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# A PERSONAL-RECOVERY-ORIENTED CARING APPROACH TO SUICIDALITY

Linda Sellin



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**A PERSONAL-RECOVERY-ORIENTED  
CARING APPROACH TO SUICIDALITY**

**Linda Sellin**

**2017**



School of Health, Care and Social Welfare

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Linda Sellin

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## Abstract

Persons who are subject to care due to suicidal thoughts and/or acts, are in a vulnerable situation, struggling with issues related to life and death as well as experiences of hopelessness and powerlessness. They may also experience themselves as a burden for their relatives. The relatives' struggle for contributing to the loved person's survival, can involve experiences of taking responsibility for things that are outside their control. Although research considering how suicidal persons and their relatives can be supported, when the person receives care in a psychiatric inpatient setting is sparse. There is also a need for research to form the basis for mental health nurses to enable caring interventions, with the potential of acknowledging the uniqueness of each individual person and their experiences. This thesis is based on a perspective of recovery as a process, where the persons experience themselves as capable of managing both challenges and possibilities in life and incorporate meaning into it. Experiences of being capable of managing problems in living are vital for this process. Thus, it is necessary to acknowledge the lifeworld as essential for personal recovery.

The overall aim of this research was to develop, introduce and evaluate a caring intervention, to support suicidal patients' recovery and health, and to support patients' and their relatives' participation in the caring process. Considering the complexity of such a caring intervention and the importance of recognizing multiple aspects of the phenomenon (i.e., recovery in a suicidal crisis), this research was conducted from a lifeworld perspective based on phenomenological philosophy. Two studies with reflective lifeworld research approach (I, II), a Delphi study (III), and a single case study with QUAL>quan mixed methods research approach (IV) were conducted.

The developed caring intervention is characterized by "communicative togetherness". This means that the nurse and the patient together explore how the patient's recovery can be supported, as a way for the patient to reconnect with self and important others, and thereby being strengthened when challenged by problems in living. It was also concluded that it is more appropriate to acknowledge this as a caring approach, rather than describe it as a specific caring intervention. The final description of the findings comprise a preliminary guide to a personal-recovery-oriented caring approach to suicidality (PROCATS). This description highlights six core aspects of the caring approach. The overall aim of the PROCATS is to support suicidal patients' recovery and health processes, even at the very edge of life. Although the findings indicate that the caring approach has potential to support suicidal patients' recovery as well as support their relatives' participation, there is a need for further evaluation of the PROCATS in a wider context.

Jag trodde inte att jag skulle överleva.  
Jag dog varje natt. Och ändå vaknade  
jag varje morgon. Det tog lång tid,  
men såren läktes och minnet gav mig  
återigen styrka att fortsätta (s. 216).

Hédi Fried, (2016) *Skärvor av ett liv*.



# ABSTRACT

Persons who are subject to care due to suicidal thoughts and/or acts, are in a vulnerable situation, struggling with issues related to life and death as well as experiences of hopelessness and powerlessness. Being in such a vulnerable situation may also mean that the persons experience themselves as a burden for their relatives. The relatives' struggle for contributing to the loved person's survival, can involve experiences of taking responsibility for things that are outside their control. Although research considering how suicidal persons and their relatives can be supported, when the person receives care in a psychiatric inpatient setting is sparse. There is also a need for research to form the basis for mental health nurses to enable caring interventions, with the potential of acknowledging the uniqueness of each individual person and their experiences. This thesis is based on a perspective of recovery as a process, where the persons experience themselves as capable of managing both challenges and possibilities in life and incorporate meaning into it. Experiences of being capable of managing problems in living are vital for this process. Thus, it is necessary to acknowledge the lifeworld as essential for personal recovery.

The overall aim of this research was to develop, introduce and evaluate a caring intervention, to support suicidal patients' recovery and health, and to support patients' and their relatives' participation in the caring process.

Considering the complexity of such a caring approach and the importance of recognizing multiple aspects of the phenomenon (i.e. recovery in a suicidal crisis), this research was conducted from a lifeworld perspective based on phenomenological philosophy. A reflective lifeworld research approach (RLR) was applied to describe the phenomenon of recovery in a context of nursing care as experienced by persons at risk of suicide (I). RLR was also used to describe the phenomenon of participation, as experienced by relatives of persons who are subject to psychiatric inpatient care due to a risk of suicide (II). Based on these two studies, the aim 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 (III). Delphi methodology was applied to develop such intervention in collaboration with participants as experts by experience. The findings reveal that a recovery-



oriented caring intervention is characterized by “communicative togetherness”. In line with a lifeworld perspective, this intervention is understood as a caring approach that has the potential to enable recovery as it facilitates a mutual understanding of the patient’s situation, and supports patients in influencing their care and regaining authority over their own lives. The final description of the findings involved a preliminary guide to a recovery-oriented caring approach. In the fourth study, was the aim to explore and evaluate how the suggested recovery-oriented caring approach was experienced by a suicidal patient in a context with close relatives and nurses (IV). A single case study was conducted with a QUAL>quan mixed methods research approach. The findings illuminate that the recovery-oriented caring approach supported the patient to reconnect with himself and important others and strengthened him when challenged by his problems in living. This did not resolve his problems in living or remove his experiences of hopelessness, but it enabled him to manage them in a different way. The findings also indicated a need to address issues related to experiences of hopelessness more explicitly in the guide to the caring approach.

When synthesizing the findings from the studies (I, II, III, IV), a new understanding of the caring approach evolved, which gave rise to the name, a personal-recovery-oriented caring approach to suicidality (PROCATS). The synthesized findings involve a description of six core aspects of the PROCATS. The core aspects highlight PROCATS as “a humanizing encounter”, “acknowledging the suicidal patient as a vulnerable and capable person”, “emphasizing reflective understanding of each individual person and experience”, “accounting for the patient’s health resources”, “supporting narration and understanding both the dark and the light life-events”, and “recognizing the relative as a unique, suffering and resourceful person”. The overall aim of the PROCATS is to support and strengthen suicidal patients’ recovery and health processes, even at the very edge of life. Although the findings indicate that PROCATS has potential to support suicidal patients’ recovery as well as support their relatives’ participation, there is a need for further evaluation of the PROCATS in a wider context.

**Keywords:** Dialogue; hermeneutics; lifeworld; mental health nursing; participation; patient’s perspective; person-centered care; phenomenology; recovery; reflective lifeworld research; reflective understanding; relative’s perspective; suicidality; suicide prevention

# LIST OF PAPERS

This thesis is based on the following papers, which are referred to in the text by their Roman numerals.

- I 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(2), 200-207. doi:10.1111/inm.12249
- II Sellin, L., Asp, M., Kumlin, T., Wallsten, T., & Wiklund Gustin, L. (2017). To be present, share and nurture: A lifeworld phenomenological study of relatives' participation in the suicidal person's recovery. *International Journal of Qualitative Studies on Health and Well-being*, 12(1). doi:10.1080/17482631.2017.1287985
- III Sellin, L., Kumlin, T., Wallsten, T., & Wiklund Gustin, L. (2017). Caring for the suicidal person: A Delphi study of what characterizes a recovery-oriented caring approach. (Manuscript re-submitted after revisions).
- IV Sellin, L., Kumlin, T., Wallsten, T., & Wiklund Gustin, L. (2017). Experiences of a recovery-oriented caring approach to suicidality: A single case study. (Manuscript).

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# INTRODUCTION

During my years as a psychiatric nurse, I have always taken an interest in encountering and understanding the world of the patient. My thoughts and reflections have touched on issues such as: What is it like to be a patient in psychiatric care? In what way are the patients' experiences accounted for in psychiatric care? What impact do patients' experiences have on their intentions, dreams and plans in life? What do the close relatives of the patients experience? My endeavour when encountering patients and their relatives has been to understand their world from their perspectives. In psychiatric inpatient care, it is common to meet patients who feel utterly powerless in relation to life, and who think about death as a way out. How is it to think about ending one's life, or even of having tried, one or more times? How is it to experience life as impossible to endure, while simultaneously being subject to care? How is it to care for these persons as a nurse? As a relative? How is it to be a relative to a person who expresses a wish to die? What characterizes nursing care when it succeeds in helping and supporting patients who are struggling with suicidal thoughts?

When I was given the opportunity to start my research education and take such thoughts and reflections further, my questions became focused on patients' recovery in a suicidal crisis. My thesis is based on the observation that caregivers often struggle with challenges associated with caring for suicidal patients. I was touched by how a respectful and humane approach to patients at risk of suicide appears to be a very important part of the care, and seems to empower the patient as well as the nurse. Throughout the entire research process, I have experienced the importance of trying to understand the meaning of what people experience and express in different ways. My endeavour has been to understand people regarding their unique and vulnerable situation. It has also been important for me to seek answers to questions about how to support the patient's recovery process in an existential boundary situation. This thesis is not only directed to nurses but also to other healthcare professionals and to a wide public. Hence, it is also for anyone who may have had doubts about continuing to live, and/or are concerned for a person who struggles with suicidal thoughts. Recovery in existential boundary situations concerns us all.



# BACKGROUND

In the following section, previous research that provided a foundation to focus on and problematize the aim of this thesis is outlined. This is followed by a description of the theoretical frame and central concepts.

## **Human vulnerability and suicide**

The prevalence of suicides shows that there are people facing vulnerable situations where suicide is considered as the only way out. The latest statistics on suicide in Sweden, where this thesis is conducted, show that 1478 people died due to suicide during 2016. This includes both certain and uncertain suicides. A case of a “certain” suicide is considered when there is no doubt that the person concerned intended to kill him/herself. The classification of “uncertain” suicide is used when there is uncertainty of the intention behind the death, considering if it was a deliberate act or an accident (National Centre for Suicide Research and Prevention of Mental Ill-Health, 2017).

The high incidence of suicide is not only a national problem, but a global one (Wasserman & Wasserman, 2009). The fact that the World Health Organization (2014) addresses the importance of preventing suicide shows the need to address these issues in today’s society. In their report they describe that aspects related to people’s living conditions have a clear link to the incidence of suicide. Some of these aspects are related to economic and social resources, culturally influenced attitudes to suicide, and relationships. One underlying idea of the approach for preventing suicide in Sweden, is that nobody should have to face such a vulnerable situation where suicide is considered as the only way out (The Public Health Agency of Sweden, 2016). Many people who commit suicide in Sweden have been in contact with healthcare before their death, but a recent report raised the question that their suicidality might not have been recognized in the conversation with caregivers (Bremberg, Beskow, Åsberg, & Nyberg, 2015). Patients who have contact with psychiatric care are highly represented among those who commit suicide in Sweden (Swedish National Board of Health and Welfare, 2015). Thus,

suicide needs to be acknowledged as a complex health, welfare- and patient safety problem, and needs to be handled with high priority in psychiatric care.

One traditional view of suicide within psychiatric care is to explicate suicide in the context of mental illness (Cutcliffe & Barker, 2002). According to a perspective of risk factors for suicide, the majority of all suicides occur due to some form of mental illness (Lönnqvist, 2009). It is simultaneously important to be aware that the diagnostic model is too limited to get an understanding considering the suicidal persons' and their relatives' own perspectives of their situation (Cutcliffe & Stevenson, 2008b). It is also important to note that it is common for individuals in a suicidal crisis to lack the ability to solve difficult and painful problems. Facing a difficult and painful life situation can mean a loss of control and a threat to existence as the person is overwhelmed by mental stimuli. (Beskow, Salkovskis, & Palm Beskow, 2009). A completed suicide can be seen as a psychological mistake (The Public Health Agency of Sweden, 2016).

## **Health and welfare aspects of suicide prevention and care**

The national action program for suicide prevention in Sweden was adopted by the Swedish parliament in 2008 (National Centre for Suicide Research and Prevention of Mental Ill-Health, 2014). This national work corresponds to the preventative work that is carried out globally, where the World Health Organization has outlined the goal to reduce the number of suicides in the member countries by at least ten per cent by the year 2020 (World Health Organization, 2014). In Sweden, the national program involves nine strategic areas of action to reduce the incidence of suicide. This provides a foundation of what initiatives can be applied to achieve this goal. One aspect of this foundation highlights that the individually-oriented work in the healthcare services, needs to be grounded in evidence-based knowledge and resources, to provide the best possible help to people who struggle with suicidality. This means that mental health nurses as key persons in psychiatric care, need access to knowledge and continuous education to maintain and advance competencies in the care of suicidal persons (National Centre for Suicide Research and Prevention of Mental Ill-Health, 2014; The Public Health Agency of Sweden, 2016). Hence, the preventative work in the healthcare services in Swedish society is important to ensure that suicidal persons are provided with the care they need.

The psychiatric mental health nurses' competence area is to protect human rights and recognize social and ethical aspects of healthcare. This involves promoting the patients' and relatives' participation, including anchoring assessments and interventions on scientific ground. The psychiatric mental health nurses' care of suicidal persons, encompasses a specific part of the Swedish welfare system and is linked to individuals' right to health (Swedish Association of Psychiatric and Mental Health Nurses, 2014). In this thesis, focus is to contribute with knowledge of relevance for suicidal persons' and their relatives' health and welfare on an individual level, and for psychiatric mental health nurses in their work within this context.

## **In view of the patients' and the relatives' perspectives**

People's experiences of suicidality may create a need for professional help in psychiatric inpatient care. However, in relation to the work with the development of suicide prevention there are still knowledge gaps. Two aspects of these knowledge gaps concern how the individual person's recovery in the struggle with suicidality (Lakeman & FitzGerald, 2008) and their relatives' participation (Sun, Chiang, Yu, & Lin, 2013), can be supported when the person is provided care in a psychiatric inpatient setting (Carlén & Bengtsson, 2007). In addition, it is unusual that previous research considering the patients' (Cutcliffe, Stevenson, Jackson, & Smith, 2006) and the relatives' perspectives (Omerov, 2013), is used as the basis for caring interventions (Gilje & Talseth, 2014; Talseth & Gilje, 2011).

Research considering the patients' perspectives describes that a dominant focus on risk factors for suicide can underpin experiences of powerlessness and stigma, when a person is struggling with suicidality in a vulnerable situation (Barker, 2003; Cutcliffe & Barker, 2002). When the care enables the patient access to a humanizing relationship and support for recovery, though it can facilitate experiences of vitality and a desire to live (Holm & Severinsson, 2011; Vatne & Naden, 2014). Another part of the issue is that the suicidal person's reasons for continuing living can be influenced by the way in which the person experiences that he/she can relate to and feel understood by the caregivers (Talseth, Jacobsson, & Norberg, 2001; Talseth, Lindseth, Jacobsson, & Norberg, 1999). It is also common that people can feel shame after a suicide attempt, and a sense of failure with the handle of problems that preceded the suicide attempt (Wiklander, Samuelsson, & Åsberg, 2003). Thus, recognizing the suicidal person's lifeworld is essential

for personal recovery, and as a way of providing meaningful care in accordance with the patient's unique needs (Vatne & Naden, 2012).

Research considering the relatives' perspectives describe that relatives can experience challenges related to stigmatizing attitudes and a lack of knowledge regarding suicide (Peters, Cunningham, Murphy, & Jackson, 2016). In addition, experiences of being disconnected from the care without access to support, may increase relatives' experiences of taking responsibility for their suicidal family member who is outside their control (Talseth, Gilje, & Norberg, 2001). This means that relatives need support of their own as individuals, as well as support to enable them to participate and give support to the loved person (Sun et al., 2013; World Health Organization, 2014). Relatives' participation processes are central to consider in work with recovery and suicide prevention, as people's experiences of being connected to each other in meaningful ways are essential for life (Gilje & Talseth, 2014; Vatne & Naden, 2016).

Accordingly, suicidal persons' and their relatives' experiences and perspectives are important in psychiatric inpatient care, as a basis for enhanced understanding of how these individuals can be encountered and supported in meaningful ways. Included in this is that the approach to the patient's care needs to be able to acknowledge the person's lifeworld (Todres, Galvin, & Dahlberg, 2014), including the person's living context with other humans. The described aspects of suicidal persons' recovery and their relatives' participation, address clinical and scientific needs that are followed up in this thesis, and are of high relevance to study within health and welfare and caring science.

## **Mental health nursing**

Caring science researchers describe suicidality as a human drama, experienced and expressed in people's everyday lives. It is also articulated that caring for suicidal persons need to be an endeavor for mental health nurses in psychiatric wards (Cutcliffe & Stevenson, 2008a; Talseth & Gilje, 2011). Suicide prevention in mental health services involves suicide risk assessments, and nurses provide most of the direct care of the patients and have the opportunity to identify warning signs of suicide and prevent suicidal behavior (Cutcliffe & Barker, 2002). However, two issues that are central to suicidal persons' care are the shortage of empirically induced theory to guide practice, and the even greater shortage of empirical evidence to support specific interventions. The recognition of individual's suicidality and "recovery needs" should enable meaningful interventions (Cutcliffe & Stevenson, 2008a).

Various studies have addressed some aspects of nurses' responses to suicidal patients. Valente and Saunders' (2002) review of literature, report that nurses' reactions to a patient's suicide involves processes of grief, self-doubt, doubt about their competence and concern for relatives. Further knowledge known about the topic is that mental health nursing care is dominated by a one-sided focus on risk factors and 'safe observations' (Cutcliffe & Barker, 2002). Cutcliffe and Stevenson's (2008a) literature review implies that caring for suicidal patients should be an interpersonal endeavor with emphasis on talking and listening. Previous research also describes that caring for suicidal patients can be challenging in various ways, which further emphasizes the need for a mental health nursing theory that supports nurses in their work (Gilje, Talseth, & Norberg, 2005).

A study by Cutcliffe et al. (2006) contributes to a theoretical foundation as a guide for clinical practice and nurses' humanizing and recovery-oriented care for suicidal patients. In addition, the contributions of Larsson, Nilsson, Runeson and Gustafsson's work (2007), show that the sympathy acceptance understanding competence model, can be used by nurses in order to improve suicidal patients' care. As a further understanding of nurses' responses to suicidal patients, Talseth and Gilje's (2011) synthesis of research literature, reports four key concepts, i.e. nurses' "critical reflections", "attitudes", "complex knowledge and professional role responsibilities", and nurses' "desire for emotional and educational support/resources". These authors imply that psychiatric mental health nurses are key persons to enable support for suicidal patients' recovery processes. In addition, previous research has also pointed to the importance of nurses engaging in a close relationship with the suicidal patient (Cutcliffe & Barker, 2002; Cutcliffe & Stevenson, 2008a; Gilje & Talseth, 2014), as well as balancing their emotions connected to involvement and distance, to provide good care of patients and themselves (Hagen, Knizek, & Hjelmeland, 2017). Accordingly, there is a call for knowledge that can enable meaningful caring interventions, i.e. a holistic and non-dualistic approach (Todres, Galvin, & Holloway, 2009; van Wijngaarden, Meide, & Dahlberg, 2017), that supports nurses in their care of patients in this context.

# THEORETICAL FRAMEWORK

In the following description, the theoretical framework that provided a foundation to focus on and problematize the aim of this thesis is presented. This includes a description of the ontological and epistemological underpinnings that contributed to the scientific approach. The thesis is grounded in a caring science perspective with the lifeworld as a basis. Caring science is an autonomous science with roots in the human sciences and is neutral to profession. The patient perspective is based on the lifeworld perspective, indicating that the patient, i.e. the human being who is in need of caring, is in focus (Dahlberg & Segesten, 2010). This includes that the attention and the interest is directed to people's experiences of the studied phenomenon, with the point of view that each person and each experience is unique (Cavalcante Schuback, 2006).

## **Lifeworld and the lived body**

To acknowledge the participants' experiences and the phenomenon in focus (i.e., recovery in a suicidal crisis), this thesis is conducted with roots in lifeworld theory (Dahlberg, Dahlberg, & Nyström, 2008) and phenomenological philosophy (Bengtsson, 2012, 2013; Merleau-Ponty, 2013/1945). This foundation contributes to the scientific approach and involves a concern to acknowledge the individual's perspective, including the relationship between humans and their world, in which each individual exists in a context with other humans (Todres et al., 2009). The grounding in phenomenological philosophy involves a concern to "go to the things themselves" (Husserl, 1970/1936), with the intention of understanding and also doing justice to human beings' own experiences in everyday life. Everyday life is understood as a unique and common world of meaning, which can also be described as the lifeworld. This world of meaning includes intersubjectivity and implies that we both experience the world from our own unique point of view, and share experiences with others. Thus, the lifeworld is a world of experience and a point of departure in relation to others and the world. This coexistence indicates that it is in relation to other humans and the

world itself, that each individual understand him/herself and “the others”. This can also be described in terms of experiencing this world and having access to this world through our lived bodies (Todres, Galvin, & Dahlberg, 2007; Todres et al., 2014).

The notion of the lived body (Merleau-Ponty, 2013/1945) involves a concern to acknowledge the mutual relationship between humans and the world, and acknowledge every human being as a resourceful person. This philosophical grounding in the lived body provides a non-dualistic and non-reductionistic alternative when exploring the phenomenon in focus (Dahlberg et al., 2008; van Wijngaarden et al., 2017). Accordingly, this intertwined mind, body and world unity (Bullington & Fagerberg, 2013; Merleau-Ponty, 2013/1945), provides a profound ontological foundation of a human as a whole, unique and resourceful person, living in a context with other humans and the world. In conclusion, this gives a perspective that enabled the opportunity to study the phenomenon in focus (i.e., recovery in a suicidal crisis) regarding the participants’ (I, II, IV) own lived experiences.

## **The flesh of the world**

Striving to understand the human being as a whole, unique and resourceful person, sharing his/her world with others, includes an awareness that there is always something in the other’s essence that can never be understood (Todres et al., 2014). During this process, there is a need to pay attention to Merleau-Ponty’s (1968/1964) notion “the flesh of the world”. This is important because the understanding of the world as “flesh” is essential for a profound ontological understanding of the lifeworld. Understanding the lifeworld as flesh shed light on an ontological connectedness and mutuality with the recognition that we belong to the same world (Dahlberg et al., 2008). The notion of flesh highlights the coming together of human and world in the unity of becoming together. This process of becoming is the core of the flesh and involves an event of becoming in relation to sentient beings (Bullington, 2013). Merleau-Ponty (1968/1964) describes the flesh in the following way:

The flesh is not matter, is not mind, is not substance. To designate it, we should need the old term “element”, in the sense it was used to speak of water, air, earth and fire, that is, in the sense of a general thing, midway between the spatio-temporal individual and the idea, a sort of incarnate principle that brings a style of being wherever there is fragment of being. The flesh is in this sense an “element” of Being (p. 139).

The concept “flesh of the world” sheds light on aspects of lifeworld phenomena, such as recovery, that can only be expressed through a language that does not claim to define it but rather acknowledges it and brings it into question. Thus, the concept flesh of the world can be understood as a concept that enables balancing between different meanings, and thereby questioning the language itself, while exploring the phenomenon in focus (Dahlberg, 2013). The notion of flesh (Dahlberg et al., 2008; Merleau-Ponty, 1968/1964) is understood as an important resource in this thesis, as it provides possibilities to acknowledge the complexities of suicidal persons’ lifeworlds, and facilitates not making definite what is indefinite in human existence, such as being in the world with others.

In particular, the concept flesh of the world (Dahlberg, 2013) enables possibilities to recognize complexities of human perception. Perception as flesh sheds light on that the human being as a lived body, both participates in and simultaneously brings forth a world. This can also be understood as perception related to palpation with a gaze or a hand, and is characterized by both knowing and questioning. Thus, the lived body is the knowledge itself as it acknowledges and simultaneously discovers the world (Dahlberg, 2013). The complexities of human beings’ lifeworlds and the relationship between knowing and questioning, indicate that there is always something there to the other’s lifeworld, an element of uncertainty that addresses the importance to approach other human beings with a careful curiosity and to expect to be surprised (Dahlberg et al., 2008). The uncertainty can also be understood to involve an abyss in the human, that may give rise to a sense of being foreign to oneself and brings resonance to a person’s foundation in life (Dahlberg, 2013). This also means that mood, as an experience of being-in-the-world with others, is intimate to an awareness that there is always something in one’s own and others’ essences that can never be understood (Todres et al., 2014).

In conclusion, this understanding of human being as flesh, provides a foundation for the concern of not making definite what is indefinite in human existence such as being in the world with others. This includes a concern to take into account the opportunity to ask questions, as ways to listen to that which is silent and facilitate expressions of what have previously not been known (Dahlberg et al., 2008). The notion of flesh provided a foundation in this thesis to emphasize what the studied phenomenon means for the persons themselves (I, II, IV) in their unique and shared world.



## **Human capability and vulnerability**

Another philosophical foundation that is central in this thesis is Ricoeur's (1992, 2011) description of the human being as both resourceful and vulnerable, with the ability to speak, act, narrate and take responsibility. Ricoeur highlights that vulnerability is intertwined with human existence in life, and can be both a resource and a burden. This also means that vulnerability has the potential to be a source of creativity and change. The contributions of Ricoeur (1992, 2011) provide ontological depth to the understanding of the human as a person striving for self-understanding and a good life – together with others within humanizing contexts, wherein human capability is grounded in “I can”. These insights also indicate the presence of conflicts and uncertainty in human existence. When people experience a lack of solutions to conflicts, this may start a search for appropriate actions needed in situations of uncertainty. Ricoeur's notion of human capability and vulnerability acknowledges the human as a person with potential to be active and find meaning in relation to both difficulties and possibilities in life.

The contributions of Ricoeur (1992, 2011) can further be understood in relation to Dahlberg and Segesten's (2010) and Todres et al.'s (2014) description of health and well-being, where human capability gives the expression of an experience of being able to carry through one's minor and major life projects. This definition of health (Dahlberg & Segesten, 2010; Todres et al., 2014), enables the recognition of a particular meaning of recovery and health in relation to suicidal persons, i.e. the life project to continue living.

## **Existential aspects of suicidality**

To recognize recovery and health as intertwined with human capability and vulnerability (Ricoeur, 1992, 2011), and as an experience of being able to carry through one's minor and major life projects (Dahlberg & Segesten, 2010; Todres et al., 2014), corresponds to a description of mental health suffering as “problems in living”. This perspective on mental health problems has been articulated both in nursing theory (Barker & Buchanan-Barker, 2005), and in humanistic psychology (Sullivan, 2011; Szasz, 1974). This gives a perspective on the human as both a resourceful and suffering human being, in which the individual's expressions of suicidality, may include expressions of the person's suffering from problems in living. Thus, human being experience challenges through life. Sometimes these challenges give rise to complex existential questions about life and death, and to experiences of

overwhelming and unbearable suffering. When people lose hope for life, suicide may occur to them as the only way out.

Based on this theoretical foundation, and in line with Orbach's (2008) and Schneidman's (1998) views on mental health problems and meaning in life, suicidality can be understood as an existential crisis rather than as a disease. Thus, recognizing the person's problems (in living), and that the person may be deeply drawn into an existential crisis as intertwined with a suicidal crisis, begins when someone aims at understanding rather than simply classifying the person (Lakeman, 2010). In conclusion, this gives a perspective of the human as an experiencing and coexisting person, in which the individual experience also gives expression of a unique and personal experience of suicidality.

## **Recovering from a suicidal crisis**

The theoretical foundation that contributes to problematizing the concept recovery in this thesis, is also related to Barker and Buchanan-Barker's (2005) perspective on recovery, where recovery is viewed as a journey toward health in which persons reclaim their narratives as well as their power to form their lives on their own terms. This means that reclamation is emphasized as: "the hard work necessary to try to turn something that was 'lost' into a constructive force for good in the world" (Barker & Buchanan-Barker, 2005, p. 238). This process of reclaiming life may be of particular importance to acknowledge when a person is struggling with life and death in a suicidal crisis. The idea of reclamation sheds light on how the work with problems in living, can provide ways forward to reclaim authority over one's own life. The contributions of Barker and Buchanan-Barker (2005) also highlight that, "The *personal* truth of our lives is embedded in *our* stories, about *ourselves*. Even when others think that we are lying to ourselves, we are telling the truth" (p. 239). Thus, to support people's processes of personal recovery, there is a need to search for understanding with focus on the individual's own perspective.

This understanding of recovery as a personal journey toward health, can further be understood in relation to Dahlberg and Segesten's (2010) description of the meaning of health. The essence of health is described as an experience of well-being in a personal rhythm of movement and stillness. However, when the rhythm for different reasons is disturbed and effects everyday life with unbalance, recovery can bring bearing into vitality and provide ways forward to restore a meaningful rhythm of movement and stillness. The human ability to find ways through recovery, toward restored rhythm and health, is supported by acknowledging the person as an expert on self and personal life history (Dahlberg & Segesten, 2010).

## **Central concepts**

In the following section, a clarification of important concepts is outlined with the intention to facilitate the reading and understanding of this thesis.

### **Suicidal patients**

In this thesis, the use of the concept “suicidal patients” is not a label that pretends to provide an explanation of the patient’s suicidality. Instead, and in line with Rehnsfeldt’s (1999) research, it involves a concern to acknowledge the vulnerability of human beings who experience themselves as being in an existential boundary situation.

### **Recovery**

The concept “recovery” is used in line with a view of health as related to experiences of being capable of fulfilling one’s projects in life (Dahlberg & Segesten, 2010) and mental ill health as an experience of problems in living and to accomplish these projects (Barker & Buchanan-Barker, 2005). Hence, recovery is not understood as a state but as a process where the person reclaims his/her strength to encounter problems in living.

### **Caring approach**

As the thesis evolves, the concept “caring approach” (Todres et al., 2014) is used instead of caring intervention. This is motivated by a strive to grasp the character of the PROCATS (i.e. a personal-recovery-oriented caring approach to suicidality), and avoid misconceptions of it as a fixed intervention and technique that can be applied in the same way with all patients. Thus, the concept caring approach is intended to highlight that PROCATS is a guide regarding what needs to be considered, in order to approach and be with a suicidal patient in such a way that each unique person’s process of personal recovery is supported and strengthened.

### **Researcher’s pre-understandings**

As this thesis is based on a phenomenological epistemology (Dahlberg et al., 2008) it is important to shed light on my (LS) pre-understandings. As described in the introduction section, my experiences as a nurse have made me realize the importance of the caring encounter and of acknowledging the patient’s and relative’s perspectives. Theoretical studies, as described in the background and theoretical framework sections, have served as a spotlight and

enabled to illuminate aspects of the phenomenon in focus (i.e. recovery in a suicidal crisis), and given new dimensions to the understanding. This is also the point of departure for designing the thesis. Hence, this understanding has guided the research process, but it is also this understanding that has been bridled (Dahlberg et al., 2008) and challenged in an ongoing process throughout the whole research, with the intention to maintain openness and sensitivity to the phenomenon and its meanings.

# RATIONALE

The background highlights that there are people who face vulnerable situations where suicide is seen as the only way out. Factors related to people's living conditions have a clear link to the incidence of suicide. Another aspect of the issue is that many people who commit suicide in Sweden have been in contact with healthcare before their death, but their suicidality may not have been recognized in the conversation with caregivers. Suicidal persons' reasons for continuing living can be influenced by the way in which the person experiences that he/she is understood and provided with meaningful help toward recovery. This means that experiences of being able to create meaning in one's own life and being able to manage problems in living, are vital for personal recovery. Even though experiences of loneliness are a risk factor for suicide, people who suffer from suicidality also live in contexts with relatives, such as family and/or friends. The relatives' struggles for contributing to the loved person's survival, can include experiences of taking responsibility for things outside their control. Previous research also describes that mental health nurses, who provide most of the direct care of the patients in psychiatric wards, can experience challenges in varied ways in their caring for suicidal persons. One issue of the care of suicidal persons in psychiatric wards, involves the lack of empirically induced theory to guide practice. There is even less empirical evidence to facilitate caring interventions, in order to enable each unique patient's experience of personal recovery in a suicidal crisis. Thus, knowledge development considering the suicidal persons' and their relatives' lifeworlds in this context, is needed. In accordance with a lifeworld perspective, the patients' and their relatives' lived experiences, can open up the space for the possibility of meaningful understanding of the phenomenon in focus (i.e. recovery in a suicidal crisis). Such knowledge has the potential to enable further studies considering the development of more specific caring approaches, directed to support suicidal patients' personal recovery and their relatives' participation while the person receives psychiatric inpatient care.

# AIM OF THE THESIS

The overall aim of this thesis is to develop, introduce and evaluate a caring intervention, to support suicidal patients' recovery and health, and to support patients' and their relatives' participation in the caring process.

The thesis comprises four studies with the following aims:

- I                    To describe the phenomenon of recovery in a context of nursing care as experienced by persons at risk of suicide.
- II                    To describe the phenomenon of participation, as experienced by relatives of persons who are subject to inpatient psychiatric care due to a risk of suicide.
- III                   To describe what characterizes a recovery-oriented caring intervention, and how this can be expressed through caring acts involving suicidal patients and their relatives.
- IV                   To explore and evaluate how the suggested recovery-oriented caring approach was experienced by a suicidal patient in a context with close relatives and nurses.

**Table 1.** Overview of the four studies in the thesis

<b>Study</b>	<b>Aim</b>	<b>Design</b>	<b>Data collection</b>	<b>Analysis</b>
<b>I</b>	To describe the phenomenon of recovery in a context of nursing care as experienced by persons at risk of suicide	RLR approach	Phenomenon-oriented interviews	Phenomenology
<b>II</b>	To describe the phenomenon of participation, as experienced by relatives of persons who are subject to inpatient psychiatric care due to a risk of suicide	RLR approach	Phenomenon-oriented interviews	Phenomenology
<b>III</b>	To describe what characterizes a recovery-oriented caring intervention, and how this can be expressed through caring acts involving suicidal patients and their relatives	Delphi methodology	Focus group interviews and questionnaires	Qualitative thematic analysis
<b>IV</b>	To explore and evaluate how the suggested recovery-oriented caring approach was experienced by a suicidal patient in a context with close relatives and nurses	Single case with QUAL>quan mixed methods research approach	Interviews, common records, supervision, self-assessment, time frame of care	Hermeneutics

# METHODS

## Design

When designing the research project reported in this thesis, striving for stringency and consistency between ontology, epistemology and methodology was a leading principle. As described previously, this study is based on phenomenological philosophy and lifeworld theory (Dahlberg et al., 2008), as this perspective enables to acknowledge the participants' experiences and the complexity of the phenomenon in focus (i.e. recovery in a suicidal crisis). In order to enable stringency and consistency, a phenomenological and hermeneutical perspective guided the design of the project. Hence, acknowledging the lifeworld involved not only having a concern to establish a theoretical framework as a foundation for reflection on the research findings, it also provided a foundation for the researcher's reflection on knowledge, and how the researcher as a human being interpreted and made sense to their own experiences, including how to account for these processes in research. In other words, a lifeworld perspective is not only something that could support nurses' understanding of patients' experiences, it also has the potential to support researchers' development of scientific knowledge.

Moreover, following Ricoeur's (1976) view of interpretation, it is central when designing a study to ensure that the researcher can deal with pre-understandings, as well as argue that the interpretations made are plausible and valid. This calls for methodological rigor throughout the design, and a use of methodological approaches that do not interfere with the ontological and epistemological underpinnings.

Hence, the chosen methodological principles (I, II, III, IV) were based on phenomenological philosophy. Within phenomenological and hermeneutical approaches, the concept of pre-understanding is central. Pre-understanding can be described as we always base our understanding of what happens "here and now" on our previous experiences. In phenomenology this is a part of human existence, which means that researchers, like all human beings, experience the world they live in. By adopting a phenomenological and hermeneutical approach, the researcher needs to identify and bridle understanding to remain open for the phenomenon as it "presented itself" in



the four studies respectively. While focusing on the phenomenon in each study, the overall design also accounts for hermeneutic principles as the included studies are not viewed as separate entities but, in line with the principles of the hermeneutic spiral related to each other to promote further understanding in relation to the aim of this thesis.

Therefore, the intention was not to use the methodological principles as “methods” with step-by-step instructions (van Wijngaarden et al., 2017). Instead, the researcher’s adoption of a phenomenological attitude of openness was characterized by “bridling” (Dahlberg et al., 2008), to examine the researcher’s pre-understanding and pay attention to how things come to be in the evolving understanding. The process of bridling understanding to remain open for the phenomenon in study, is considered to be essential to the ability to take responsibility for the researcher’s involvement in the same world that is investigated, and where the intention is to reveal meanings that are valid (Dahlberg et al., 2008; van Wijngaarden et al., 2017). Adopting what could be described as a phenomenological attitude in contrast to a naïve and un-reflected stance (Wiklund Gustin, 2017), means to direct one’s intentionality and reflect on what is happening throughout the whole research process. This is not restricted to the collection, analysis and interpretation of data but also the way data is presented. As put forth by van Manen (2017a) it is essential to account for phenomenology when presenting the findings and use a language that reflects the meanings of the lived experiences of the studied phenomenon.

As articulated, phenomenology and hermeneutics provide a solid ontological, epistemological and methodological ground for researching and understanding a complex phenomenon, such as recovery in a suicidal crisis. To address this complexity and answer the research aim, it was also considered necessary to explore it by means of different methodological approaches.

In the first studies (I, II) a Reflective Lifeworld Research (RLR) approach (Dahlberg et al., 2008) was chosen, as a review of the literature revealed that the dominating interventions in the care of suicidal persons was based in a tradition where the persons own perspective was less prominent. Hence, there was a need not only to acknowledge patients’ and their relatives’ experiences in nursing care, but also in research. In the RLR approach, participants’ perspectives are emphasized throughout the research process, as the approach is not only focused on posing relevant questions to participants, but to listen carefully to the voices of the their narratives, and to strive to reveal meanings by describing a meaning structure that encompasses essential as well as varied and nuanced meanings.

The understanding of what really matters in the process of care and recovery from the perspective of suicidal patients (I) and their relatives (II), was the point of departure for the following study. In study III people who were considered knowledgeable in relation to care of suicidal persons, either based on their professional experiences, or by own lived experiences of being engaged in these kinds of issues were invited. By means of Delphi methodology (Keeney, McKenna, & Hasson, 2011), these participants with their special knowledge of the topic reflected on caring for the suicidal person, and how nursing care could support patients' recovery, and involve patients' relatives. This approach did not only address the phenomenon. Delphi methodology was used to take into account the participants' experiences in the knowledge development, but it also provided means to challenge the researcher's pre-understandings as not only participants' professional and personal experiences were reflected on, but also the findings from the researcher's previous studies. The Delphi methodology with the different steps of data collection and analysis comprised a hermeneutical movement between parts and whole.

Just as important is the reflection on the findings of each study in relation to the developing understanding as a whole. Dahlberg (2006) describes this as a movement between figure and background. Hence, before continuing with study IV, findings from study I, II and III were reflected on in the light of each other. These reflections gave rise to a preliminary guide intended to facilitate nurses in supporting suicidal patients' recovery.

The guide was introduced in a clinical setting in study IV. In this final study a single case design with QUAL>quan mixed methods research approach was adopted (Dattilio, Edwards, & Fishman, 2010; Sandelowski, 2000). This design accounted for the participants lived experiences of the guide, but it also involved quantitative data to give new nuances to the findings. This was considered to enable a way toward richer understanding of the complexity of the phenomenon (i.e. recovery in a suicidal crisis).

Thus, qualitative data has been paramount, and the lifeworld theory with its roots in phenomenological philosophy has served as a guiding spotlight through the whole research process. Accordingly, the individual studies do not articulate the complexity of the phenomenon or give the answer to the aim of this thesis by themselves. Rather it is in the relationship between the whole and the parts that a new pattern arises. Hence, the final step in the research process was to, once again, consider the findings of each study in the light of each other. This ended up in a preliminary guide (Appendix 1) to a personal-recovery-oriented caring approach to suicidality (PROCATS), which should be considered as the answer to the overall aim of this thesis.

The preliminary guide to PROCATS (Appendix 1) is based both on the findings from the four studies (I, II, III, IV), and theories concerning recovery from mental health problems. A major source of inspiration, both in regards to the understanding of recovery, and to the structure of the guide is Barker and Buchanan-Barker's (2005) description of the Holistic assessment in the Tidal model.

## **Participants and settings**

The collection of data regarding the four studies in the thesis, were conducted in psychiatric services in a County Council in the middle of Sweden (I, II, III, IV). This includes collection of data among people with personal experiences of being subject to care due to suicidality (I, IV), or of being a relative to such a person (II, IV), or having personal and/or professional experiences in suicide prevention (III, IV). In the following text, the participants and setting will be presented in relation to each study.

### **Participants and setting – study I**

The aim of the first study was to describe the phenomenon of recovery in a context of nursing care as experienced by persons at risk of suicide. Participants were recruited from a psychiatric clinic in the middle of Sweden. The participants were patients who received psychiatric inpatient care due to suicidality, and wanted to contribute with their experiences of relevance for the aim of this study. Thus, the patients were recruited paying attention to their interest and ability to talk about their experiences from their own perspectives within this specific context. This means that the interest in this research is not directed to psychiatric diagnosis, but to suicidality as an existential crisis that actualized a need for psychiatric care. However, to enable participation and support the persons in narrating their experiences, vulnerability related to psychotic symptoms was an exclusion criterion. The author conducted the recruitment of participants in collaboration with nurses at the psychiatric clinic, who identified and made first contact with persons who fulfilled the criteria for inclusion. Eleven women and three men, aged between 20 and 70 were included in the study. A more detailed description of participants and setting can be found in the article.

## **Participants and setting – study II**

The aim of the second study was to describe the phenomenon of participation, as experienced by relatives of persons who are subject to inpatient psychiatric care due to a risk of suicide. Participants were recruited among the relatives of participants from the first study in this thesis. The author asked participants in that study to invite relatives they considered as important persons in their life. The persons who agreed were contacted by the author, and given further information about the study. The participants consisted of relatives who expressed an interest to contribute with their experiences regarding the aim of this study. Five women and three men, aged between 30 and 80 were included in the study.

## **Participants and setting – study III**

The aim of the third 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. As previous studies focused on patients' (I) and relatives' (II) perspectives, this study was directed to engage people that could shed light on the care of suicidal persons from other perspectives. In line with the Delphi approach, participants were recruited as experts by experience. Potential participants were informed about the study and invited to participate by the author. Sixteen persons (twelve women and four men) were included in the study. These were A) five representatives from a Swedish organization that works with suicide prevention and support to relatives who have lost a close one to suicide; B) six registered nurses at a County Council in Sweden; and C) five researchers with special knowledge about suicide prevention.

## **Participants and setting – study IV**

The overall aim of the fourth study was to explore and evaluate how the suggested recovery-oriented caring approach was experienced by a suicidal patient in a context with close relatives and nurses. Since the intention was to conduct the study at psychiatric inpatient care, a setting at a psychiatric clinic in Sweden was contacted. The author gave information about the research at meetings to those who expressed an interest in participating in the study. Mindful that the intention was to conduct the study as a small-scale pilot study with a single case design, and evaluate the preliminary caring approach on an individual level, the numbers of participants were small.

Participants were recruited in three steps. Since the caring approach aimed to be applied by registered nurses, three nurses who expressed an interest in participation in the evaluation of the caring approach were recruited as a first step. These nurses were introduced to the guide and obtained training in how to use it.

In the second step, the author conducted the recruitment of patients in collaboration with informed nurses in the setting. The inclusion criteria were that the person was admitted to psychiatric inpatient care due to suicide attempt, and expressed an interest to contribute in the study. The considerations of vulnerability and diagnosis were approached in line with the considerations in study I. Thus, psychotic symptoms were an exclusion criterion, and the patient was recruited due to his interest and ability to talk about his experiences from his own perspective within this context. A late middle-aged man expressed his willingness to participate in the study.

In the third step, the patient who participated in this study was asked to invite one or more relatives. The patient invited one relative who agreed to be contacted by the author who gave further information about the study. The relative was middle-aged and was a close relative to the patient. Thus, three nurses (two women and a man), a patient (a man), and a relative (a woman) were included in the study.

## **Data collection**

In the following text, a presentation of data and data collection is presented in relation to each study. However, study I and II were conducted with the same research approach and will be presented together. An overview of the methods for data collection in the four studies can be found in Table 1.

### **Phenomenon-oriented interviews – study I and II**

In order to describe the phenomenon of recovery as experienced by persons at risk of suicide (I) and the phenomenon of participation as experienced by relatives of persons who are subject to inpatient psychiatric care due to a risk of suicide (II), phenomenon-oriented interviews (Dahlberg & Dahlberg, 2003; Dahlberg & Dahlberg, 2004) were conducted as a basis for data. The author conducted all interviews. The interviews were carried out in the guiding light of methodological principles for reflective lifeworld research approach (RLR), as described by Dahlberg et al. (2008). In such a way, the interviewer strived to maintain openness and sensitivity to both the participant and the phenomenon during the interview. The interviewer's awareness of

intersubjectivity included reflection on the relation to the participant and the phenomenon, which supported the interviewer to bridle her understanding and to be present and respectful to the participant and what the person shared in the interview situation (Boden, Gibson, Owen, & Benson, 2016; Dahlberg et al., 2008). The interviews were carried out in conversation rooms at a health care setting (I), and in conversation rooms at a health care or a University setting (II). One participant chose a telephone interview, and another participant chose to be interviewed at home (II). All participants were supported to narrate their experiences from their own individual perspectives. All participants were also told to feel free to express themselves with regard to their own unique experiences (Dahlberg et al., 2008). The initial question in study I, encouraged participants to describe their experiences of recovery while they received psychiatric inpatient care. In study II, the initial question encouraged participants to describe their experiences of participation while their close relatives were received care in a psychiatric inpatient setting. To support participants in elaborating their descriptions, open-ended follow-up questions were included such as: “Can you tell me more about that?”, and “What does this mean for you?” In such ways, the interviewer strived to bridle her understanding and remain open and sensitive to both the participant and the phenomenon itself. The interviews lasted between 25 and 120 minutes (I), and 45 and 119 minutes (II), and were recorded with a digital voice recorder and transcribed verbatim.

### **Focus groups and questionnaires – study III**

This study was based on the results from the two previous studies (I, II), 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 intention was to take into account people as experts by experience regarding caring of suicidal persons, and ask for their opinion on important issues in this context. Therefore, this study was conducted by means of a Delphi approach (Keeney et al., 2011). This approach provided the opportunity to recruit participants as experts by experience, to develop new knowledge of the phenomenon in question, through a dialogical process between the experts and the researchers. This means that data collection was conducted step by step following 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). Participants consisted of the following three areas of expertise. Expert/focus group 1: five representatives from a Swedish organization that works with suicide prevention and support to relatives who have lost a close one to

suicide; Expert/focus group 2: six registered nurses; Expert/focus group 3: five researchers with special knowledge about suicide prevention. 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. Secondly, these interviews were followed up with three rounds of questionnaires in which responses were redistributed to the expert panel by email.

### **“Mixed methods” – study IV**

This study was designed as a small scale pilot study (Brinkmann & Kvale, 2015; Yin, 2009), to explore and evaluate how the suggested recovery-oriented caring approach (III) was experienced by a suicidal patient in the context with close relatives and nurses. With regard to the complexity of the caring approach and the importance of recognizing and acknowledging multiple aspects of the case, a mixed methods approach was chosen (Dattilio et al., 2010). This included that focus was on experiences rather than effects, to gain understanding about what was experienced as helpful and what may be problematic. This focus on experiences related to the lifeworld perspective (Dahlberg et al., 2008; Todres et al., 2014) underpinning the development of the caring approach in this thesis. Thus, a single case study with a QUAL>quan (Sandelowski, 2000) mixed methods approach was chosen,

Data collection was conducted during a period of ten weeks. Qualitative data consisted of digitally recorded and verbatim transcribed interviews with the participants. Two interviews were conducted with the patient, one with the close relative, and one interview was conducted with each nurse, i.e. the case is based on a total of six interviews. The place for the interviews was chosen according to participants’ wishes to enable them to feel comfortable. All interviews were conducted by the author. The initial question encouraged participants to describe their experiences of the caring approach. Follow up questions aimed to support participants in elaborating their descriptions. The second interview with the patient was conducted one week after he was discharged from the ward. Here the initial question invited the participant to describe his experiences of the caring approach from a retrospective perspective.

Additional qualitative data included the nurses’ and the patient’s common records of the conversations during the caring approach, and digitally recorded supervision with the nurses. Additional quantitative data included the patient’s self-assessment according to the Beck’s Hopelessness Scale (Beck, Brown, Berchick, Stewart, & Steer, 1990; Beck, Brown, Steer, Dahlsgaard, & Grisham, 1999); and information about the length and frequencies of the patient’s previous admittance to psychiatric inpatient care.

## **Data analysis**

The analysis of data in study I and II were conducted from the same research approach and will therefore be presented together. The analysis of data in study III and IV were carried out from different research approaches and will be presented study by study.

### **Phenomenology – study I and II**

A reflective lifeworld research approach (RLR), as described by Dahlberg et al. (2008) as chosen to illuminate and describe the meaning structure of the phenomenon in study I and II. This research approach is grounded in phenomenological philosophy and emphasizes an understanding of an individual human as lifeworld, and involves a concern to do justice to the lived, pre-reflective meanings of people's experiences (Husserl, 1970/1936). This includes a philosophical grounding in an understanding of an individual human as lived body and involvement in the world, and provides a non-dualistic and non-reducionistic alternative (Dahlberg et al., 2008; Merleau-Ponty, 2013/1945) when exploring the phenomenon in focus. To acknowledge the human being as a lived body, enables recognizing human beings as experiencing bodies including the relationship between humans and the world. In line with this tradition, the analyses of data were carried out through the researcher's adoption of a phenomenological attitude. This means that the dialogue with the transcribed text were characterized by the researcher's openness and sensitivity to the complexities of lived experiences, reflection upon the meanings, while bridling the researcher's understanding. The guiding principle, to "bridle" the understanding, opened up the possibility of slowing down the process of understanding the phenomenon, restraining researcher's pre-understanding, with the intention of not making definite what is indefinite. The dialog with the text and the dwelling work with meanings, included a movement between whole-parts-whole, and use of the principle figure and background, in order to understand and describe the essential meaning of the phenomenon (Dahlberg, 2006; Dahlberg et al., 2008). In addition, this reflective process was characterized by a wondering exploration on certain questions, such as, "Is this phenomenological meaning?", "Is this really grounded in the text?", "Is this a description of the essential meaning without theorizing?", and "What does this mean?"



### **Qualitative thematic analysis – study III**

The focus group interviews were subject to analysis following Robson's (2011) recommendations for this kind of data, to describe what characterizes a recovery-oriented caring intervention, and how this can be expressed through caring acts involving suicidal patients and their relatives. Characteristics that related to each other were grouped into themes. 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. Expert panel members were asked to evaluate suggested caring acts on a scale. In Delphi round 3 participants were asked to evaluate suggested caring acts related to conversation with the suicidal patient, with focus on two scales. When the participants emphasized different aspects in their comments on caring acts, this was considered as a finding that indicated the complexity of a recovery-oriented caring intervention, and enabled recognition of central aspects of the characteristics. 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, and understood as a caring approach. Here participants were asked to evaluate suggested caring acts on a scale. The final description of the characteristics involved a description of a preliminary guide to a recovery-oriented caring approach to suicidality.

### **Hermeneutical interpretation of meaning – study IV**

Since the intention was to focus on experiences in the evaluation of the suggested guide to the recovery-oriented caring approach to suicidality, the overall design of this study could be understood in relation to Ricoeur's (1976) hermeneutic arc, and interpretation as a movement between understanding and explanation. This analysis process included not only the patient's perspective, but comprised a wider context where a relative, and three nurses who were involved in the application of the caring approach, were accounted for. This wider context also included some quantitative data. Hence, the interviews with the patient constituted the basis for the analysis, but additional data were also included in the interpretation before synthesizing the understanding of data to a comprehensive whole.

# ETHICAL CONSIDERATIONS

The four studies in this thesis were approved by an ethical review board (registration number 2013/123 and 2016/336), and conform to the ethical principles described in the Declaration of Helsinki (World Medical Association, 2013). These ethical principles mean that I as a researcher have a legal, ethical and moral responsibility to protect the health and rights of the individuals that participate in the study. Vulnerable individuals (Liamputtong, 2007) such as the patients and relatives, may have difficulties in manifesting human rights in their everyday life. Thus, one of the first steps to uphold the right to health is to support vulnerable individuals to make their own voice heard. To achieve this, I (LS) strived to approach and act to: A) ensure that patients, relatives, nurses, and researchers participate voluntarily; B) conduct the research with respect and responsibility for confidentiality; C) and to enable an available and mutual relationship with the individuals who participate in the study. This striving included that the relationship needed to be grounded in trust and trustworthiness through the different steps in the whole research process (Dahlberg et al., 2008; Lévinas, 1990; Liamputtong, 2007; Lögstrup, 1992).

The lifeworld perspective (Dahlberg et al., 2008; Merleau-Ponty, 2013/1945; Todres et al., 2014) that is used as a theoretical frame in this thesis, is developed with roots in phenomenological philosophy. This research approach provides a foundation for an ethical approach, which has been expressed through the researcher's approach of attentiveness, openness and sensitivity to the participants and what they brought to the interview situation. This means that I have also endeavored to carry through an active reflection process (Dahlberg et al., 2008) in relation to the participants, the phenomenon, and my own way of being and approaching. During the data collection, I have, for example reflected upon questions as ways to problematize my understanding, and enhance awareness of how I participate in the encounters with the participants. The questions involved were for example: "How did the participants experience the information about the study?", "How did the participants experience their participation in the study?", "How did the participants experience my role and presence as a researcher?", "How did I as a researcher experience the participants?" and "How did I experience my

participation in the encounters with the participants?" I also reflected upon questions concerning the aim of the thesis, and what the conducting of the research and the findings mean for the participants. Hence, I was concerned about adopting and expressing a reflective approach in relation to the participants, the phenomenon, and myself to provide a foundation for conducting the research in accordance with the ethical principles and considerations.

The ethical and reflective approach as described above was an important resource during data collection, and in relation to my responsibility to consider possible disadvantages and benefits for the individuals' participation. Through careful and thorough considerations of possible disadvantages, the conclusions were that the overall benefits with conducting the four studies in the thesis, broadly outweighed possible disadvantages.

Considering the risk that sharing one's experiences in an interview could arouse distressing thoughts for the participants, a plan for relevant and available resources was established before data collection. All the patients had contact with a psychiatric professional network that they could turn to if the interview raised issues that needed a follow-up conversation. All the patients were also given oral and written information explaining that I as researcher had responsibility to support the person to contact their mental health nurse or their psychiatrist for a follow-up conversation, if I considered that there was an enhanced risk for suicide in connection with the interview. All the interviews with the patients were conducted without the need to take such action. At this point, I used my ten years of experiences when I worked as a mental health nurse within acute psychiatric care, by being attentive to the patients' implicit and explicit expressions and experiences. I also asked the patients at the end of the interview how they felt and how they experienced the situation, ready to give information to a responsible mental health nurse and/or psychiatrist if needed. Thus, the patients were in vulnerable situations due to suicidality, and there was an available and supportive collaboration with responsible caregivers when needed.

All the relatives were given oral information that they could turn to the psychiatric professional network if the interview raised issues that needed a follow-up conversation. The participating nurses and researchers had access to supportive resources connected to their work. In addition, all participants were given oral information explaining that they could contact me (LS) after the interview if the interview raised issues and/or questions that needed a follow-up conversation. All participants gave their written informed consent before the interview. All participants were also given opportunities to withdraw or to pause the interview at any time if they wanted to.

# FINDINGS

In the following section the findings are presented in two steps. Firstly, a summary of the main findings is presented in relation to each study (I, II, III, IV). Secondly, a synthesized understanding of the findings is presented. A more detailed description of the findings can be found in the articles (I, II) and in the manuscripts (III, IV).

## Summary of the findings

### **Reconnecting with oneself while struggling between life and death: The phenomenon of recovery as experienced by persons at risk of suicide (I)**

The findings reveal that the phenomenon of recovery means “reconnecting with oneself while struggling with life and death”. Reconnecting with oneself means being involved in questioning how life can become worthwhile and possible to live. Being amid this struggle for recovery includes having a fear of being left alone, as one not only questions the meaning of life, but also one’s ability to handle everyday life. Reconnecting with oneself in relation to these challenges toward recovery, arises through a mutual relationship with important others who can facilitate a sense of belonging and grounding in everyday life. This reconnecting process is strengthened through the presence of a nurturing connectedness that opens up the space for the possibility of a shared experience of humanity.

### **Being in an expressive space and giving voice to oneself**

This meaning constituent means to experience the possibility of being oneself through the narration of oneself in relation to a professional caregiver that takes his/her time to really listen. When one can give voice to this ongoing narrative about one’s own life, the hidden can become visible. Being able to go through and talk about what really matters in the struggle with suicidality is a challenge, but also a relief that enables recovery. Hence, the personal

narrative and the presence of a human dialogue, provides a foundation for self-understanding and elucidation of new meaning in life.

### **Regaining dignity through nurturing connectedness**

This aspect of recovery means being reaffirmed as a unique person and valuable human being. This can also be described as a regained dignity that is heartened through genuine encounters with professional caregivers and supportive relatives. Being seen and acknowledged in such ways can balance experiences of loneliness and doubt in one's own value in the struggle with life and death. The regained dignity means a reciprocal sharing that is intertwined with an experience of closeness with the other in which one's becoming in the present moment is nourished. This can also be understood as the lived connectedness giving time to reconnect with oneself in a sense of being met as a human being. The lived and nurturing connectedness with both oneself and important others, nourishes experiences of belonging and a capability of recovering further.

### **Finding a balance in the tension between life and death**

Being in a balancing process involves a concern for influencing one's vulnerable situation. The balance is more associated with finding one's place in a moment that enables a sense of personal recovery, rather than achieving a steady state. This balancing process includes allowing a vital rhythm in everyday life to acknowledge one's varied needs. Holding on to the possibilities for recovery in everyday life, gives possibilities to participate at one's own pace and on one's own terms. The vital rhythm involves a self-reflection and a striving to embrace one's experience-based knowledge. Thus, finding a balance in the tension of life and death, enables moving toward personal recovery in a self-reflected experience of humanity.

### **To be present, share and nurture: A lifeworld phenomenological study of relatives' participation in the suicidal person's recovery (II)**

The findings illuminate that the phenomenon of participation means "being actively involved in the process in which the person regains the desire to live". It is about being allowed to acknowledge the relations to each other, even while one of the family members is provided inpatient care. Being actively involved in the process in which the person regains the desire to live, includes a concern to contribute to the loved person's survival, and maintaining contact when the person is emotionally distant in the struggle with life and death. Participation also means being engaged in a mutual communication with both

the suicidal person and the professional caregivers concerned. The relative's ability to contribute with one's own perspective regarding what has happened and what may be of importance to do, and to understand what is happening in the ongoing situation, is crucial for experiences of participation. Experience of being disconnected from what is going on, entails a fear of losing the loved person you care about and may feel unable to help. Being able to carry through the relation with the loved person in accordance with the other's wishes and needs, nurtures experiences of being actively involved.

### **Struggling for being able to be present for the person at risk of suicide**

This meaning constituent means being present as a helpful resource regarding the loved person's concerns. Reaching one's own resourcefulness as a relative can be challenging as awareness of the risk of losing the loved person can involve doubt about one's ability to contribute in a meaningful way. Experiences of connectedness with the loved person and professional caregivers concerned, enables relatives to be present and participate in a meaningful way. Reaching one's own resourcefulness in such way, also means facing that life is vulnerable and not something that can be taken for granted. Hence, striving for being present for the person at risk of suicide, facilitates embracing what matters in relation to both the loved person and oneself.

### **Being able to share everyday life**

This aspect of participation means searching for contact with the person as a way of being able to participate in what is going on in the concrete situation. This search for contact includes a reciprocal communication with the professional caregivers. Being able to talk about and share everyday life experience in such ways, is of particular importance when the loved person temporarily loses the ability to put words to his/her experiences and needs a relative who can contribute. This focus on the loved person's everyday life is experienced as crucial when the person struggles with suicidality as it facilitates responding to the other in a meaningful way. Hence, this space for connecting and sharing in everyday life is a resource for the persons concerned, and needs to be acknowledged in the process in which the person regains the desire to live.

### **Nurturing sources for vitality**

This aspect of participation means holding on to the relationship with the suicidal person and is understood as an expression of caring. This caring can contribute to a context of possibilities in life, while simultaneously agonizing over the risk of losing the loved person. This includes relatives' concern to acknowledge meaningful alternatives in the encounters with the person, as

ways of nurturing sources for vitality. This nurturing and caring presence provides a foundation to carry through the relations to each other, and is considered as a resource for being actively involved in the family member's process of personal recovery and continuing life.

### **Caring for the suicidal person: A Delphi study of what characterizes a recovery-oriented caring approach (III)**

The findings illuminate that a recovery-oriented caring intervention is characterized by a “communicative togetherness”. This means that communication is at the core of such an intervention, and it also implies that it is more in line with the lifeworld perspective to describe it as a recovery-oriented caring approach than an intervention. This communicative togetherness 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 encourages a mutual understanding of the complexities of the person's situation, and supports patients in influencing their care and regaining authority over their own lives. The description of what characterizes a recovery-oriented caring approach will be presented in more detail with focus on the following three core aspects: facilitating giving voice to implicit and explicit experiences, enabling resources and rhythm in everyday life, and acknowledging relationships and contexts with others.

#### **Facilitating giving voice to implicit and explicit experiences**

When a recovery-oriented caring approach is characterized by a communicative togetherness, it evolves in accordance with the patient's needs. This communication enables a space for the person to give voice to his/her implicit and explicit experiences. Inviting the person to conversation and supporting the person to talk about and share what is going on in the person's life, involves asking questions and considering suicidality. The conversation opens up a mutual space for the person and professional caregiver to talk about what contributes to the person's experience that life is not worthwhile and possibly to live 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 a way, facilitates understanding and acknowledgement of the person both as a suffering and resourceful human being.

### **Enabling resources and rhythm in everyday life**

Another aspect that provides a 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. This includes reflecting at a calm pace together with the person considering how these experiences can be resources in the present situation. Discovering the person's narrative together with the person in such a way, can support the person in finding a vital rhythm in everyday life, and acknowledge varied needs. This communicative togetherness is intertwined with making oneself available in a mutual and close dialogue with the person, listening with sensitivity, and paying attention to opportunities to ask questions, as a foundation to further understand what can support the person's project of recovery and continuing life.

### **Acknowledging relationships and contexts with others**

Recognizing the person's struggle with life and death is core in a recovery-oriented caring approach and includes giving the person possibilities to talk about important relationships. 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/she wants to invite, and how the person wants relatives to participate. Communicative togetherness also includes recognizing the unique needs of relatives, as they may need individual support to be able to carry through their participation processes and lives. Acknowledging relationships and contexts with others in such a way, can be understood as a common dialogue and a shared collaboration, as a foundation for the person's reconnecting with oneself and important others in life. Thus, communicative togetherness has the potential to contribute to a substance and direction of the suicidal patient's recovery and care, in accordance with what is meaningful for the patient as a unique person and resourceful human being, living in a world with other humans.

### **Experiences of a recovery-oriented caring approach to suicidality: A single case study (IV)**

The findings are elucidated through a synthesis of the findings. The findings give rise to an understanding of the caring approach as a lived space of recovery, where mutual understanding of the patient's life-situation and struggles can evolve and be addressed by the patient, relatives and nurses. This supported the patient to reconnect with himself and important others, and strengthened him when challenged by his problems in living. Instead of



reducing the patient's experiences of hopelessness and suicidality to problems that can be solved with a specific method, nursing care needs to be based on the patient's and the nurses' co-creation of the patient's recovery and care, so the care can be of relevance for the patient's unique and varied needs in his living context with others. This common exploration of what the patient struggled with, as well as experiences of being reconnected with self and important others, enabled a foundation for what could be described as an ongoing project in the patient's life – the life project to continue living. Accordingly, the recovery-oriented caring approach was experienced as contributing not only to the patient's and his relative's participation in care in an ordinary manner, but to experiences of being acknowledged and involved as valued persons, in a way that supported experiences of being more able to manage both challenges and possibilities in everyday life than before.

## **The synthesis of the findings – a comprehensive whole**

The overall aim of this thesis is to develop, introduce and evaluate a caring intervention, to support suicidal patients' recovery and health, and to support patients' and their relatives' participation in the caring process. To approach this aim, the lifeworld theory with its roots in phenomenological philosophy, served as a guiding light through the whole research process. The importance of a lifeworld perspective when caring for persons suffering from suicidality, was the point of departure when formulating the aim of this thesis, and lifeworld theory is also used to interpret the findings. The epistemological and methodological concerns have their origins in a phenomenological and hermeneutical tradition. In line with this, each included study (I, II, III, IV) is understood as parts, that need to be related to each other to obtain a more nuanced and richer understanding in relation to the overall aim. That would not be possible by merely presenting the findings of each study. This final interpretive step is inspired by Ricoeur's (1976) theory of interpretation. This means that different parts are synthesized into a comprehensive whole. Following Ricoeur (1976) this interpreted whole comprises a heterogeneous synthesis. A heterogeneous synthesis is the result of a dialectic process, where new understandings arise in the tension between competing possibilities and where the synthesis unites what from the beginning appear to be disparate. An example of a heterogeneous synthesis in Ricoeur's writings is his view of the hermeneutic arc, and understanding as comprising both explanatory and interpretive processes. Hence, the final step in the research process was to

consider the findings of each study in the light of each other, as well as in relation to theoretical sources. The latter works as a means of supporting the process of synthesizing.

This final interpretive process ended up in an understanding of the importance to individualize the caring approach to the specific needs of each person, and thereby a description of a personal-recovery-oriented caring approach to suicidality (PROCATS), which should be considered as the answer to the overall aim this thesis. The heterogeneous synthesis is related to an understanding of caregivers' support to suicidal persons' recovery as a communicative process, where experiences of hopelessness and an effort to continue living are transformed from being opposed to each other to being possible to experience in the present moment, and give expression to these experiences. Narrating one's experiences in this communicative process can be a challenge, but also a relief that seems to make the dark more bearable. Hence, the developed caring approach is characterized by a "communicative togetherness", which has the potential of enabling a mutual understanding of the patient's situation and facilitate embodied participation, for supporting patients' personal recovery. By acknowledging both despair and resources, the PROCATS also supports the person to regain a sense of reconnecting with both self and other important persons, and thereby also reconnect with life itself. This means that the PROCATS has the potential to support the person to regain a sense of balance in life (IV). The given foundation from the lifeworld, signifies that relationality is central, and involves a certain intimacy in the mutual relationship. This mutuality is recognized as important for the patient's experiences of the conversations with the nurses (IV), but is also found to be vital for understanding what can support patients' personal recovery in the suffering from suicidality (I, II, III, IV).

The synthesized understanding of the findings and the existential aspects that are central in the analysis, includes a development of the preliminary guide to the caring approach (Appendix 1) compared to the one developed in study III, and applied in study IV. Hence, the thesis resulted in a description of a personal-recovery-oriented caring approach to suicidality. The overall aim of the caring approach, PROCATS, is to support and strengthen suicidal patients' recovery and health processes, even at the fringes of life. In the following, this synthesis will be further described in relation to six core aspects that underpin the PROCATS. These core aspects are intertwined and comprise PROCATS as "a humanizing encounter", "acknowledging the suicidal patient as a vulnerable and capable person", "emphasizing reflective understanding of each individual person and experience", "accounting for the patient's health resources", "supporting narration and understanding both the

dark and the light life-events”, and “recognizing the relative as a unique, suffering and resourceful person”. The separation of the core aspects under different headings is only a means of structuring and articulating the synthesis.

## **A humanizing encounter**

To comprehensively understand the potential of the PROCATS, findings from previous researchers need to be recognized as a point of departure. Talseth and Gilje (2011) not only describe how suicidal patients’ struggle with experiences of being powerless, but that experiences of being subject to “standard procedures”, such as surveillance during hospitalizations may increase these experiences. From a lifeworld perspective it is not possible to give a detailed description of what counts as a good conversation in each unique situation. Rather it is a question about identifying a direction that can provide support to the caregivers’ and the patient’s co-creation of the patient’s recovery and care. Therefore, the PROCATS focuses on personal recovery rather than “safe observations”. This does not mean that the caregivers should only talk about the patient’s strengths and resources. The caregiver should invite the patient at risk of suicide into a dialogue, where the intention is to support the patient’s recovery and health processes, by acknowledging the patient as a unique person and as a suffering and resourceful human being, who is currently struggling with issues related to life and death (I, III, IV). In addition, the patient may also be in a context of family and/or friends, i.e. a person that in one way or another, may be involved in the patient’s process of recovery (II, III, IV). Hence, it is about giving room for a conversation considering what things, issues and/or questions are important for the patient to talk about (III, IV). To acknowledge the patient in this way needs to be understood as a humanizing encounter, where the patient is recognized as an expert on him/herself (Dahlberg & Segesten, 2010; Todres et al., 2009), which does not mean that the patient knows everything about everything. Instead, the caregiver needs to have the ability to establish a foundation that enables not only the caregiver to understand what the patient is trying to express in the present situation, but also supports a change in the patient’s self-understanding. In this process both the patient and the caregiver are experts, but in different ways. Accordingly, it is not about “either or”, where it either is the caregiver or the patient that is the expert. Instead, it is about a mutual connection and dialogue between the caregiver and the patient, where both persons’ expert-knowledge needs to be acknowledged and respected (Todres et al., 2014).

Another aspect of this ethical call relates to the paradoxical nature of the mutual connectedness (I, II, IV). Even though both the caregiver and the

patient are both considered as experts, the relationship is also characterized by asymmetry. This asymmetry is not only related to the roles of the patient and the caregiver. As highlighted by Fredriksson and Eriksson (2003), who based their research on the philosophy of Ricoeur (1992) and Lévinas (1990), asymmetry is also related to the fact that suffering implies passivity in relation to one's own life. Thus, creating an in-balance in power between the patient and the caregiver, that relates to existence rather than to roles. Accordingly, there is an ethical demand that calls for the caregiver's responsibility for how the "communicative togetherness" evolves, and for applying the PROCATS in an individualized way, together with each person (III, IV). The general principle described in PROCATS needs to be understood and applied in a way that is in accordance with both the patient's and the caregiver's perspectives, including the ethics of the lived world and existential and social contexts (van Wijngaarden et al., 2017). This understanding of the PROCATS, includes a view of the caring relationship as being both reciprocal and asymmetric, as well as an understanding of the process of recovery as a reconnecting with both oneself and other important persons, and thereby also life itself (I, IV). This will be used as a guiding light in the continuing description of the aspects that constitute PROCATS.

### **Acknowledging the suicidal patient as a vulnerable and capable person**

A view of the PROCATS as a humanizing encounter also implies that the caregiver needs to be aware of the suicidal patient as a person, who is struggling at the very edge of life, and is thus vulnerable (I, IV). This calls for the caregiver to be open and sensitive to the patient's perspective, not only to avoid increasing the patient's experiences of powerlessness and despair, but also to facilitate a common understanding of what needs to be approached and done. Openness and sensitivity is about acknowledging the uniqueness and otherness of the other (Todres et al., 2014).

Openness and sensitivity also means talking "with" the patient, rather than "to" the patient (I, III, IV). This is understood as contributing to a connection that may reconnect the person not only with others, but with one self as he/she is supported to give voice to oneself and feel free to talk from the heart (I, IV). From the patient's perspective, this way of being seen and listened to can enable a sense of trust, security and vital relief, in relation to strong feelings of loneliness and hopelessness in the suicidal crisis (IV). Considering Fredriksson (2003) and his theory of the caring conversation, it is essential that the caregiver has the ability to be with the patient and stay with the patient, when the patient shares his/her experiences of suffering. Hence, the caregiver

needs to communicate that he/she is available for talking about such issues during the PROCATS (III, IV). This can help the patient to connect to the caregiver without being driven to articulate oneself too fast. If the patient is not allowed to create a sense of genuine trust to the caregiver, it can be difficult for the patient to open up and talk about experiences that are complex and painful, experiences that have possibly never been spoken about before. If the patient experiences it difficult to talk with the caregiver it may lead to the patient withdrawing, so lived experiences of suicidality may not be articulated in the conversation (IV). Thus, the caregiver needs to be with the patient in the present moment, listen with sensitivity, and acknowledge the “person”, so the patient’s experiences of being able to talk from the heart, can be supported and strengthened (I, III, IV). This may mean that the eye contact between the patient and the caregiver, and how the patient experiences the caregiver’s facial-expressions, mood, body-language and/or attention, can be decisive for the patient’s experience of trust in the encounter with the caregiver (IV). These conversation and care processes are of particular importance as experiences of failure and shame are common after a suicide attempt (Wiklander et al., 2003), as well as the stigma of suicide and experience of loss of health resources (Vatne & Nåden, 2014). If caregivers can enable such conversation and care, it can have the potential to strengthen patients’ desire to live (IV).

In conjunction with the reciprocity of the PROCATS “talking with” is not only a matter of talking about the patient’s personal experiences, it is also a joint exploration of what it means to be human (IV). This also implies a challenge that is not only related to the otherness of the patient, but to what could be understood as an openness and sensitivity to the “sameness”, as the issues patients are struggling with are both personal and related to our common humanity.

### **Emphasizing reflective understanding of each individual person and experience**

The PROCATS is not supposed to be used as a step-by-step instruction in the conversation and the care with the patient. Rather, the PROCATS emphasizes reflection and understanding considering the uniqueness of each individual person and experience (III, IV). This may be a challenge for caregivers, but it is described as a challenge that is also experienced as beneficial when the intention is to be genuinely supportive for patients at risk of suicide (IV). However, connecting with the patient does not only facilitate understanding based on the patient’s perspective. It also means being touched by the heart in an encounter with a suffering human being, an encounter that evokes thoughts and feelings (IV). These reactions could be related to experiences of the

patient's lifeworld and seen as distant and hard to understand, but also as being close to human existence. Compassion and a desire to help is described as conflicting with own experiences of self-doubt or even inadequacy (IV). Just as the caregiver needs to support the patient to give voice to his/her experiences and make them subject to further reflections, the caregiver needs to attention and acknowledge his/her own reactions without judging. If not, the caregiver might withdraw from the connection with the patient as a self-protective strategy (Wiklund Gustin, 2017a). Hence, the caregiver not only needs to have the ability to reflect on the uniqueness of the patient, but also on his/her own experiences and reactions.

### **Accounting for the patient's health resources**

With the humanizing encounter as a basis for supporting the suicidal patient's personal recovery and health processes, another aspect of the conversation and care is related to facilitating the patient's narration of lived experiences in the suicidal crisis (I, III, IV). This means that the conversation and care needs to take its point of departure in a language that encourages the patient to feel secure and free to narrate from the heart in the present moment (I, IV). The caregiver needs to listen and communicate with "openness and sensitivity" to the patient's personal language, so the patient can experience himself/herself capable of giving voice to intentions, plans, dreams and fears (III, IV). From the patient's perspective this way of communication together with the caregiver, can hearten the patient for personal recovery, although the dark is present (I, IV). Expression and social space are vital (I, II, IV) and the caregiver needs to have the ability to carefully support the patient's narration through sensitive listening, and the formulation of summarizes and questions (III, IV), in a way that help the patient to feel acknowledged as a unique, suffering and resourceful person (I, IV). In particular, the patient needs support to experience oneself capable of narrating the dark meanings of the lived world, as experienced and expressed in the suicidal crisis (I, II, III, IV). The patient's ability to more deeply and genuinely share the complexity of difficult and painful life-events (I, IV), means that the caregiver needs to be able to be present with the patient through the conversation (III, IV). Here, the ethical opportunity and demand in the conversation and care, is to respond in a comprehensive way, and genuinely acknowledge, encounter and answer the patient's spoken and unspoken questions (III, IV).

However, the PROCATS's emphasizes on the suicidal patient's health resources, does not mean the conversation should be demanding for the patient (III, IV). If the patient for example experiences strong loneliness and hopelessness (IV), it is important that the patient can feel free to experience

what the patient experience and give expressions to these experiences (I, III, IV). The conversation must not be reduced to a hearing or a one-dimensional project of problem solving. Thus, the conversation and care needs to focus on understanding the nuanced meanings of the patient's lifeworld (III, IV), so the patient can feel free to experience and narrate on his/her own terms (I, IV). Accounting for the patient's health resources is vital for supporting the patient's experiences of personal recovery in a suicidal crisis (I, II, III, IV). The opportunity to encounter the patient in this way, and strive to understand the patient as a unique, suffering and resourceful person, is considered a strength of the PROCATS. From the patient's perspective, the opportunity to be seen, listened to and understood as a person, can mean the difference between life and death in strong experiences of hopelessness and loneliness (IV).

However, as indicated above, this care style is also a challenge for the caregiver, as the encounter with the patient who experience strong hopelessness and loneliness and consider suicide as the only way out, means that the caregiver is faced with the complexity of being human and existence (IV). As highlighted by Källerswald (2007) obstacles for conversation with the patient in an existential boundary situation, can be related to the caregivers' experiences of challenges and insecurity considering how to be present and talk about existential questions. Indeed, the guide to the PROCATS needs to acknowledge these challenges and consider the patients', the relatives' and the caregivers' perspectives (I, II, III, IV). Therefore, it is a paramount in care practice and in this research to understand if and how the care supports the patient's plans and dreams in life. This means that the guide to the PROCATS needs to be complemented with further themes and questions, to improve the basis for conversation and care in this context. Thus, the themes should consider lived experiences of the dark meaning nuances of the patient's lifeworld, with emphasize on aspects of "suicidality", "hopelessness", and "loneliness" (IV). In relation to these themes, the suggested questions need to support the caregiver to give support to the patient's narration (III, IV). In order to support patients in elaborating their descriptions, open-ended-follow-up questions need to be included, such as: "Can you tell me more about that?" and "What does this mean for you?" In such ways, the caregiver also can get support to reflect upon his/her understanding, and remain open and sensitive to the patient and his/her experiences and expressions (IV).

It is concluded that even though the findings from study IV indicate that PROCATS has potential as a caring approach, there is a need for further evaluation of the PROCATS in order to develop a deeper and more nuanced

understanding of how the persons at risk of suicide and their' life projects to continue living, can be supported and strengthened.

### **Supporting narration and understanding both the dark and the light life-events**

With the patient's narration as a basis for supporting the patient's personal recovery and health processes, additional aspect of the conversation and care involves to enable the patient the opportunity to further explore lived experiences together with the caregiver (IV). This means that the conversation needs to take its point of departure in the patient's narration in the present moment, where the caregiver invites the patient to calm reflection on important experiences (III, IV). Topics that the patient may experience a special interest and engagement in, such as books, music, culture, nature, physical activity, close relations, relatives, everyday life, and society, may be topics that help the patient to approach issues that the patient really wants to talk about in the suicidal crisis (IV).

Communication based on the patient's personal interests, enables the patient time and space to connect with the caregiver, which provides a bridge to narrate and explore crucial issues in everyday life (IV). Thus, to support the patient's experiences of being able to narrate both dark and light life-events, the conversation needs to be carried out through a meaningful rhythm of movement and stillness (Dahlberg & Segesten, 2010) that helps the patient feel well and comfortable with the caregiver. This includes that "being capable" does not mean to handle or solve everything on your own, rather it is about an experience of being capable to express need of help and/or receive help when hopelessness occurs (IV). Thus, it is important that the caregiver listens with openness and sensitivity and does not judge the patient, and strives to tune in to what the patient narrates and describes, and to understand experiences related to previous suicidality and/or psychiatric care (III, IV). This also means that the patient's narration provides a basis for supporting the patient's experiences of a nurturing rhythm in everyday life during the inpatient care (I, III, IV). Accordingly, the conversation and care need to help the caregiver and the patient understand the patient's life- and recovery situation, and how wellbeing can be facilitated although the dark is present.

### **Recognizing the relative as a unique, suffering and resourceful person**

Enabling conversation and care in the guiding light of the PROCATS, means placing emphasis on the patients' own perspectives in their recovery, health,



ill health, and their life situation and care (IV). This also means that a vital part of personal recovery involves the patient's experiences of being able to reconnect not only with oneself, but also with relatives as important others (I, II, III, IV). Being able to reconnect with oneself in a mutual relationship with relatives, facilitates acknowledging life itself and participation on own terms (I). However, the relationship with relatives can involve the paradox that the patient on one hand wants to protect relatives and/or feels shame and guilt in front of them, and on the other hand also experiences relatives as resourceful and close companions in life (IV). From the relative's perspective, there is a need that the presence of such connecting, facilitates relatives' experiences of being able to acknowledge the relationship with the person as a loved family member (II, IV). This includes that the PROCATS needs to support relatives' experiences of being able to communicate in a mutual connection with professional caregivers (II, IV). Thus, being able to acknowledge the relationship with the loved person is essential for being actively involved in the family member's personal recovery (II).

However, the relationships with the loved person can involve the paradox that the relative on one hand wants to do everything that is possible to help the person at risk of suicide, and on the other hand also experiences the struggle for help as a source of own vulnerability (II, IV). Hence, a personal-recovery-oriented caring approach to suicidality must include accounting for the relative's perspective. Acknowledging the relatives' individual participation processes and needs is necessary, when a patient receives care due to suicidality and wants relatives to participate in the care and/or in the recovery process (III, IV). Accounting for the relatives' perspectives does not only enable relatives to contribute knowledge from their perspectives. Relatives also need support to be able to handle the situation and give support to the suicidal person, and as a support to themselves (II, IV). Thus, the psychiatric mental health nurses are responsible for the quality of the care, and considering that the creation of the care takes place in collaboration with the patient, the relatives, and other caregivers (Swedish Association of Psychiatric and Mental Health Nurses, 2014). Accordingly, acknowledging the patient as a "person" in the guiding light of the PROCATS, encompasses recognizing what impact the relatives' individual experiences, needs and plans have in relation to the patient's process of recovery.

# DISCUSSION

The overall aim of this thesis is to develop, introduce and evaluate a caring intervention, to support suicidal patients' recovery and health, and to support patients' and their relatives' participation in the caring process. The arriving answer to the overall aim is a preliminary guide to a personal-recovery-oriented caring approach to suicidality (PROCATS). This focus on recovery was motivated as previous research (Sun, Long, Boore, & Tsao, 2006) has identified that experiences of powerlessness can constrain caring for suicidal patients. Developing a caring approach, that focuses on recovery as a process, where the patient is supported to experience him/herself capable of handling life itself, and when it is needed, ask for and/or receive support from others, rather than withdraw from others and life, these issues were addressed.

## **Reflections on the findings**

Rather than a specific method, the overall aim of the PROCATS is to support and strengthen suicidal patients' individual recovery and health processes. This research is focused on the contribution of the knowledge needed to enable personal recovery in this context. In the following, the findings will be reflected upon and discussed in relation to previous research.

## **The relational aspect of the PROCATS**

In the personal-recovery-oriented caring approach to suicidality, the relationship between the caregiver, the patient and eventually also the patient's relative(s) has been described as vital. In a wider perspective this could be understood in the light of psychotherapeutic research about what helps in psychotherapy, and the researchers descriptions of what has been called "common factors" (Wampold, 2001). These factors are not related to any specific method, but appear as important for the outcome of psychotherapy. The common factor that appears to have the highest impact on the outcome is the therapeutic relationship (Sandell, 2004). Hence, it is not surprising that the relational aspect underpins the PROCATS. The nurse-

patient relationship is put forth in a similar way by numerous nursing theorists (Alligood, 2017). However, in PROCATS the reciprocity of the relationship is understood not only as a means to promote trust in the caregiver and intervention, or to support the patient's experiences of central nursing values, like respect, autonomy and dignity (Svensk sjuksköterskeförening, 2016). In addition, the "communicative togetherness" is understood as a way of being with the other. This by itself supports recovery by providing an opportunity for the patient to reconnect to important persons and to self.

This communicative togetherness goes beyond the kind of relationship that evolves in traditional care of suicidal patients. Even though the patient might constantly have a caregiver by his/her bedside, these relationships could more be described in terms of "having company" than as "togetherness". At its worst, they might even be seen as being monitored and controlled, rather than being protected from suicidal behaviour (Berg, Rortveit, & Aase, 2017).

The findings in this thesis reveal that the establishment of this kind of caring relationship is related to the caregiver as being open and sensitive, and confirming the patient as a vulnerable yet capable person. Furthermore, the reciprocity in the relationship also means that the evolving, joint understanding of the patient's experiences evokes thoughts and feelings in the caregiver. Some of these feelings could be related to compassion, while others are more related to the caregiver's personal experiences of short-comings. This is similar to Fredriksson's (2003) description of the relational aspect of the caring conversation as related to presence, touch and listening. Just as in the caring conversation, the PROCATS is dependent on the caregiver being present as a person in the encounter with the patient, rather than taking part as a formal role. This means also that the relation between the caregiver and the patient is characterized by connection, rather than as a formal contact, which is essential for the dialogue and conversation as caring. The relational approach, as it is understood with basis in the findings in this thesis, is thus a personal approach with roots in an ethic and ontology, and not an approach on a technological level.

### **The narrative as a path to manage problems in living although the dark is present**

The findings in this thesis also contribute with nuances to the description of the caring conversation (Fredriksson, 2003), where the overall aim is to relieve suffering, with emphasis on meaning creation through narration. This author highlights that the relation and the creation of the patient's narrative of suffering means a new possibility for the patient to be grounded in oneself and the world. This also means that the patient's expression of experiences through

words, enables the patient to turn these experiences into personal experiences, and thereby also approach oneself. Furthermore, by exploring the patient's narrative of suffering and relating it to the patient's narrative of life, it might become possible to ascribe both "meaning in" and "meaning with" suffering. Thus, also to reconcile with suffering (Fredriksson, 2003). In this thesis, the overall aim of the conversation and care, as described in the guide to the PROCATS (Appendix 1), is to support and strengthen suicidal patients' recovery and health processes. This means that the patient's narrative of suffering is understood as a path to bear hopelessness, and when it is needed, ask for and/or receive help instead of withdraw from others and life. Thus, strong loneliness and hopelessness as experienced by the patient at risk of suicide may not be reduced by the PROCATS. In contrast to Fredriksson's (2003) focus on the caring conversation and reconciliation with suffering, this indicates that the suicidal patient's experience of personal recovery is not dependent on the patient being able to reconcile with suffering. Rather it appears as the patient being able to endure his/her suffering, as the PROCATS may support the patient's experience of being able to manage problems in living, although the dark is present. The findings correspond to Berglund, Nässén, Hedén, and Gillsjö (2016) description of reflective STRENGTH-giving dialogues, where the conversation is considered to help the patient to shift focus from what is not possible to change, and instead focus on and acknowledge what is possible to do and influence in the situation. In line with the findings in this thesis, as well as research on reflective STRENGTH-giving dialogues (Berglund & Gillsjö, 2017), the view of learning is based on lifeworld theory where learning is acknowledged as a development of understanding, thoughts, feelings and actions. This also means that the view of conversation emphasizes the patient's narrative as a basis for reflection upon experiences, where the whole body (Merleau-Ponty, 2013/1945) is involved in the patient's understanding process and experiences of being able to manage the situation.

### **Facilitating the patient's experiences of being understood and thereby participate in the world with others**

The findings in this thesis also add nuances to the manual Attempted Suicide Short Intervention Program, ASSIP (Gysin-Maillart, Schwab, Soravia, Megert, & Michel, 2016). These authors point out the necessity of listening sensitively to the suicidal patient's narrative, in order to meet the patient in the right way. In this thesis, conversation based on the patient's narrative is understood to involve an expressive and social space, where the togetherness between the patient and the caregiver imply to be vital for the patient's

experience of belonging in everyday life. Thus, the PROCATS has not only the potential to enable the suicidal patient to have a humanizing relationship, but also offers a context of meaning for the patient as an individual. This includes that the patient's narrative facilitates understanding what the patient is saying in the specific situation, and supporting the patient's experience of togetherness in care, in relation to acute loneliness and hopelessness. This is also about to acknowledge the vulnerability of the patient as a human being in an existential boundary situation (Rehnsfeldt, 1999). Accordingly, if caregivers can recognize an encounter the patient's narrative in this way, it can have the potential to facilitate the patient's experience of being understood and thereby participate in the world with others.

### **Recognizing both the dark and the light meaning nuances of the patient's lifeworld**

Based on the findings in this thesis, and in line with the contributions of Barker and Buchanan-Barker (2005), conversation and caring with the patient at risk of suicide needs to be understood as an opportunity and responsibility by the caregiver to create a personal security plan in partnership with the patient. However, the guide to the PROCATS also highlights that this emphasize on the patient's health resources, needs to enable a deeper understanding of the dark of the suicidal patient's lifeworld. This also means that the patient needs support to experience what the patient experiences, and feel free to express these experiences. If the emphasis on the patient's health resources lacks openness and sensitivity to the patient's lifeworld (Hörberg, 2017), and does not acknowledge the patient's suffering in the suicidal crisis, the caring potential in the conversation is reduced. Thus, it is vital that the caregiver recognize and understand both the dark and the light meanings of the patient's lifeworld. This includes that the caregiver needs to acknowledge and respond to the patient's unique and lived experiences of suicidality and life, in the co-creation of the patient's personal recovery and care.

### **The ethics of the PROCATS**

With the given insights above as a background, and being based on a caring science perspective, it is concluded that being a caregiver, needs to involve a comprehensive and genuine presence in the encounter with the patient at risk of suicide. This can be described as the caregiver needing to acknowledge a self-understanding of personal place in the world, as derived from a way of being and approaching oneself and the world. Merleau-Ponty's (1968/1964, 2013/1945) notion of the human being as a lived body, highlights that this way

of being in a “personal style”, can be understood as the caregiver as a human being recognizing his/her own way of being in the world. In this thesis, this is understood as the caregiver recognizing a way of participating in the conversation with the patient at risk of suicide. This personal style, which is embodied by the caregiver’s presence in the encounter with the patient, is understood to be vital for acknowledging the uniqueness of each patient and experience (Danielsson, 2017). Thus, it is of great importance that the caregiver is open and sensitive to the patient’s “being” in the mutual connectedness with the patient (Dahlberg & Segesten, 2010; Dahlberg, 2013; Merleau-Ponty, 1968/1964). This includes that the caregiver attention the patient’s personal narrative, as well as his/her unique needs, rather than using the PROCATS as a “check-list” for “what to do”.

The given insight into the PROCATS signifies that relationality is essential and involves a certain intimacy in the encounter with the patient. This intimacy can be understood in the light of Carlsson’s (2003) description of the “naked caring” which means a present caring in an existential boundary situation. This present caring also means that the caregiver’s way of being and acting is a caring potential, when the caregiver is able to be authentic and reach the patient as a person, and simultaneously is able to be touched by the patient in the encounter. Accordingly, the guide to the PROCATS needs to be understood and applied in a way that is effective due to evidence from both the patient’s and caregiver’s perspectives, including the ethics of the lived world and existential and social contexts (van Wijngaarden et al., 2017). With these insights as a background, it is concluded that guidelines to conversation and care with patients at risk of suicide need to help caregivers by clarifying what this level of care style means, and how it can be embodied and applied in care practice. This includes that the nurses need meaningful support and education in their work (Swedish Association of Psychiatric and Mental Health Nurses, 2014; Talseth & Gilje, 2011; Titelman & Wasserman, 2009), to be able to provide meaningful care in relation to the unique needs of each individual person, sharing his/her world with others.

## **Methodological considerations**

Reflection upon the methodological aspects of the research process in this thesis will be carried out with focus on the overall design. This means that the common ontology and epistemology that has served the methodological process will be highlighted on the way to conclusions. Reflection upon particular methodological aspects related to each study can be obtained in the articles and in the manuscripts.

The overall design of this thesis is based on an ontology and epistemology found in lifeworld theory (Dahlberg et al., 2008). This foundation allowed a common ground in the transforming of the philosophy into research practice in this thesis. The concern for emphasizing a common ground of lifeworld theory, is related to the complexity of the phenomenon in focus, and the question of how an open and scientific attitude to the phenomenon can be maintained through the whole research process. This research approach provided a way of relevance to the ambition to answer complex research questions with focus upon human existence.

Phenomenological philosophy has been criticized for providing an approach to research where the methodological flexibility tends to generate results that are not valued as scientific evidence. Although debates concerning the scientific value of the research are important, it can be problematic if these debates are related to positivistic quantitative approaches and criteria as model for qualitative research. Although there is a challenge to understand different traditions and nuances within the phenomenological field (van Manen, 2017a, 2017b), it is important in this thesis that the ontological and epistemological foundation in phenomenology has served the researcher's ambition for evidence in terms of validity. Here, validity is for example a question of the researcher being aware of the difference between content and meaning in a narrative, in order to be able to understand the deeper meanings of lived experiences (Dahlberg et al., 2008).

The opportunity of adopting a phenomenological attitude of openness to the complexity of the phenomenon (i.e. recovery in a suicidal crisis), has contributed throughout the whole research process. This phenomenological attitude enabled the freedom to "bridle" the researcher's understanding through the different methodological approaches (I, II, III, IV). From this common ground, it was possible to first listen carefully to the voices of the participants, and strive to articulate these insights through description of a meaning structure, and use this as foundation in the movement toward answering the research aim. It is of great importance that human science researchers find out ways of being open and sensitive to the studied phenomenon, with regard to the meanings that are embedded in the "the flesh of the world" (Dahlberg et al., 2008). This includes the researcher's awareness that the studied phenomenon involves a world that the researcher is already a part of, a being that encompasses lived experiences and new experiences in the "here and now" (Dahlberg, 2013). This also means that the researcher's adoption of a phenomenological attitude has helped to maintain an ongoing process of problematizing own pre-understanding, to slacken the intentional threads that tie the researcher as a human being to the world (Merleau-Ponty,

2013/1945; van Wijngaarden et al., 2017). This reflective approach requires a self-reflection and the intention to restraining one's pre-understanding, to not letting previous experiences hinder an open attitude in the process of understanding that which shows itself. I (LS) have experienced it very interesting and important to learn about the process of bridling through reading theoretical literature regarding these methodological principles (Dahlberg et al., 2008), but above all I have strived to develop a reflective ability through being in and experiencing this approach. During this process, I experience that my attention "here and now" and integration of lifeworld theory, has facilitated to maintain a reflective and bridling approach that is needed in this research. In the beginning of this process, during work with data analysis, I was concerned about restraining my pre-understanding by staying close to data, and being careful with my creativity and ideas to avoid making definite what is indefinite. As the work proceeded in this process, I also trained my creativity, and experienced it more as an important resource in the research and in relation to my intention of being present and maintain an open attitude. This learning process also means that I experienced enhanced awareness of the difference between including theory as an external source of data in the analysis and using theory as a spotlight to illuminate those aspects of the phenomenon that remain dark after the first part of the analysis. Furthermore, this reflective approach does not emphasize overcoming subjectivity, rather it enables the researcher to make a movement between a subjective experience in relation to the background of the objective and intersubjective shared world. Here, objectivity is a question of bridling the researcher's understanding as a whole through the different activities in the research process, and striving to remain open to evolving understandings and own interpretations, and see the phenomenon as it shows itself (Dahlberg et al., 2008).

This approach based on phenomenology is considered to have an important ethical value in this research considering vulnerable individuals as persons at risk of suicide. Therefore, instead of being limited by the challenge to adopt a phenomenological attitude through the different methodological approaches, the opportunity to bridle and examine the researcher's understanding, is considered to be a strength. This means that the lifeworld perspective that has served the methodological process, has not only supported the researcher's openness and sensitivity to the phenomenon throughout the research, it is also considered to have an ethical value (Dahlberg et al., 2008) when conducting this research with vulnerable individuals (Liamputtong, 2007), such as the patients and relatives.

Moreover, the question of essences, which relates to both particular meanings, including lived contextual nuances, and to the more essential,



abstract or general meanings, enabled meanings of the phenomenon to be seen. This helped reveal and articulate more clearly the black meanings related to aspects of loneliness and hopelessness of the phenomenon. Although the phenomenon (i.e., recovery in a suicidal crisis) is indeed intertwined with meanings of health and wellbeing, the understanding of recovery in this thesis includes aspects of vulnerability and darkness in suicidal persons' lifeworlds. This also encompasses that the understanding of recovery does not exclude mental illness or suffering, but the person needs to be able to encounter and deal with mental illness or other kinds of illness, as a way of facilitating experiences of personal recovery. Therefore, it is considered that it could have been an alternative to use reflective lifeworld research (Dahlberg et al., 2008) as an approach through all the studies in this thesis. The opportunity to carry out the research in such way may have enabled lifeworld theory, which is the basic ontological foundation in this thesis, to cast stronger light on existential and contextual aspects in the understanding of the complexity of the phenomenon.

However, with regards to the aim of the thesis as well as the complexity of the phenomenon in focus, some other methodologies were included into the design. Therefore a Delphi study (III) as well as a single case study with QUAL>quan mixed methods research approach (IV) were used to account for the complexity and diversity relating to human experience. Thus, having an open approach to methodological principles has enabled the application different methods for comprehensively exploring aspects of the phenomenon. Furthermore, this research approach has also supported the researcher's understanding of contextual aspects and process in the intervention (IV) in the clinical setting (Andrew & Halcomb, 2009).

Another issue of importance is related to generalization of the findings, or transferability, which is a concept used in qualitative research (Dahlberg et al., 2008) in order to address the possibility to apply the research findings in other contexts. It is important to bear in mind that the guide to PROCATS (Appendix 1) is preliminary, and need to be further evaluated before launching in a wider context. Another aspect of transferability is related to possible differences between the local, the national and the global context. Even though this thesis is conducted in Sweden, previous research from an international perspective (Gysin-Maillart et al., 2016), indicates that the phenomenon in focus (i.e., recovery in a suicidal crisis) is a human phenomenon. Thus, the lifeworld perspective with its focus on suicidal persons' struggle with life is supposed to be relevant also in other contexts than the local or national, even though some adjustments might be necessary in order to the organization of care that might differ between different hospitals as well as different context.

As the PROCATS focuses on issues that need to be addressed during the caring process, rather than dictating “how” to do it, it is probably possible to account for the core aspects of the caring approach in other settings.

# **FUTURE RESEARCH AND CLINICAL IMPLICATIONS**

The overall aim of this thesis is to develop, introduce and evaluate a caring intervention, to support suicidal patients' recovery and health, and to support patients' and their relatives' participation in the caring process. The synthesized findings in this thesis contribute to knowledge about a description of a personal-recovery-oriented caring approach to suicidality (PROCATS). The overall aim of the developed caring approach, PROCATS, is to support and strengthen suicidal patients' recovery and health processes, even at the very edge of life.

Although the findings indicate that PROCATS has potential to support suicidal patients' recovery as well as support their relatives' participation, there is a need for further evaluation of the PROCATS. This knowledge could enable a deeper and more nuanced understanding of the phenomenon (i.e. recovery in a suicidal crisis), and the potential of its characteristic "communicative togetherness". Furthermore, such evaluation need to include larger scaled studies that focus on the impact on suicidal patients' recovery and health processes, before launching and implementing PROCATS outside a research context. As experiences of recovery in a suicidal crisis may involve aspects of importance between different ages, gender and cultural backgrounds, it would be of importance to account for this in an evaluation of the PROCATS with larger groups. This would also strengthen the relevance of a personal-recovery-oriented caring approach to suicidality in an international perspective.

Considering that mental health nurses are key persons in enabling support for suicidal patients' personal recovery, further research considering mental health nurses' experiences of the PROCATS would be highly warranted. The six core aspects of the PROCATS highlight the meanings of a personal-recovery-oriented caring approach to suicidality, as a natural basis for more differentiated studies.

Even though the PROCATS is preliminary, and there is a need for further research, it is important to reflect on opportunities and challenges associated with clinical implementation of this caring approach. To enable PROCATS in practice, caregivers need to gain knowledge of its core aspects. These aspects

comprise PROCATS as “a humanizing encounter”, “acknowledging the suicidal patient as a vulnerable and capable person”, “emphasizing reflective understanding of each individual person and experience”, “accounting for the patient’s health resources”, “supporting narration and understanding both the dark and the light life-events”, “recognizing the relative as a unique, suffering and resourceful person”.

In order to develop such a caring approach, there is a need for reflective understanding of both the patient and self (Andersson, 2015; Hörberg, Ozolins, & Ekebergh, 2011). Thus, applying PROCATS as a caring approach and a value basis indicates the need of supervision as described by Ekebergh (2011), where the caregivers are given support through didactic strategies as a way for implementing a reflective approach and understanding of the patient’s world in the care. Such reflections could also support the caregivers’ self-compassion, which is considered important as encountering the other’s suffering and suicidality can be both challenging and demanding. As highlighted by Wiklund Gustin (2017b), the caregiver’s ability to bear the feelings evoked when encountering the other’s suffering, and bear that which is not always possible to understand, is facilitated if the caregivers are able to take care of their own reactions through self-compassion rather than self-judging. When applying PROCATS it is as important as in other contexts where the caregivers come in close contacts with the suffering of others, to support caregivers’ self-compassion as this can enable caregivers to be present and open for the other’s narrative, and in the encounter with the patient’s narration also understand more of what it means to be a human.

Emphasizing understanding of the suicidal patient as a person in this way, provides not only a basis for the patients’ and their relatives’ health and welfare as unique individuals. It also implies that person-centred care (Dahlberg & Ekman, 2017; Ekman, 2014) of patients at risk of suicide, needs to account for an understanding of the patients’ and their relatives’ lifeworlds, including existential and social contexts (Dahlberg, Todres, & Galvin, 2009). Thus, PROCATS has the potential to contribute to form a basis for methods, that are underpinned by an approach and an ethic where the patient is not only seen as diagnosis or processes of illness, but rather as a person in a living context with other humans and the world (Todres et al., 2007). In this thesis, this is understood to be important when the intention is to provide genuinely support for the patients to account for their resources, understandings and vitality, in order to strengthen their recovery and health processes, and facilitate their experiences of balance in life, despite illness and the dark. In addition, the ethical aspect of the PROCATS, helps the caregiver to understand the patients at risk of suicide as both vulnerable and capable, and

with emphasis on the existential vulnerability. This also means an approach and a value basis that opens up for acknowledging the patient as an expert on self and his/her recovery and life-situation. This may not only contribute to the patient's experiences of trust and security in the caring relationship with the caregiver, it may also have implications on organizational and societal levels.

On an organizational level, the application of this knowledge in practice needs to be anchored and supported not only by the professionals concerned, but also on different levels in the organization to establish a profound foundation for the patients' and the caregivers' co-creation of the patient's personal recovery and care. Without organizational support there is a risk that the person-centeredness in this caring approach is jeopardized if confronted with other perspectives (Moberg, 2017). On a societal level, the PROCATS corresponds to the preventative work that is carried out globally (World Health Organization, 2014). Supporting people's recovery and participation in care is in line with the roots of the recovery-movement (Karlsson & Borg, 2017) as a means to support engagement in one's own life and inclusion in society. Hence, a personal-recovery-oriented caring approach to suicidality is valuable in relation to health and welfare not only by addressing suicidality as a major health problem in today's society, but also by supporting and strengthening the persons afflicted by it.

# SVENSK SAMMANFATTNING

Personer drabbade av suicidalitet är i en sårbar situation och kämpar med utmaningar relaterade till såväl liv och död som upplevelser av hopplöshet och maktlöshet. Att brottas med allvarliga självmordstankar kan även innebära att personen upplever sig som en börda för närstående. Närståendes kamp för att hjälpa sin anhörige kan innebära att närstående tar ansvar för sådant som är utanför deras kontroll. Trots detta är det sparsamt med forskning om hur suicidala personer och deras närstående kan stödjas när personen vårdas inom den psykiatriska heldygnsvården. Denna avhandling baseras på ett perspektiv om återhämtning som en process, där personerna upplever sig som kapabla att hantera både utmaningar och möjligheter i livet och införliva mening i det. Därför är det angeläget att beakta den suicidala patientens livsvärld som en utgångspunkt för patientens personliga återhämtning.

Det övergripande syftet med denna avhandling är att utveckla, introducera och utvärdera en omvårdnadsintervention, för att stödja suicidala patienters återhämtning och hälsa, samt stödja patienters och deras närståendes delaktighet i vården.

Med beaktande av komplexiteten av en sådan omvårdnadsintervention, och vikten av att uppmärksamma mångfaldiga aspekter av fenomenet återhämtning i en suicidal kris, har denna forskning genomförts ur ett livsvärldsperspektiv med fenomenologisk filosofi som grund. Reflekterande livsvärldsforskning (RLR) har tillämpats som forskningsansats för att beskriva fenomenet återhämtning i ett omvårdnadssammanhang, så som det upplevs av personer med risk för självmord (I). RLR har också tillämpats för att beskriva fenomenet delaktighet, så som det upplevs av närstående till personer som vårdas med risk för självmord (II). På basen av dessa två studier var syftet att beskriva vad som kännetecknar en återhämtnings-orienterad omvårdnadsintervention, och hur det kan uttryckas i vårdande som involverar suicidala patienter och deras närstående (III). Delphi metodologi tillämpades för att utveckla en sådan intervention i samarbete med erfarenhetsbaserade experter som deltagare. Resultatet belyser att en återhämtnings-orienterad omvårdnadsintervention kännetecknas av "kommunikativ gemenskap". Denna kommunikativa gemenskap innebär att sjuksköterskan och patienten tillsammans utforskar hur patientens återhämtning kan stödjas, och utgör en

väg för patienten att återerövra en känsla av att vara kapabel att hantera livsproblem och införliva mening i sitt liv. En slutsats var också att det är mer lämpligt att beakta detta som en vårdande hållning, snarare än att beskriva det som en specifik omvårdnadsintervention. Resultatet omfattar en preliminär guide till en återhämtnings-orienterad vårdande hållning. I den fjärde studien var syftet att utforska och utvärdera hur den preliminära återhämtnings-orienterade vårdande hållningen upplevdes av en suicidal patient i sammanhang med närstående och sjuksköterskor (IV). En single case studie genomfördes med KVAL>kvant ”mixed methods” som forskningsansats. Resultatet visade att den återhämtnings-orienterade vårdande hållningen stöttade patienten i att återanknyta till sig själv och betydelsefulla andra, och stärkte honom i utmaningen med hans livsproblem. Det löste inte livsproblemen eller tog bort upplevelserna av hopplöshet, men det hjälpte honom att hantera dem på ett annat sätt. Resultatet indikerar också att guiden till den återhämtnings-orienterade vårdande hållningen behöver utvecklas med fokus på svårigheter relaterade till upplevelser av hopplöshet.

I syntesen av resultaten från delstudierna (I, II, III, IV) växte en ny förståelse fram för den vårdande hållningen, och gav upphov till namnet ”en personlig-återhämtnings-orienterad vårdande hållning till suicidalitet” (a personal-recovery-oriented caring approach to suicidality, PROCATS). Beskrivningen av resultatet omfattar sex kärnaspekter av PROCATS: ”ett personcentrerat möte med utgångspunkt i patientens livsvärld”, ”bekräftande av den suicidala patienten som en sårbar och kapabel person”, ”tillägnande av reflekterad förståelse för varje individuell person och erfarenhet”, ”tillvaratagande av patientens hälsoresurser”, ”stöd till berättande och förståelse av både de mörka och de ljusa livserfarenheterna”, och ”beaktande av den närstående som en unik, lidande och resursrik person”. Det övergripande syftet med PROCATS är att stödja suicidal patienters återhämtnings- och hälsprocesser, även i svåra existentiella gränssituationer. Samtidigt som resultatet indikerar att PROCATS har potential att främja såväl suicidal patienters återhämtning som deras närståendes delaktighet, finns det behov av ytterligare utvärdering av PROCATS i ett vidare sammanhang.

**Nyckelord:** Delaktighet; fenomenologi; hermeneutik; livsvärld; patientens perspektiv; personcentrerad vård; psykiatrisk omvårdnad; reflekterad förståelse; reflekterande livsvärldsforskning; närståendes perspektiv; samtal; suicidalitet; suicidprevention; återhämtning

# TACK

Att bedriva forskarstudier och skriva en doktorsavhandling har för mig varit en berikande tid som inneburit både möjligheter och utmaningar. Att så här i slutskedet reflektera över avhandlingsarbetet synliggör en mängd dialoger och samarbeten med andra människor. Det är tydligt att denna avhandling inte hade varit möjlig utan de människor som på olika sätt har hjälpt och stöttat mig. Jag är djupt tacksam för ert frikostiga givande.

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# APPENDIX



## Appendix 1

# **PROCATS**

- En vägledning till samtal med suicidnära personer
- **PRELIMINÄR VERSION**

## INLEDNING

Det övergripande syftet med PROCATS är att främja patienters återhämtnings- och hälsoprocesser i en suicidal kris. Intentionen med denna guide är att stödja dialogen mellan patient och sjuksköterska, som steg på vägen för att främja såväl patienters återhämtning som deras närståendes delaktighet. Frågorna i högra kanten av guiden är förslag som kan användas som stöd i dialogen med patienten. Det innebär inte att alla frågor behöver ställas, och inte heller att de behöver ställas i en viss ordningsföljd. Däremot kan det vara viktigt att också följa upp patientens svar genom att uppmuntra personen; ”Berätta mer”, ”Vad hände?”, ”Hur tänkte/kände du då?” och/eller ”Så här i efterhand, hur ser du på det som hände?” samt ”Vilken betydelse har det för hur du ser på situationen idag?”, är exempel på frågor och kommentarer som kan stödja personens berättelse och det gemensamma utforskande. Några sådana förslag finns i frågespalten, men infoga gärna fler så att dialogen kan utvecklas och fördjupas.

Bekräfta också patientens känslor när han/hon delger något, t ex ”Om man, som du ju berättar om (inte ser någon utväg/tänker att man är maktlös/något annat personen berättar om i sin förståelse av situationen), är det inte konstigt att du känt dig nedstämd/maktlös/ensam (eller vilken känsla/upplevelse personen berättat om). Minst lika väsentligt är det att bekräfta det personen gjort som är betydelsefullt, t ex ”så när du tog kontakt med X/gjord Y, så kändes det lite bättre”. Däremot bör man undvika generella komplimanger och påpekanden som personen inte kan ta till sig, t ex att man säger att ”du har ju mycket att leva för” om detta inte är en bekräftelse på att personen själv påpekat det.

Koppla således ihop alla bekräftelser med det patienten berättar för att uppmärksamma styrkor, och undvik generella uttalanden som inte är kopplade till något specifikt. Var lyhörd för om patienten verkar trött eller besvärad, fråga om det är OK att gå vidare och erbjud en paus om det behövs. Utgångspunkten är att eftersträva en dialog som är följsam till var patienten befinner sig ”här och nu”, och välja frågor utifrån det, snarare än att använda guiden som en checklista. Med denna följsamhet i åtanke kan emellertid materialet användas som underlag för vårdplanering, även om syftet primärt inte är datainsamling och planering, utan att underlätta det gemensamma utforskandet och meningsskapandet. De inledande sidorna är lämpliga att utgå från i det första samtalet, medan man i senare samtal kan börja direkt på sidan 6. Var transparent. Låt patienten se det som skrivs (och gärna formulera/skriva själv om han/hon så önskar). Ge patienten en kopia efteråt.

<b>Namn:</b>	
Samtalande ssk:	
Datum:	Tid:
<b>Övriga kontaktpersoner:</b>	
<b>Mina tankar om att vara här just nu:</b>	

## Samtal för återhämtning

Erbjud det första samtalet så snart som möjligt efter att personen kommit till avdelningen. Skapa sedan utrymme för spontana och planerade samtal genom hela vårdtiden.

Presentera dig själv och förklara syftet med samtalet, dvs. ett första samtal om patientens situation och behov just nu.

Informera personen om vem/vilka som är kontaktperson/-er och att han/hon kommer att ha möjlighet att också prata med andra än dig när du inte är i tjänst.

Fråga som en inledning till samtalet, om personens tankar om hur det är att vara här just nu, och hur det kommer sig att han/hon är här.



<b>Vad jag ser som viktigt att prata om just nu:</b>
<b>Vad jag tänker har bidragit till min nuvarande situation:</b>
<b>Liknande situation(er) som jag varit med om:</b>
<b>Vad som hjälpt mig att klara svårigheter tidigare:</b>
<b>Hur jag tänker att det som har hjälpt mig tidigare kan användas nu:</b>

## Samtal för återhämtning

**Ge personen utrymme att uttrycka och berätta vad som är angeläget i situationen:** "Vad är angeläget för dig att prata om just nu? Vad innebär det för dig? Vilka svårigheter/ problem skapar det i ditt liv? Berätta! ? Vad tänker/känner du kring det? Ta vara på det som är viktigt. När ni pratat om det/ om personen exempelvis svarar "vet inte", på frågan om vad som är angeläget att prata om just nu, fråga:"...är det OK att vi pratar om bakgrunden till att du kommit hit och hur din livssituation ser ut?"

**Skäl till nuvarande situation:** "Vad tänker du har bidragit till den nuvarande situationen?" Utforska patientens tankar hur han/hon tänker att det hänger ihop.

**Tidigare erfarenheter:** "Hur har det varit tidigare i livet?" "Har du varit i en liknande situation förr? Vad tänkte du då? Hur kände du dig? Vad tänkte du om dina möjligheter att påverka situationen? Hade du tankar på att du lika gärna kunde ge upp? Berätta mer! Vad innebär det för dig? Vad tänker/känner du kring det?"

**Vad som har varit hjälpsamt i tidigare erfarenheter:** "...och vad hjälpte dig att ta dig igenom dessa situationer? Vad gjorde du? Vad gjorde andra?"

**Tillvaratagande av tidigare erfarenheter/lärdomar:** "Har du tankar om hur det du varit med om kan användas i situationen som är nu?"

<p><b>Hur jag ser på mina relationer till andra människor (just nu):</b></p>
<p><b>Människor som är viktiga för mig:</b></p>
<p><b>Hur jag ser på mina närståendes delaktighet:</b></p>
<p><b>Hur jag ser på relationen till närstående:</b></p>

## Samtal för återhämtning

**Be om tillåtelse att fortsätta** och introducera att det kommer några frågor om personens närstående.

**Påverkan på relationer:** "...och hur har det här påverkat dina relationer med andra människor? Vad innebär det för dig? Vill du berätta mer om det?"

**Människor som är viktiga:**  
 "Vem/vilka är viktiga i ditt liv – familj, släkt, vänner, arbetskamrater, grupper med människor, andra?"

**Närståendes delaktighet:** "Har du närstående som du önskar skall vara delaktiga?" Om personen vill att närstående skall vara delaktiga, fråga vilka närstående som personen vill bjuda in, och på vilket sätt personen vill att närstående skall vara delaktiga.

**Relationen till närstående:** Om personen vill/inte vill att närstående skall vara delaktiga, erbjud personen att prata om relationen till närstående.

Sådant som är viktigt i mitt liv:

Idéer eller tankar om livet som är viktiga för mig:

## Samtal för återhämtning

### Tillvaratagande av personliga

**resurser:** Be personen att beskriva personliga resurser som kan bidra till att livet känns mer hanterbart och meningsfullt.

### Vad har varit viktigt för dig i ditt

**liv** – t.ex. i intressen, saker som du uppskattar eller ditt hem? Hur stort är ditt intresse för dessa saker nu? Om intresse finns, reflektera med patienten över möjligheter att nära intresset. Om patienten tappat intresset, fråga om vad som skulle kunna göra att det blev intressant igen.

### Vilka tankar och värderingar

om livet är viktiga för dig i allmänhet, t ex gällande tro eller personlig filosofi? Vad innebär det för dig? Vill du berätta mer om det? Har det alltid sett ut på det här sättet? Om personen svarar nej, följ upp: Vad har förändrats? På vilket sätt? Vad tänker du att den förändringen beror på?

Vad är viktigast just nu?

<b>Vad jag ser som viktigt att prata om just nu:</b>
<b>Hur jag haft det sen vi talades vid sist:</b>
<b>Hur den här dagen varit:</b>
<b>Vad tänker jag har varit bra/Vad tänker jag inte har varit bra:</b>
<b>Hur jag kan dra nytta av dessa erfarenheter:</b>
<b>Vad jag kämpar med just nu:</b>
<b>Vad jag tänker behöver förändras för att det skall bli bättre:</b>

## Samtal för återhämtning

**Om detta görs i samband med tidigare frågor** – gå direkt på dagen som varit.

**Om detta inte är det första samtalet, utan du börjar samtalet här inleder du med att höra dig för om patientens behov av samtal just nu, t ex genom att fråga:**

**Vad är viktigt att tala om just nu?** Se även inledande frågor på sidan 3. Om patienten säger t ex "vet inte" gå direkt på frågan om hur personen haft det sen sist, t ex "Innan vi går vidare vill jag gärna veta hur du haft det sen vi talades vid sist".

**Dagen som har varit:** "Hur har den här dagen varit för dig?"

**Om dagen har varit bra:** Fråga vad som varit bra, och vad det var som bidrog till det.

**Om dagen inte har varit bra:** "På vilket sätt har dagen inte varit bra? Berätta mer. Vad innebär det för dig?"

**Hur kan erfarenheterna användas framåt** "Hur kan du/vi dra nytta av (summera det centrala i det som sagts om dagen/sen sist) när vi planerar för resten av dagen/ i morgon?"

**Vad patienten kämpar med i sitt liv** "Om vi inte bara tittar på hur dagen varit här på avdelningen, utan på hur du har det. Vad kämpar du med just nu?" "Vad innebär det för dig? Vill du berätta mer om det?"

**Vad behöver förändras** för att den kampen skall bli mindre tung/mindre svår?

<p>Hur vet jag när saker och ting har förändrats till det bättre:</p>
<p>Vad jag behöver/vill ska hända nu:</p>
<p>Vad jag tänker att jag själv kan göra (för att få livskraften tillbaka, tex bidra till att lösa problem eller tillgodose behov):</p>
<p>Vad jag tänker att andra kan göra:</p>
<p>Vad jag förväntar mig att sjuksköterskan ska göra:</p>

## Samtal för återhämtning

**Förändring till det bättre:** Be personen berätta hur han/hon vet när problemet har blivit löst eller när behovet har blivit tillgodosett. "...och kan du mig ett exempel på hur saker och ting skulle vara annorlunda då?"

**Behov, begär, önsningar och förväntningar:** "...och vad behöver/önskar du skall hända nu för att du skall må bättre?" Ge personen utrymme att uttrycka och berätta. Ta hjälp av uppföljningsfrågorna på sidan 1, och andra frågor som faller sig naturligt.

**Egna handlingar:** "Utifrån det ...vad tänker du att du kan göra för att bidra till det? Just nu? På lite längre sikt?"

**Stöd från andra:** "Vad tänker du att andra kan göra för att bidra till det? Den närmaste tiden? På lite längre sikt? Hur kan du be dem om hjälp med det?"

**Stöd från samtalande sjuksköterska:** "Vad tänker du att jag kan göra för att bidra till det här?"

<b>Hur jag ser på samtalet:</b>	
<b>Vad jag speciellt tar med mig från samtalet:</b>	
<b>Vad jag önskar att sjuksköterskan följer upp till/under nästa samtal:</b>	
<b>Datum för kommande samtal:</b>	<b>Tid:</b>

## Samtal för återhämtning

**Fråga om samtalet:** "Hur känns det nu i samtalet som vi har? Är det något du funderar över? Är det någon mer fråga, och/eller annat som du vill prata om? Är det något jag kunde gjort annorlunda för att samtalet skall bli så bra som möjligt för dig?"

**Behållningen av samtalet:**  
Vad tycker du har varit speciellt betydelsefullt av det vi talat om idag?

**Avrunda och summera samtalet,** med dokumentation om vägen vidare för fortsatt vårdande, tillsammans med personen.

Utifrån det vi talat om idag, är det redan nu något du tänker att jag behöver förbereda inför nästa samtal?

**Boka tid för nästa samtal** i överenskommelse med personen. Gör också personen uppmärksam på möjligheten att kontakta vårdare för spontana samtal om det behövs innan nästa planerade samtal.