

Caring for the suicidal person: A Delphi study of what characterizes a recovery-oriented caring approach.

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Abstract

More research is needed for supporting mental health nurses in their caring for suicidal individuals, including the ontological and epistemological foundations for mental health nursing. This study aims to describe what characterizes a recovery-oriented caring intervention, and how this can be expressed through caring acts involving suicidal patients and their relatives. Using Delphi methodology, research participants were recruited as experts by experience in order to explore a recovery-oriented caring intervention in a dialogical process between the experts and the researchers. The findings elucidate that a recovery-oriented caring intervention is characterized by a “communicative togetherness”. This communication is associated with enabling a space for suicidal persons to really express themselves and to reach for their own resources. Such communication has potential to support recovery as it induces a mutual understanding of the complexities of the patient’s situation and supports patients in influencing their care and regaining authority over their own lives. Mental health nurses need to listen sensitively to what suicidal persons really say, acknowledging their lifeworlds, and need to be open to individual variations of their recovery processes. This includes acknowledging available and supportive relatives as capable of contributing to the patient’ projects of recovery and continuing life.

Keywords: Communication; epistemology; interventions; lived body; mental health nursing; phenomenology; psychiatry; qualitative research; recovery; suicidality

Introduction

The literature pointed to the importance of acknowledging a relational dimension of suicide prevention to encounter the unique needs of each suicidal person (Gaebel et al., 2014; Stefenson & Titelman, 2016; Waern, Kaiser, & Renberg, 2016). In the light of Gysin-Maillart, Schwab, Soravia, Megert and Michel (2016) and Cutcliffe, Stevenson, Jackson and Smith's (2006) words it could be said that the relational dimension, with its implied emphasis on narration and meaning, is in focus. This is in contrast to a perspective of risk factors, which considers previous self-destructive behaviours, and in particular attempted suicide, as the major risk factor for future suicide (World Health Organization, 2014).

Available methods for suicide risk assessment are often designed to consider risk factors for suicide. However, the Swedish agency for health technology assessment and assessment of social services (SBU, 2015), have conducted a systematic literature review in order to evaluate the scientific evidence for, and the reliability for such suicide risk assessment methods. The SBU's report (2015) stated that scientific evidence for the methods in focus is poor. Research considering the patients' perspectives highlights another aspect of the issue, stating that clinical suicide risk assessment needs to take place in a careful and thorough conversation, where the suicidal person's narrative is acknowledged as an essential resource for understanding the person's needs (Gysin-Maillart et al., 2016).

Individual needs as a foundational starting point for a human related suicide prevention have been addressed earlier, by for example Schneidman (1998) and Talseth, Lindseth, Jacobson and Norberg (1999). Caring science researchers such as Todres, Galvin and Dahlberg (2014) have also paid specific attention to this foundational phenomenon in relation to caring, thus focusing on what it means to understand another human, and more importantly how to act on this understanding in caring ways. These authors have, in particular, acknowledged a phenomenologically oriented reflection upon the ways that the

findings of phenomenological studies can lead to deeper insights for both theoretical and applied purposes. This can also be described as the value and philosophy of lifeworld-led care provides a humanizing basis to underpin methodological progress (Todres, Galvin, & Dahlberg, 2007). Thus, researchers in suicide prevention and caring science acknowledge the value of interventions that have the potential to humanize suicide prevention and healthcare in a profound way. However, more research is needed to facilitate a deeper understanding of humanizing activities in all its complexity (Cutcliffe et al., 2006; Dahlberg, Todres, & Galvin, 2009; Galvin & Todres, 2009; Tzeng, Yang, Tzeng, Ma, & Chen, 2010).

Focusing on the relational dimension and encouraging a humanizing way to approach the patient's caring needs means a shift of focus from behaviour to an understanding of what the patient is trying to express, and articulating a framework as a value base for guiding practice. This includes taking into account the unique experiences of individuals rather than emphasis objectifying definitions of human needs (Todres, Galvin, & Holloway, 2009). In particular, research considering suicidal patients' perspectives describes that experiencing unmet needs, where the relational component of patient safety is considered the most vital aspect of care, can contribute to patients feeling unsafe and lead to an increase in their suicidal behaviour during inpatient care (Berg, Rortveit, & Aase, 2017). This corresponds to research considering mental health nurses' perspectives of caring for suicidal patients in psychiatric wards (Hagen, Knizek, & Hjelmeland, 2017). These authors highlight that caring for suicidal patients involves challenges related to finding a balance between involvement and distance in the relationship with the patient. By providing close care and enhancing understanding of the patient, nurses have opportunities to respond to patients' expressions of suicidality and support their recovery processes in meaningful ways. This includes a work with emotions for the nurses, and critical reflection upon one's own attitudes evoked in the encounter with suicidal patients (Talseth & Gilje, 2011) Research acknowledges the importance of nurses

engaging in close relationships with the suicidal patient (Gilje & Talseth, 2014; Lakeman, 2010), where the patient is acknowledged as a resourceful human being (Jordan et al., 2012; Vatne & Naden, 2014), and is thus enabled to reconnect with him/herself through personal narration (Sellin, Asp, Wallsten, & Wiklund Gustin, 2017). The humanization of patients' care also means acknowledging relatives' nurturing and sharing presence as a resource in the suicidal person's project of recovery and continuing life (Sellin, Asp, Kumlin, Wallsten, & Wiklund Gustin, 2017). Caring for the persons concerned in such ways can also be described as enabling the patient to move from a death-oriented position to a life-oriented position through the process of re-connecting with humanity (Cutcliffe et al., 2006). This corresponds to Orbach's (2008) and Schneidman's (1998) view of mental health problems and meaning in life which gives a perspective of suicidality as an existential crisis rather than as a disease. Hence, in this study the use of the concept "suicidal patients" is not a label that pretends to provide an explanation of the patient's suicidality. Instead it involves a concern of acknowledging human beings in an existential boundary situation (Rehnsfeldt, 1999).

In order to acknowledge the participants' experiences and the phenomenon in focus in previous research (Authors, 2017a, 2017b), this study is conducted with grounding in lifeworld theory (Dahlberg, Dahlberg, & Nyström, 2008), and phenomenological philosophy (Merleau-Ponty, 2013/1945). This foundation contributes to the scientific approach and involves a concern to acknowledge the individual's perspective and the relationship between human beings and their world, in which human beings exist in a context with other humans (Todres et al., 2007, 2014, 2009). These ontological and epistemological underpinnings correspond to the foundation in caring science where people are acknowledged as experts in their own experiences through life (Barker & Buchanan-Barker, 2005; Gilje & Talseth, 2014). In summary, mental health nurses' caring for suicidal patients needs to be expressed through interventions that take into account patients' perspectives and also are sensitive to the unique

nature of human existence. However, more research is needed as a basis for supporting mental health nurses in their work with recovery-oriented caring interventions. This study is a part of a research project where the overall aim was to develop such intervention based on previous research, focusing suicidal patients' experiences of recovery (Authors, 2017a) as well as their relatives' experiences of participation during their loved one's psychiatric inpatient care (Authors, 2017b). Therefore, this study aims to describe what characterizes a recovery-oriented caring intervention, and how this can be expressed through caring acts involving suicidal patients and their relatives.

Methodological approach

In order to take into account peoples' experiences of caring for suicidal persons, this study was conducted by means of a Delphi approach (Keeney, Hasson, & McKenna, 2001, 2006; Keeney, McKenna, & Hasson, 2011). The significant thing with this approach is that research participants are recruited as experts in experience, and that new knowledge is developed in a dialogical process between the experts and the researchers. This means that data collection and analysis were carried out step by step in accordance with the Delphi methodological principles (Keeney et al., 2011; Robson, 2011). In the first step, focus group interviews were conducted with the experts (Keeney et al., 2011; Liamputtong, 2011). These interviews were analyzed and followed up with three rounds of questionnaires in which responses were analyzed and redistributed to the expert panel by email. These methodological stages provided possibilities for participants to discuss issues and elaborate on their views. Each round also gave a possibility for the researchers to refine and validate their interpretations in dialogue with the experts. Through this interaction between experts and researchers a shared understanding of the characteristics of recovery oriented caring interventions and how to realize them as caring acts emerged. Within this approach, the researchers' reflection process was carried out with regard to a reflective lifeworld research approach (RLR) as described by

Dahlberg et al. (2008). This reflection involved slowing down the process of understanding the characteristics, which included restraining the researchers' pre-understanding, to avoid making conclusions too quickly. This included simultaneously maintaining sensitivity in the continuing process of discovery.

Participants and setting

Participants were recruited through: A) representatives from a Swedish organization which works with suicide prevention and support to relatives who have lost a loved one to suicide; B) registered nurses at a County Council in Sweden; and (C) researchers with special knowledge about suicide prevention. The inclusion criteria were that participants: (1) based on their personal and/or professional experiences could be seen as experts in suicide prevention; (2) were at least 18 years old; and (3) were able to understand and speak Swedish. Five representatives from the organization, eight registered nurses and five researchers were included in the study (i.e., three groups of expertise).

[Inserting Table 1 here. The table can be found at the end of this manuscript].

Ethical considerations

This study was approved by an ethical review board (grant number 2013/123-3/4), and conforms to the ethical principles clarified in the Declaration of Helsinki (World Medical Association, 2013). The research was conducted with respect and responsibility for confidentiality, and protected the participants' integrity and identity. This includes that each expertise, i.e., representatives from a Swedish organization that works with suicide prevention and support to relatives who have lost a loved one to suicide, registered nurses and researchers, were invited to a homogeneous focus group interviews, to facilitate the focus group members in feeling comfortable in expressing their opinions (Keeney et al., 2011; Liamputtong, 2011). With respect to the risk that sharing one's experiences in a focus group

interview could arouse distressing thoughts for the participants, information was given about the possibility to contact the interviewer (the first author) afterwards. All participants also had personal and/or professional networks that they could turn to if the focus group interview raised issues that needed a follow-up conversation. Written informed consent was obtained from all participants before the focus group interviews. In order to protect the privacy of the participants and maintain confidentiality, information about the participants' age and gender are not included in this article (Morse & Coulehan, 2015).

Data collection and analysis

In accordance with the methodological principles (Keeney et al., 2001, 2006, 2011), Delphi round 1 was carried out through focus group interview with the expert panel. The focus group interview took its starting point in the findings of two previous studies (Authors 2017a, 2017b). These findings provided a foundation for the focus group interview and were presented by the moderator (the first author) in the form of the following four themes: “Enabling the suicidal person the possibility to express him/herself and to be him/herself in the struggle between life and death”, “Providing the patient the possibility to be in a vital rhythm in everyday life”, “Allowing relatives to contribute with their perspectives in the tension between life and death”, and “Contributing to a nurturing connectedness with the persons concerned”. The themes focused on aspects of recovery as experienced by suicidal patients and aspects of participation as experienced by relatives of suicidal patients. The opening question in the focus group interview (Keeney et al., 2011; Liamputtong, 2011) encouraged participants to discuss and describe what thoughts of caring acts the themes gave rise to. In order to support participants to elaborate on their descriptions, follow up questions were included such as: “What do you think that the professional caregivers could do?”, “What do you think is most important in that?”, “Have any of you experienced good examples of that?” In this way, the moderator led the conversation and was simultaneously restrained in

her role, to give space for participants to elaborate on what they thought was of relevance, and thus exchange experiences and reflect upon the topic. The role of the observer (the last author) was to observe the communication, summarize the discussion and give feedback to the participants, and also highlight reflections that the group conversation aroused in her. Participants' discussions contributed to a variation in the data.

The focus group interviews were subject to analysis following Robson's (2011) recommendations. Characteristics that related to each other were grouped into themes described as "The meaning of narration in relation to recovery", "The rhythm of everyday life and recovery", "The meaning of safety in relation to recovery", and "The relationship between context and recovery". The description of themes included examples of how the characteristics of a recovery-oriented caring intervention could be expressed through caring acts involving suicidal patients and their relatives. Based on this analysis of the focus group discussions, a questionnaire was developed prior to proceeding to round 2 (Keeney et al., 2011), and was administered to the expert panel by email. This enabled participants to continue their reflections on the topic. Expert panel members were asked to evaluate suggested caring acts on a scale (table 2). Level two of the fourth graded scale (i.e., sufficient) was considered as a point of reference in order to handle the level of consensus. This way of approaching consensus was also used in Delphi round 3. Here participants were asked to evaluate suggested caring acts related to conversation with the suicidal patient, with focus on two scales (table 2). When the participants emphasized different aspects in their comments on caring acts, this was considered as a finding that highlighted the complexity of a recovery-oriented caring-intervention, and enabled to attention and acknowledge central aspects of the characteristics. Thus, one participant highlighted, for example, that it is important that the professional caregiver shows that he/she cares about the patient and that he/she is touched by what the patient brings to the encounter, but it is simultaneously very important that the

professional caregiver also balances this engagement and shows that he/she accepts and carries what the patient narrates. This can also be described as “both – and” need to be considered through the caring process in order not to reduce the caring to “either – or”. If the participants answered very differently in their evaluation of suggested caring acts, this could, for example, be handled through a round of voting between the participants. As a final stage in Delphi round 4, a description of the characteristics that were considered to constitute a recovery-oriented caring intervention was formulated. Here participants were asked to evaluate suggested caring acts on a scale (table 2). The description of the characteristics, which is further presented in the findings, can be understood as a description of a caring approach with examples on how this can be accomplished by caring acts involving suicidal patients and their relatives. With the intention to maintain openness and sensitivity to the human experiences of the people that are in focus in this study, the concept “person” is used in the description of the findings instead of the concept “patient”.

[Inserting Table 2 here. The table can be found at the end of this manuscript].

Findings

The findings from the Delphi study elucidate that a recovery-oriented caring intervention is characterized by a “communicative togetherness”. This means that communication is at the core of a recovery-oriented caring intervention. This communication is not only about “asking the right questions” but also includes communicating concern for the other, hope and having an understanding of the suicidal person as vulnerable, yet capable of following through his/her projects of living. Such a caring approach enables a space for suicidal persons to express themselves and reach for their own resources. One participant commented: ‘I think it is important to point out that it is pivotal for the professional caregiver to listen so that they are able to ask questions at all.’ Communicative togetherness has potential to support recovery as it evokes a reciprocal understanding of the person’s situation and it supports

persons to influence their care, and hence also their lives. Another participant commented: ‘It is important to point out that there is a value “to be together” and “to be allowed to narrate and be listened to” so the focus is not on the “doing”.’ This communicative togetherness simultaneously includes an openness for the otherness of the person and an awareness that the other cannot be fully understood. Hence, this communicative togetherness reaches beyond the verbal to a creation of a common space where the person can express him/herself and important others can be invited and present. The description of what characterizes a recovery-oriented caring intervention will be presented more in detail with focus on the following three aspects of communicative togetherness: facilitating giving voice to implicit and explicit experiences, enabling resources and rhythm in everyday life, and acknowledging relationships and contexts with others. The description includes examples of caring acts associated with this understanding of a recovery-oriented caring approach.

Facilitating giving voice to implicit and explicit experiences

When a recovery-oriented caring intervention is characterized by a communicative togetherness it will evolve in accordance with the person’s needs. This kind of communication enables a space for the person to give voice to his/her implicit and explicit experiences, even while questioning how life can become possible and worth living.

Facilitating giving voice to implicit and explicit experiences in the struggle with suicidality can be accomplished by inviting the person into conversation and supporting the person to talk about and share what is going on in the person’s life, regarding the person’s challenges of recovery and what this means for their daily life. An aspect that provides a particular nuance of this communicative togetherness involves asking questions and considering suicidality.

One participant commented: ‘This primarily includes asking about the patient’s immediate survival, i.e., acute suicidality, and secondly the problems that right now make it impossible for the person to live, and finally other kinds of problems.’ This includes sharing knowledge

of what has happened with the person, for instance an episode of sincere suicidal ideas and/or plans or a suicide attempt, as a pivotal basis for supporting the person's recovery. Caring that the person needs access to meaningful support, and showing that one is touched by what the person gives voice to in the conversation has meaning for authenticity. This caring and sharing presence is also understood as a balancing act in the core of a recovery-oriented caring intervention, and means showing that one accepts and is able to carry what the person expresses, as well as inviting to share. This can be accomplished by considering a calm pace in reflection with the person in order to acknowledge problems and needs of relevance for the person. The conversation provides a mutual space for the person and professional caregiver to talk about what contributes to the person's experience that life is not worth and possible living at that moment. The conversation also provides a space for the person to give voice to what can contribute to make life possible and worth living. Anchoring the conversation in the person's expressions and experiences in such ways, facilitates acknowledging the person both as a suffering and resourceful human being.

Enabling resources and rhythm in everyday life

Another aspect that provides a particular nuance of this communicative togetherness involves discovering the person's narrative together with the person, and asking what previous experiences can enable support in the present situation in everyday life. Experiences that have enabled a sense that life is manageable and worth living, during the current period of care or in earlier life situations, need to be acknowledged in the caring process. Previous experiences can also be related to experiences where problems have been solved and contributed to alternatives in life. The reconnecting with previous experiences can support the person in finding a vital rhythm in everyday life and acknowledging varied needs. This rhythm can also be understood as a way for the person to participate at their own pace and on their own terms. Communicative togetherness can be accomplished by focusing on specific and concrete

circumstances that the person brings up in the narration, and joint reflections considering how these experiences can be resources in the present situation. Providing the person a space to reconnect with his/herself and integrating previous experiences with new experiences and self-perception, supports the person in identifying possibilities and alternatives in life and to sense their own strengths and values. Enabling resources and rhythm in everyday life in such ways, is intertwined with making oneself available in a close and mutual dialogue with the person and listening with sensitivity. This availability and listening involves asking if the conversation raised thoughts, feelings and/or questions that need a follow-up conversation. One participant commented: ‘To know that the conversation also works spontaneously and not only through planned conversations shows that the interest is genuine and enhances safety in the relation.’ This can also be understood as maintaining mutual connectedness, and includes paying attention to opportunities to ask questions, as a means to further understand what can support persons carrying through their projects of recovery and continuing life.

Acknowledging relationships and contexts with others

Acknowledging the person’s struggle between life and death is core in a recovery-oriented caring intervention and includes giving the person possibilities to talk about important relationships. The experiences of being connected to important others is necessary for life, and available and supportive relatives, such as family and/or friends, need to be acknowledged in the person’s life. If the person wants relatives to be actively involved during inpatient care, this needs to be acknowledged by talking with the person and asking which relatives he or she wants to invite, and in which ways the person wants relatives to participate. Communicative togetherness can be accomplished by asking questions related to relatives during conversation, and in such ways a space is provided for the person to talk about what the person experiences as important in everyday life. Communicative togetherness includes recognizing the specific needs of relatives as they may need support of their own to be able to

carry through their participation processes and lives. Thus, available and supportive relatives need to be acknowledged as unique and resourceful human beings throughout the persons' recovery and caring processes. One participant commented: 'My experience is that there is often shame and guilt that contribute to obstacles for involving relatives in acute care. And that professional caregivers sometimes need to work more actively to involve relatives.' The same participant also commented: 'There is a need to remind ourselves that there are important others who care about the person and that you are working towards enabling, "to connect", after a suicide attempt.' Acknowledging relationships and contexts with others in such ways, can be understood as a shared collaboration toward the person's reconnection with oneself and important others in life. Communicative togetherness is intertwined with documentation that enables understanding of what recovery means for the persons themselves with regard to their relationships and contexts with others. The documentation needs to include understanding of how the person's recovery process can be supported through the caring process. Communicative togetherness can be accomplished by encompassing the person's experiences and narrative as a foundation for the relationship between the person, relatives and professional caregivers. Acknowledging relationships and contexts with others in such ways indicates the importance of a common dialogue that helps to express and understand what the situation means for the person, relatives and professional caregivers concerned. Thus, communicative togetherness has the potential to contribute to a substance and direction of the person's recovery and care, with regard to what is of relevance for the person as a unique and resourceful human being living in a world with other humans.

Discussion

The aim of this study was to describe what characterizes a recovery-oriented caring intervention, and how this can be expressed through caring acts involving suicidal patients and their relatives. The findings show that a recovery-oriented caring intervention is

characterized by “communicative togetherness”. Thus, rather than being related to the technological aspects of care, a recovery-oriented caring intervention is characterized by relational aspects of caring. The findings will therefore be discussed not only in the light of research that acknowledges recovery related to caring, but also in the light of research that gives a perspective on relations. This includes reflecting on the ontological and epistemological foundation on which mental health care needs to be based. This also includes authors’ awareness that even if there are competing factors that are addressed as prioritized in the organization (Aili & Hjort, 2010; Hjort, 2007), professional caregivers need to be supported to express a caring approach in accordance with the patients’ individual needs (Todres et al., 2014).

In the light of Barker and Buchanan-Barker (2005) a “caring intervention” can be understood as being related to the psychiatric/mental health nurse’s professional responsibility and is based on scientific knowledge and evidence and acknowledges ethical values. Assessment of caring needs involves understanding the patient as a unique person and resourceful human being, and acknowledges what the person wants help with in relation to their wishes and individual needs (Barker, 2003, 2004). This includes considering recovery as reclaiming one’s life by solving and learning to live with problems encountered in life, and living one’s life as meaningfully as possible in relation to available personal, interpersonal and social resources (Barker & Buchanan-Barker, 2011). Hence, a recovery-oriented caring intervention could be understood as being characterized by communication in togetherness with the suicidal person in the process in which the person reclaims his/her life. This caring approach includes acknowledging the unique person’s experiences and narrative as a foundation for the patient’s care and way forward. This also corresponds with research describing a three-stage healing process considering mental health nurses’ care of suicidal patients (Cutcliffe et al., 2006), where “reflecting an image of humanity” is an initial stage

toward patients' recovery. In line with Barker's (2003, 2004) and Barker and Buchanan-Barker's (2005, 2011) and Cutcliffe et al.'s (2006) research it could be concluded that "communicative togetherness" involves both individual and mutual processes. In addition, based on our findings we conclude that in this context what Todres et al. (2009) describe as "humanization of care" does not only mean acknowledging the patient's individual experiences of the situation, but also acknowledging the context in which the person exists together with other people. This includes recognizing that a person's experiences of loneliness need to be understood in relation to the person's existence with others. Thus, experiences of loneliness are intertwined with experiences of togetherness as "being" is about being in a world, and the world is always something that we share with others. This means that loneliness can occur when togetherness is lacking as well as when togetherness is presence (Dahlberg, 2009). Considering the meanings of loneliness and togetherness are particular important when a person struggles with suicidality as experiences of loneliness are a risk factor for suicide (Levi-Belz, Gvion, Horesh, & Apter, 2013; Nagra, Lin, & Upthegrove, 2016). This caring approach provides a foundation for mental health nurses to be open and sensitive to both similarities and differences, to both common meanings and unique nuances in encounters with suicidal persons, in relation to one's own lifeworld. In this study, the aspects of "individual and mutual processes" are understood as taking place in the caring for the patient through a communicative togetherness, and are, for example, described as intertwined with listening very carefully and talking about events of relevance for the unique person in his/her struggle between life and death; joint reflections in a human dialogue that embraces the complexity of existence; and collaboration to enable the suicidal person's reconnection with oneself and important others in life. Hence, a recovery-oriented caring intervention is characterized by being involved in a relationship with the potential of enhancing understanding of both the patient and oneself, and what is of importance for the

patient to experience to feel capable of managing their own lives. This can also be understood as a recovery-oriented caring intervention provides support to a humanizing emphasis for the patient's care, which may nurture nurses' sensitivity to the human complexities of care in the present situation.

Mental health nurses' opportunities to support the patients' recovery and daily life during inpatient care, and thereby support the persons to participate at their own pace and on their own terms indicate, as described by Fredriksson and Eriksson (2003), an ethical dimension of communicative togetherness. In this study, the ethical dimension is understood as an opportunity for psychiatric mental health nurses to enable communication and conversation with a starting point in the suicidal person's lifeworld, as a key that carries a sound of a mutual relationship and co-creation of the patient's care and way toward recovery. This is pivotal in psychiatric care where the intention is to provide care of relevance for the patient as an individual person living in contexts together with other humans. How the encounters between mental health nurses and patients are manifested can contribute to influence patients' lives, and needs to be reflected upon including the ontological and epistemological foundation on which mental health care is based.

Our findings and the description of "communicative togetherness" is also relevant to reflect upon in relation to the national action program for suicide prevention as described by the Public Health Agency of Sweden (2016). One underlying idea of this approach to suicide is that nobody should have to face such a vulnerable situation where suicide is considered as the only way out. Based on our findings, and in line with this national action program for suicide prevention, highlighted possibilities to help people regain control over their own lives, is to listen to their narratives. This sheds light on the importance to listen sensitively to what suicidal persons really say in order to encounter them in meaningful ways. Regarding the insights into what characterizes a recovery-oriented caring intervention, we would also like to

highlight the central foundations of such a caring approach, i.e., its relational value, and the individual and contextual aspects of human experience, as well its benefits of opening up a space for the possibility of meaningful understanding of human experiences. This corresponds to the notion of lifeworld-led care and the importance to recognize a nondualistic approach (Todres et al., 2007, 2014, 2009) as ways to enable a foundation for a more holistic and humanizing practice of care. Thus, when professional key persons are given the opportunity for education in their work with preventing suicide (The Public Health Agency of Sweden, 2016), it is pivotal to consider how a perspective on being human can contribute to openness and sensitivity to the human complexities of care and recovery in the concrete situations.

Methodological considerations

Reflection on issues considering the methodological process in this study will be outlined regarding Delphi methodology as described by Keeney et al. (2001, 2006, 2011). This includes placing focus on how the use of the theories has acknowledged a phenomenological perspective. The relevance for using this research approach is related to the opportunity to recruit research participants as experts by experience, and that new knowledge can be developed in a dialogical process between the experts and the researchers. Based on this interaction between experts and researchers, a shared understanding of the characteristics of a recovery-oriented caring intervention and how to realize them as caring acts emerged. The dialogical process included the researchers' intention to maintain openness and sensitivity to the participants' experiences while exploring the characteristics throughout the research, which corresponds to a reflective lifeworld research approach (Dahlberg et al., 2008) that has been used in previous research (Authors, 2017a, 2017b). Thus, the analysis and the description of what characterizes a recovery-oriented caring intervention acknowledges participants' abilities to contribute with data from different perspectives within this specific context. The Delphi approach (Keeney et al., 2001, 2006, 2011) applied in this study, in

which attention is paid to enhance understanding of the characteristics while acknowledging the perspectives of participants, can be seen as one of its main strengths. This includes the theoretical and philosophical underpinnings that contributed to the scientific approach. In this study, phenomenological philosophy, the notion of the lifeworld and the lived body (Merleau-Ponty, 2013/1945; Todres et al., 2007, 2014, 2009), the existential dimensions (Rehnsfeldt, 1999) of the processes of recovery (Barker & Buchanan-Barker, 2005) and suicidality (Cutcliffe et al., 2006), have contributed to the ontological and epistemological underpinnings. These underpinnings and the grounding in phenomenological philosophy provided ways for slowing down the process of understanding the characteristics (Dahlberg et al., 2008), which included restraining the researchers' pre-understanding, to avoid making conclusions too quickly.

The concern to acknowledge the perspectives of the participants includes that the place of theory (Robson, 2011) in this study, has been taken into account as an opportunity in the discussion of the findings, and thus there is focus on developing the understanding of the findings rather than using the theories as an external material in the analysis of data (Dahlberg et al., 2008). Carrying out the research process in such ways has facilitated loosening the researchers' threads of intentionality (Dahlberg et al., 2008; Merleau-Ponty, 2013/1945) and maintaining openness and sensitivity in the continuing process of discovery. This includes reflection upon strengths and limitations in relation to the researchers' intention to conduct this Delphi study with grounding in phenomenological philosophy and as a foundation for the researchers' processes of reflection and understanding. We conclude that strengths are related to the opportunity to stabilize openness and sensitivity to both the participants' experiences and the characteristics in focus, by restraining the researchers' pre-understanding, and not making definite what is indefinite. This includes authors' awareness of problematizing and slowing down the process of intentionality when arriving at, and putting into written language

(van Manen, 2017a, 2017b), as well as understanding that the complexities of what characterizes a recovery-oriented caring intervention are a challenge. Accordingly, limitations may be related to the possibility to do justice to the varied meaning nuances of the characteristics in the description of the findings. Regarding the complexity of that task, using phenomenological philosophy as a foundation for the researchers' processes of reflection and understanding (Dahlberg et al., 2008) is considered as a resource in our striving to acknowledge the opportunities on the way. In conclusion, this research approach has facilitated establishing validity and reliability (Keeney et al., 2011) towards acknowledging the aim of this study and describing the different stages and the processes in focus through the research.

Implications for clinical practice and future research

The findings contribute to knowledge about what characterizes a recovery-oriented caring intervention. A traditional way of carrying out clinical suicide risk assessment methods from a perspective of risk factors need to be complemented with knowledge that embraces the relational, narrative and existential aspects of caring for suicidal patients. When a person struggles with suicidality, mental health nurses need to acknowledge the uniqueness of each individual including the person's narrative and implicit and explicit experiences and expressions as a pivotal foundation for recovery and caring from the patient's perspective. This includes acknowledging that the relationship between mental health nurses and patients has the potential to influence patients' lives, and needs to be reflected upon including the ontological and epistemological foundation on which mental health care is based. When a recovery-oriented caring intervention is characterized by "communicative togetherness", this is understood as a caring approach that enables a space for suicidal persons to really express themselves and to reach for their own resources. Such communication has potential to support recovery as it induces a mutual understanding of the patient's situation and supports

patients in influencing their care, and hence also their lives. Thus, mental health nurses need to listen sensitively to what suicidal persons really say, acknowledge their lifeworlds, and be open to individual variations of their recovery and participation processes. This includes acknowledging available and supportive relatives as capable of contributing to the patients' projects of recovery and continuing life. Further research that enhances understanding of how the findings of this study can be applied is seen as a natural step in order to reach toward caring interventions that have the potential to be meaningful to the unique individuals themselves within their unique contexts.

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Table 1. Aim of Delphi rounds 1-4; Methodology/Methods; and Number of participants.

Aim of Delphi rounds 1-4	Methodology/methods	Number of participants
<p>The aim of Delphi round 1 was to explore what characterizes a recovery-oriented caring intervention and how this can be expressed through caring acts involving suicidal patients and their relatives</p>	<p>Focus group interview The time for each focus group varied between 1) 124 minutes; 2) 127 minutes; and 3) 116 minutes, and were recorded with a digital voice recorder Qualitative thematic analysis of interview data</p>	<p>Expert/Focus group 1: Five representatives from a Swedish organization that works with suicide prevention and support to relatives who have lost a loved one to suicide. Expert/Focus group 2: Six registered nurses. Expert/Focus group 3: Five researchers</p>
<p>The aim of Delphi round 2 was to clarify and enhance understanding of identified caring acts in the light of participants' experiences</p>	<p>Questionnaire with evaluation of caring acts according to a scale</p>	<p>Expert group 1: Five representatives from the organization. Expert group 2: Eight registered nurses. Two of these nurses were not able to participate in the initial round. Expert group 3: Five researchers.</p>
<p>The aim of Delphi round 3 was to concretize and value identified caring acts in the light of participants' experiences</p>	<p>Questionnaire with evaluation of caring acts on two scales</p>	<p>Expert group 1: Five representatives from the organization. Expert group 2: Eight registered nurses. One of these nurses chose to discontinue participation. Expert group 3: Five researchers.</p>
<p>The aim of Delphi round 4 was to describe what characterizes a recovery-oriented caring intervention in the light of participants' experiences and how this can be expressed through caring acts involving suicidal patients and their relatives</p>	<p>Questionnaire with evaluation of caring acts according to a scale</p>	<p>Expert group 1: Five representatives from the organization. Expert group 2: Seven registered nurses. Expert group 3: Five researchers.</p>

Table 2. Example of caring acts and the scales of Delphi rounds 2-4.

Example of a caring act and the scale of Delphi round 2	Example of a caring act and the scales of Delphi round 3	Example of a caring act and the scale of Delphi round 4
<p>Example of a caring act: To have the capacity to ask about what is difficult, and say that I have a thought that you are going to commit suicide, and I have become worried – should I be?</p> <p>Evaluate the sufficiency of the caring act according to the scale:</p> <p>“Very sufficient”, “Sufficient”, “Less sufficient”, “Not sufficient”</p> <p>Give your own comments on the caring act’s value in your own words</p>	<p>Example of a caring act: Confirm the person and include the patient’s lived context through asking if the patient has relatives that the patient wants to be allowed to participate in the care. If the patient does not want relatives to be involved in the care, enable the patient the possibility to talk about his/her relationship to the relative (s).</p> <p>Evaluate the feasibility of the caring act according to the scale:</p> <p>“Very feasible”, “Feasible”, “Less feasible”, “Not feasible”</p> <p>Evaluate the importance of the caring act according to the scale:</p> <p>“Very important”, “Important”, “Less important”, “Not important”</p> <p>Give your own comments on the caring act’s value in your own words</p>	<p>Example of a caring act: Provide support to the person’s narration through asking: “What does this mean for you?”, “What do you think/feel about that?”, “Can you tell me more about that?” To encounter a person who experiences that life is unbearable and not possible to live can also mean encountering a person who is tired, vulnerable and afraid. The narration can involve the person talking about taboo subjects. The patient is therefore in much need of all the support the person can get. It is also important to confirm and validate the person’s thoughts and feelings. Thus, the person needs to be allowed to think, and feels as he/she does, and also gives expressions to that.</p> <p>Evaluate the caring act according to the scale:</p> <p>“Can be included as it is”, “Needs to be clarified to be understandable”</p> <p>Give your own comments considering what needs to be clarified</p>