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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.

KEYWORDS
communication, grounded theory, nurse–patient relationship, nursing, psychiatric hospitals, qualitative research, suicidal ideation, suicide

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 (SI), 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, Sara, Ryan, & Large, 2015).

Theoretical insights indicate that SI is often underpinned by loneliness, social isolation and interpersonal trauma. These insights emphasize that the sensitive development of interpersonal relationships is of crucial importance for patients experiencing SI (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 SI is a fundamental component of suicide prevention (Fleischmann et al., 2008; Inagaki et al., 2015; Luoma, Marti, & Pearson, 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.

1.1 | Background

Qualitative studies indicate that nurses can initiate and develop warm, regular and care-based human-to-human contact with patients experiencing SI, thus providing a foundation on which to establish nurse–patient relationships with therapeutic potential (Cutcliffe, Stevenson, Jackson, & Smith, 2006; Lees, Procter, & Fassett, 2014; Talseth, Lindseth, Jacobsson, & Norberg, 1999). A body of knowledge has emerged regarding the potential impact of the interpersonal relationship on the recovery of patients experiencing SI. 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, Asp, Wallsten, & Wiklund Gustin, 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, Knizek, & Hjelmeland, 2017; Lees et al., 2014; Samuelsson, Wiklander, Asberg, & Saveman, 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, Chambers, Nolan, Thomas, & Watts, 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 SI, including holding negative attitudes towards patients, having limited time and experiencing a lack of training, supervision and emotional support (Bolster, Holliday, Oneal, & Shaw, 2015; Hagen, Knizek, 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 SI (Hagen, Hjelmeland, & Knizek, 2017; Horsfall & Cleary, 2000; Manuel, Crowe, Inder, & Henaghan, 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, Hunt, Horsfall, & Deacon, 2012; Gunasekara, Pentland, Rodgers, & Patterson, 2014). The authors of this study suggest that these fundamentals can be understood by uncovering how nurses make contact with hospitalized patients experiencing SI. The formulation "patients experiencing SI" is used consistently to acknowledge the hospital context while recognizing and validating patients' individuality and the range of suicidal thoughts and feelings they can experience.

2 | THE STUDY

2.1 | Aims

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

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 SI.

2.3 | Participants

Nurses were recruited on wards in four psychiatric hospitals where adults experiencing SI are regularly admitted. The hospitals were spread across (Flanders); the (Dutch-speaking) part of (Belgium).

The first author contacted head nurses who approached potential participants. Interested nurses were emailed to schedule an interview. All nurses had to have experience caring for patients experiencing SI 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. mentalization-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 summarized in Table 1.

2.4 | Data collection

A male PhD candidate (first author) 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 experiencing SI?". 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 author asked the head nurses to recruit nurses who attach more importance to interpersonal elements in their contacts with patients experiencing SI.

2.5 | Ethical considerations

The ethics committees of the participating settings approved this study (B670201630531). The first author 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.

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 author listened to the audio recordings and read the transcripts repeatedly. Another researcher with advanced

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[a]					
Closed	2	2		1	5
Open	2	5	5	2	14
	4	7	5	3	

[a]Ward types: entrance of the ward is open or closed

qualitative research experience read all transcripts. Both researchers made memos. For each interview, the first author 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 cross-checked between the researchers to elaborate concepts and relations between concepts. To develop meaningful insights, three additional discussions were organized 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 program. 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).

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 author. 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).

3 | FINDINGS

The analysis indicated two interconnected core elements. Nurses make contact with patients experiencing SI 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.

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 SI.

3.1.1 | Creating avenues to patients experiencing SI

Nurses perceived that a large number of patients experiencing SI 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 SI. Nurses stressed the importance of an ongoing active involvement characterized by initiating regular contact on formal and informal moments; being present, accessible, approachable; and reaching out to patients. For the same reason, they emphasized 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 emphasized that they have to initiate conversations about SI. Some nurses ask about and name SI 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 SI is not a taboo subject. Other nurses rather initiate conversations about SI 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 formalized 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 emphasized 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 organizational 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)

3.1.2 | Creating a safe atmosphere to talk about suicidality

Nurses perceived that patients often do not disclose SI 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' SI. Nurses reported challenges communicating with patients who feel ashamed of their SI, have been rejected previously when disclosing SI, experience extreme distress or hopelessness and verbalize SI 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 SI:

"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 SI is an emotionally loaded subject. They emphasized that they have to "dare to discuss" SI with patients. To enable patients' communication of SI, 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 SI 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 SI. 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 SI 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 SI 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 than 10 years of working experience stressed the importance of taking assessment as part of an open conversation, informing 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 formalized 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)

3.2 | Developing an accurate and meaningful picture of patients

Nurses perceive that patients' open and genuine communication about SI 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 SI, 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, nurses stressed the need for recurring assessment to capture fluctuations in SI, to capture changes in risk and protective factors and to refine their picture of patients based on patients' gradual disclosure of SI 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 SI such as self-harm and social isolation. When nurses suspect SI, they try to characterize 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 SI. 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 SI. 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 nurses, there are patients who "wear a mask" to hide SI 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 SI 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 SI. These nurses emphasized 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 standardized 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 categorizing suicide risk and the sincerity of suicidal expressions (e.g. "genuine death wish" vs. "bids for attention"). The checking approach is also concerned with assessment of protective factors and with explicit efforts to elicit hopeful elements, for instance, using check lists. 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 than 10 years of working experience, it was also seen in nurses with more than 10 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 emphasized 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 than 10 years of working experience, it was also seen in nurses with less than 10 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)

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, nurses try to enable patients' communication about SI 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 SI and to identify risk and protective factors. Overall, these insights shed new light on the evidence indicating that recognizing and discussing suicide may reduce, rather than increase patients' SI and therefore is a critical component of suicide prevention (Dazzi, Gribble, Wessely, & Fear, 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 emphasized barriers to suicide risk assessment, including their perception that patients may find it difficult to talk about SI or even conceal or deny SI. Studies indicate that these phenomena are associated with patients' feelings of hopelessness and shame, experiences of rejection when disclosing SI and decisions not to let anyone intervene (Fulginiti, Pahwa, Frey, Rice, & Brekke, 2016; Isometsä, 2001; Samuelsson et al., 2000). Furthermore, the present findings suggest that patients sometimes conceal or deny SI during assessments to avoid perceived restrictive and controlling interventions, such as standardized 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 SI (Bolton, Gunnell, & Turecki, 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, Hjelmeland, 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 SI (Bowers, Gournay, & Duffy, 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 standardized 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, Rørtveit, & Aase, 2017; Lakeman & FitzGerald, 2008; Lees et al., 2014; Sellin et al., 2017; Sun, Long, Boore, & Tsao, 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 potential indications of nurse characteristics that mediate nurses' contribution to effective interpersonal practice in the context of contact and communication with patients experiencing SI. 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 authors 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 SI.

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 standardized 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, emphasize 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 guidelines and educational programmes 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 SI 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 health care settings and especially for nurses who maintain distant relationships with patients experiencing SI, do not know how to assess and evaluate SI and avoid communication about SI (Bolster et al., 2015; Rebair & Hulatt, 2017; Talseth, Lindseth, Jacobsson, & Norberg, 1997).

Policy makers 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, Knizek, 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 emphasize 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.

4.1 | Limitations

Although the findings can be related to evidence obtained from the perspective of patients experiencing SI, 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 may 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 SI (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, criminalization of suicide) that can influence the individuals' lived experiences of SI, the (student) nurses' attitudes towards suicide and suicide attempts and the (student) nurses' engagement in recognizing and discussing suicide (Flood et al., 2018; Osafo, Akotia, Boakye, & Dickson, 2018; Vedana et al., 2018).

Overall, the authors 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 recognizing and discussing SI (e.g. "daring to discuss SI") and how this involvement provides an essential perspective from which to assess and document suicide risk can meaningfully inform nursing practice.

5 | CONCLUSION

The study enhances the conceptual understanding of how nurses on psychiatric wards enable patients' communication of SI 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 SI; to develop multifaceted and interpersonal approaches to suicide risk assessment; and to develop and use nurse–patient relationships with preventive and therapeutic potential.

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CONFLICT OF INTEREST

No conflict of interest has been declared by the authors.

AUTHOR CONTRIBUTIONS

JV, DB, AVH, BD, ED, SV made substantial contributions to conception and design, or acquisition of data, or analysis and interpretation of data; JV, DB, AVH, BD, ED, SV involved in drafting the manuscript or revising it critically for important intellectual content; JV, DB, AVH, BD, ED, SV given final approval of the version to be published. Each author should have participated sufficiently in the work to take public responsibility for appropriate portions of the content; JV, DB, AVH, BD, ED, SV agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

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