
During the last week I gave the patient information concerning the duration of his/her stay	4-point*	434	2.77	0.940			.413										
Information sharing and dialogue: informed consent **eigenvalue: 3.416**																	
During the last week I told patients before a test, examination or treatment what would happen	4-point*	448	3.36	0.749					.820								
During the last week I told patients before a test, examination or treatment why it was needed	4-point*	460	3.36	0.719					.820								
During the last week I told patients before a test, examination or treatment what the possible consequences are	4-point*	430	2.96	0.855					.747								
During the last week I asked permission to a patient before I did a test, an examination or a treatment	4-point*	440	3.12	0.841					.523								
Information sharing and dialogue: support **eigenvalue: 2.680**																	
During the last week I asked whether the patient had understood the information	4-point*	529	3.30	0.709									.556				
During the last week I explained to patients on which items they could decide	4-point*	516	2.93	0.843									.775				
During the last week I stimulated patients to (co-) decide about the choices that had to be made in their tests, examinations or treatments	4-point*	503	2.83	0.858									.733				
During the last week patients could inspect their personal treatment plan (*e.g.* delivery of a copy of the treatment plan or medication schedule, access to the patient's file)	4-point*	419	2.44	1.027									.462				

* 4-point Likert scale + not applicable

	Likert scale	N	mean	SD	Factor 1	2	3	4	5	6	7	8	9	10	11	12	13
Information sharing and dialogue: discharge eigenvalue: 1.829																	
During the last week I tried to understand the patient's expectations concerning the daily living with the disease	4-point*	510	3.05	0.769											.411		
During the last week I informed patients concerning their treatment after their dismissal from the hospital (e.g. about lifestyle rules, the use of drugs or devices, follow up appointments)	4-point*	480	3.20	0.775											.737		
During the last week I asked patients if they felt ready for dismissal	4-point*	497	3.09	0.861											.579		
During the last week I asked patients for any practical problems concerning aftercare at home e.g. staircases, lavatory interior, steps, handrails	4-point*	440	2.87	0.936											.518		
Information sharing and dialogue: treatment plan eigenvalue: 2.780																	
During the last week I had a dialogue with the patient prior to the multidisciplinary meeting / treatment discussion to elicit his / her expectations and wishes	4-point*	491	3.04	0.907							.686						
During the last week I informed patients after the multidisciplinary meeting / treatment discussion	4-point*	481	2.94	0.907							.829						
During the last week I gave the patient a voice in the preparation of his / her individual treatment plan (needs / expectations)	4-point*	481	2.94	0.916							.826						
Information sharing and dialogue: personal needs eigenvalue: 1.822																	
During the last week I gave the patient a voice about aspects of living together on the ward (agreements concerning TV, kitchen service)	4-point*	423	2.82	0.947												.768	
During the last week I gave the patient a voice in the drafting of individual agreements (smoking, money management)	4-point*	416	2.71	0.870												.791	
During the last week I gave the patient a voice in in his or her therapy program so that it was tailored to his or her individual needs.	4-point*	465	2.92	0.831												.491	
Type of problem: Factual questions eigenvalue: 5.071																	
I am positive toward patients asking: "how long they have to stay in the hospital"	4-point	532	3.41	0.576		.782											
I am positive toward patients asking: "how long their pain will last".	4-point	532	3.36	0.618		.873											
I am positive toward patients asking: "which signals could mean they are e not recovering as they should"	4-point	532	3.40	0.608		.777											
I am positive toward patients asking: "when they can resume their normal activities"	4-point	532	3.48	0.561		.793											
I am positive toward patients asking: "how a certain procedure is executed"	4-point	532	3.51	0.547		.766											
I am positive toward patients asking: "what the policy is on the ward regarding medication, specific to their situation"	4-point	532	3.50	0.557		.732											
Acceptance of a new role eigenvalue: 2.965																	
I am positive toward patients who ask questions or offer suggestions concerning patient safety	4-point	509	3.47	0.527						.497							
I stimulate patient to ask questions concerning patient safety	4-point	509	2.95	0.744						.732							
I perceive it as important to inform patients about the results of the hospital regarding patient safety topics (e.g. medication errors)	4-point	509	2.51	0.778						.768							
I perceive it as important to inform patients regarding a safety incident when they are a part of this incident	4-point	508	3.21	0.660						.614							
Patients should be supported to make their own notes regarding patient safety (e.g. their medication schedule)	4-point	508	2.93	0.734						.641							

* 4-point Likert scale + not applicable

	Likert scale	N	mean	SD	Factor 1	2	3	4	5	6	7	8	9	10	11	12	13
Type of problem: Challenging questions eigenvalue: 2.648																	
I am positive toward patients asking: "whether the medication they receive is correct"	4-point	504	3.59	0.571										.647			
I am positive toward patients asking: "what the name of the healthcare workers is and what they are about to do"	4-point	504	3.65	0.517										.694			
I am positive toward patients asking: "why a healthcare worker removes an apparatus" (monitoring device)	4-point	504	3.62	0.537										.718			
I am positive toward patients asking: "if the healthcare worker has washed / disinfected his or her hands"	4-point	504	3.39	0.688										.663			
Type of problem: Notifying questions eigenvalue: 7.725																	
I think patients need to be encouraged saying: "they have not received the results of their tests yet"	4-point	504	3.58	0.529	.666												
I think patients need to be encouraged saying: "if they think a fault has happened in the care they receive"	4-point	504	3.68	0.479	.796												
I think patients need to be encouraged saying: "if they think their wound is infected"	4-point	504	3.75	0.449	.854												
I think patients need to be encouraged saying: "If there are situations or conditions that increase their risk on suicide or self-harm"	4-point	504	3.77	0.420	.878												
I think patients need to be encouraged saying: "if the actions of healthcare workers in managing aggression are unsafe or inappropriate"	4-point	504	3.64	0.500	.780												
I think patients need to be encouraged saying: "if another patient has a possible risk on self-harm or suicide"	4-point	504	3.69	0.497	.803												
I think patients need to be encouraged saying: "if the patient experiences side effects due to prolonged intake of psychotropic drugs"	4-point	504	3.76	0.439	.863												
I think patients need to be encouraged saying: "If there are unsafe situations due to behaviour of other patients"	4-point	504	3.76	0.425	.876												

* 4-point Likert scale + not applicable

Addendum 2: the PaCT-PSY and factor loadings (Dutch version)

	Likert scale	n	mean	SD	Factor 1	2	3	4	5	6	7	8	9	10	11	12	13
Competence **eigenvalue: 2.723**																	
Ik voel me competent om patiënten te informeren	4-point	603	3.45	0.452								.856					
Ik voel met competent om rekening te houden met de mening en de voorstellen van de patiënten	4-point	603	3.45	0.548								.882					
Ik voel me competent om patiënten mee te laten beslissen over bepaalde aspecten van de zorgverlening	4-point	603	3.25	0.600								.820					
Support **eigenvalue: 4.058**																	
Het ziekenhuismanagement zorgt voor een werkklimaat dat patiëntenparticipatie bevordert	4-point	574	2.74	0.608				.798									
De acties van het ziekenhuismanagement illustreren dat patiëntenparticipatie een topprioriteit is	4-point	574	2.47	0.675				.805									
Mijn supervisor heeft een positieve houding ten opzichte van patiëntenparticipatie op de afdeling	4-point	573	3.17	0.598				.774									
Mijn supervisor toont waardering wanneer we patiënten laten participeren in de zorg	4-point	573	3.17	0.588				.812									
Mijn supervisor houdt rekening met suggesties van medewerkers/collega's om de mate van patiëntenparticipatie op de afdeling te verbeteren	4-point	572	3.14	0.606				.804									
Mijn supervisor maakt resultaten van patiëntenparticipatie zichtbaar op de afdeling	4-point	572	2.53	0.730				.647									
Medewerkers en collega's steunen elkaar / moedigen elkaar aan om patiënten te betrekken in de zorg	4-point	572	2.92	0.664				.541									
Mijn supervisor is persoonlijk betrokken bij het uitwerken van een missie/visie rond patiëntenparticipatie	4-point	571	3.25	1.033				.584									
Perceived lack of time **eigenvalue: 1.616**																	
Onvoldoende bestaffing remt patiëntenparticipatie af	4-point	570	2.63	0.894													.855
De drukte op de afdeling bepaalt de mate van patiëntenparticipatie	4-point	570	2.75	0.782													.841
Patiëntenparticipatie leidt op korte termijn tot tijdsverlies in de individuele zorg voor de patiënt	4-point	570	1.90	0.634													.457
Information sharing and dialogue: disease and treatment **eigenvalue: 5.029**																	
Informeerde ik de patiënten over de oorzaak van hun aandoening	4-point*	386	2.66	0.830			.791										
Informeerde ik de patiënten over de mogelijke behandelingswijzen voor hun aandoening	4-point*	419	2.95	0.796			.736										
Informeerde ik de patiënten over de algemene resultaten die we in het ziekenhuis behalen voor de behandeling van hun aandoening	4-point*	367	1.90	0.844			.773										
Informeerde ik de patiënten over de mogelijke gevolgen van hun aandoening	4-point*	444	2.80	0.807			.737										
Informeerde ik de patiënten over hun resultaten van onderzoeken/behandelingen	4-point*	353	2.93	0.906			.502										
Gaf ik informatie over de vermoedelijke verblijfsduur aan de patiënten	4-point*	434	2.77	0.940			.413										
Information sharing and dialogue: informed consent **eigenvalue: 3.416**																	
Vertelde ik aan de patiënten voor een onderzoek, behandeling of verzorging wat er precies zou gebeuren	4-point*	448	3.36	0.749					.820								
Vertelde ik aan de patiënten voor een onderzoek, behandeling of verzorging waarom iets nodig was	4-point*	460	3.36	0.719					.820								
Vertelde ik aan de patiënten voor een onderzoek, behandeling of verzorging wat de mogelijke gevolgen konden zijn	4-point*	430	2.96	0.855					.747								
Werd goedkeuring aan de patiënten gevraagd voorafgaand aan het uitvoeren van onderzoeken, behandeling of verzorging	4-point*	440	3.12	0.841					.523								

* 4-point Likert scale + not applicable

	Likert scale	N	mean	SD	Factor 1	2	3	4	5	6	7	8	9	10	11	12	13
Information sharing and dialogue: support eigenvalue: 2.680																	
Vroeg ik na of de patiënten de informatie begrepen hadden	4-point*	529	3.30	0.709									.556				
Vertelde ik aan patiënten waarover ze mee konden beslissen	4-point*	516	2.93	0.843									.775				
Stimuleerde ik de patiënten om mee te beslissen over de keuzes van hun onderzoeken, behandeling of verzorging	4-point*	503	2.83	0.858									.733				
Kregen de patiënten inzage in hun individueel behandelplan (bijv. afgifte van een kopie van het behandelingsplan of medicatieschema, inzage in het patiëntendossier)	4-point*	419	2.44	1.027									.462				
Information sharing and dialogue: discharge eigenvalue: 1.829																	
Probeerde ik de verwachtingen van de patiënten op vlak van hun dagelijks functioneren met de aandoening te achterhalen	4-point*	510	3.05	0.769											.411		
Informeerde ik de patiënten over de verdere behandeling na zijn / haar ontslag uit het ziekenhuis (bv. over de regels voor levensstijl, rust en werken, het gebruik van medicijnen of hulpmiddelen, controle afspraken)	4-point*	480	3.20	0.775											.737		
Vroeg ik aan de patiënten of zij vonden dat ze ontslag klaar waren.	4-point*	497	3.09	0.861											.579		
Vroeg ik aan de patiënten naar eventuele praktische problemen i.v.m. de nazorg thuis bv. trappen, inrichting toilet, opstapjes, handgrepen	4-point*	440	2.87	0.936											.518		
Information sharing and dialogue: treatment plan eigenvalue: 2.780																	
Had ik een overleg met de patiënt voorafgaand aan het multidisciplinair overleg/behandelplanbespreking om te peilen naar zijn/haar verwachtingen en wensen	4-point*	491	3.04	0.907							.686						
Informeerde ik de patiënt na het multidisciplinair overleg/behandelplanbespreking	4-point*	481	2.94	0.907							.829						
Gaf ik de patiënt inspraak in het opstellen van zijn/haar individueel behandelplan	4-point*	481	2.94	0.916							.826						
Information sharing and dialogue: personal needs eigenvalue: 1.822																	
Gaf ik de patiënt inspraak in aspecten m.b.t. het samenleven op de afdeling (afspraken rond TV kijken, keukendienst, …)	4-point*	423	2.82	0.947												.768	
Gaf ik de patiënt inspraak bij het opstellen van individuele afspraken (roken, geldbeheer, …)	4-point*	416	2.71	0.870												.791	
Kreeg de patiënt inspraak in zijn of haar therapieprogramma zodat dit aangepast was aan zijn of haar individuele noden	4-point*	465	2.92	0.831												.491	
Type of problem: Factual questions eigenvalue: 5.071																	
Hoe lang ze in het ziekenhuis moeten verblijven	4-point	532	3.41	0.576		.782											
Hoe lang hun pijn/ziekte zal aanhouden	4-point	532	3.36	0.618		.873											
Welke signalen er kunnen op wijzen dat hun genezing niet verloopt zoals het zou moeten	4-point	532	3.40	0.608		.777											
Wanneer ze hun normale activiteiten kunnen hernemen	4-point	532	3.48	0.561		.793											
Hoe een bepaalde procedure (bv. onderzoek, behandeling, techniek) verloopt	4-point	532	3.51	0.547		.766											
Wat het beleid op de afdeling is omtrent medicatie, specifiek voor hun situatie	4-point	532	3.50	0.557		.732											

* 4-point Likert scale + not applicable

	Likert scale	N	mean	SD	Factor 1	2	3	4	5	6	7	8	9	10	11	12	13
Acceptance of a new role eigenvalue: 2.965																	
Ik ervaar het als positief dat patiënten vragen stellen of suggesties geven m.b.t. patiëntveiligheid	4-point	509	3.47	0.527						.497							
Ik stimuleer patiënten om vragen te stellen m.b.t. patiëntveiligheid	4-point	509	2.95	0.744						.732							
Ik vind het belangrijk dat patiënten geïnformeerd worden over de algemene resultaten die we in het ziekenhuis behalen m.b.t. aspecten van patiëntveiligheid (bv. aantal medicatiefouten)	4-point	509	2.51	0.778						.768							
Ik vind het belangrijk dat patiënten geïnformeerd worden over een patiëntveiligheidsincident, indien ze daarvan het onderwerp uitmaken	4-point	508	3.21	0.660						.614							
Patiënten moeten aangemoedigd worden om eigen notities en aantekeningen in het kader van patiëntveiligheid bij te houden (bv. hun medicatieschema)	4-point	508	2.93	0.734						.641							
Type of problem: Challenging questions eigenvalue: 2.648																	
Of de medicatie die de zorgverlener aan hen geeft wel de juiste medicatie is	4-point	504	3.59	0.571										.647			
Wat de naam van de zorgverlener is en wat deze bij hen komt doen	4-point	504	3.65	0.517										.694			
Waarom een zorgverlener een apparaat (bv. monitoring toestel) wegneemt	4-point	504	3.62	0.537										.718			
Of de zorgverlener zijn/haar handen ontsmet/gewassen heeft	4-point	504	3.39	0.688										.663			
Type of problem: Notifying questions eigenvalue: 7.725																	
Indien ze hun resultaten van hun onderzoek nog niet ontvangen hebben	4-point	504	3.58	0.529	.666												
Indien ze denken dat er een fout is gebeurd in de zorg die ze krijgen	4-point	504	3.68	0.479	.796												
Indien ze denken dat hun wonde geïnfecteerd is	4-point	504	3.75	0.449	.854												
Indien er situaties of omstandigheden zijn die het risico op suïcide of zelfverwonding voor zichzelf vergroten	4-point	504	3.77	0.420	.878												
Indien de gestelde handelingen bij agressie(bejegening) onveilig of ongepast zijn	4-point	504	3.64	0.500	.780												
Indien een andere patiënt mogelijks een gevaar loopt op zelfverwonding of suïcide	4-point	504	3.69	0.497	.803												
Indien de patiënt bijwerkingen ervaart t.g.v. het langdurig innemen van psychofarmaca	4-point	504	3.76	0.439	.863												
Indien er zich onveilige situaties voordoen t.g.v. gedrag van andere patiënten	4-point	504	3.76	0.425	.876												

Addendum 3. Search filter entered in PubMed

POPULATION: Persons with suicidal ideation and behaviour

MeSH Terms combined with 'OR': patients; hospitalization; inpatients; outpatients

Text words combined with 'OR': patient(s); hospitalization; hospitalized; hospitalisation; hospitalised; client(s); consumer(s); inpatient(s); in-patient(s); survivor(s); user(s); service user(s); person(s); individual(s); outpatient(s); outpatient; people

AND

MeSH Terms combined with 'OR': suicide; suicide, attempted; suicidal ideation

Text words combined with 'OR': attempted suicide; suicide attempt; suicidal behavior; suicidal behaviour; suicidal ideation; suicide ideation; suicidal thoughts; suicidal; suicidal thinking; suicidality; suicide risk; suicidal crisis; suicide crisis; death wish

AND

PHENOMENON OF INTEREST: interaction with nurses

MeSH Terms combined with 'OR': communication; nonverbal communication; communication barriers; counselling; safety

Text words combined with 'OR': communication; communicate; communicating; nonverbal communication; non-verbal communication; communication barrier(s); nurse-patient communication; conversation(s); talking; talk; talked; listening; listen; listened; counseling; counselling; contact(s); nurse-patient interaction; interaction(s); interact; interacting; interacted; connecting; connection; connect; connected; engaging;

engagement; engaged; collaborating; collaborate; collaborated; collaboration; response(s); responded; responding; present; presence; being there; being with; attend; attending; attention; acknowledge; acknowledged; acknowledging; to know; knowing; treat; treated; care; cared; caring; power; empower; empowered; empowering; partnership(s); participating; participation; participate; involvement; involving; involve; involved; interpersonal; sharing; shared; share; trust; trusting; safe; safety; distance; distancing; distant; close; closeness; closed; open; openness; disclose; disclosed; disclosing; disclosure; discuss; discussed; discussing; confirm; confirmed; confirming; avoid; avoidance; avoiding; rapport; defensive; react; reacted; reaction; protecting; protected; protect; protection; control; controlled; controlling; responsible; responsibility; persuasive; persuade; persuaded; coercive; coercion; coerced; contain; contained; containing; non-judgemental; judgemental; judge; judging; understand; understood; understanding; reliable; trustworthy; genuine; meaning; meaningful; hope; hopeful; encounter; encountering; advise; advised; advising; advises; information; informing; inform; informed

AND

MeSH Terms combined with 'OR': nurses; nursing staff; nursing; nursing services; psychiatric nursing; nursing care

Text words combined with 'OR': nurse(s); nursing staff; nursing; nursing care; nursing services; psychiatric nursing; psychiatric nurse(s); mental health nursing; mental health nurse(s); case manager(s)

AND

CONTEXT: inpatient or community mental health and emergency services

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MeSH Terms combined with 'OR': psychiatry; mental health; mental health services; hospitals, psychiatric; hospital units; emergency hospital services; psychiatric emergency services; ambulatory care; ambulatory care facilities; community health; community psychiatry; community mental health centers; community health services; community health nursing; primary health care; primary care; home health nursing; home care services; outpatient clinics; hospital; community mental health services

Text words combined with ‘OR’: psychiatry; mental health; mental health services; mental health setting(s); hospital(s); primary health care; psychiatric hospital(s); mental health hospital(s); mental health ward(s); psychiatric ward(s); ward(s); hospital unit(s); psychiatric unit; unit(s); emergency hospital service(s); psychiatric emergency service(s); emergency department(s); ambulatory care; ambulatory care facilities; ambulatory care facility; nurses, community health; community care; community psychiatry; community mental health center(s); community mental health centre(s); community mental health service(s); community; communities; community health service(s); community service(s); community health nursing; community nursing; community nurse(s); home health nursing; home care service(s); home care; home; outpatient care; outpatient health service(s); outpatient service(s); outpatient clinic(s); assertive community treatment

Caring for individuals with suicidal ideation: rudiments of interpersonal interactions and relationships in mental health nursing

The doctoral dissertation is based on seven studies with a range of research designs and methods. It comprises three qualitative studies based on grounded theory, one systematic international review, one quantitative cross-sectional multilevel study, and two studies on the development and psychometric evaluation of two distinct instruments. The use of both quantitative and qualitative approaches enabled the researchers to address the complex research objectives. More specifically, this doctoral dissertation enhances the understanding of the rudiments of interpersonal interactions and relationships in the context of providing nursing care for people with suicidal ideation. This understanding can inform reform in suicide prevention and the treatment of suicidal ideation. Moreover, it can encourage the development of mental health services wherein people with suicidal ideation can participate in their care and treatment, and access nurses who interact with them as unique individuals in sensitive and competent ways. While studying the interactional and relational aspects of nursing care in the context of suicidality is very complex, this complexity should neither be feared nor simplified, but embraced and further studied. Such research efforts can enhance the understanding—and support the implementation—of a person-centred and collaborative paradigm. Nursing care for people with suicidal ideation needs to be an interpersonal endeavour, one characterised by meaningful contact, connecting with patients as unique individuals, and engaging in collaborative and therapeutic interactions.

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