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## Enduring personality changes in patients living at home and challenges for community nursing

Trajne osebnostne spremembe pri pacientih v domačem okolju in izzivi za patronažno zdravstveno nego

Bernardka Maček, Mojca Zvezdana Dernovšek, Radojka Kobentar

**Key words:** personality changes; traumatic experiences; patient; community nursing

**Ključne besede:** osebnostne spremembe; travmatične izkušnje; pacient; patronažno zdravstvena nega

Bernardka Maček, MSc, RN; Community Health Centre Ljubljana – Vič, Community Nursing, Šestova ul. 10, 1000 Ljubljana,

Correspondence e-mail/  
Kontaktne e-naslov:  
bernarda.macek@gmail.com

Professor Mojca Zvezdana Dernovšek, PhD, MD; University Psychiatric Hospital Ljubljana, Studenec 48, 1260 Ljubljana

Assistant Professor Radojka Kobentar, PhD, MSc, BSc, prof. defect., RN; Faculty of Health Care Jesenice, Spodnji Plavž 3, 4270 Jesenice

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### ABSTRACT

**Introduction:** Personality and behaviour disorders include enduring personality changes which cannot be attributed to brain injury or disease. Traumatic experiences can cause personality vulnerability. The research aimed to determine the characteristic enduring personality changes, the risk factors and the quality of life of patients living in their home environment.

**Methods:** The field research is based on a quantitative method. The data were gathered through a structured questionnaire. The sample consisted  $n = 606$  of patients (18.56 %) from the Central Slovenia region, aged between 20 and 92 years. The data were processed using descriptive statistics, the  $\chi^2$  test, group classification and discriminant analysis.

**Results:** The enduring personality changes are present in 9 % ( $n = 53$ ) of the patients who tend to be older, with lesser educational attainment. Only a quarter of the enduring personality changes patients ( $n = 10$ ) are receiving psychiatric treatment. Among the groups of patients with or without enduring personality changes statistically significant differences have been observed in relation to their past experiences with a traumatic event ( $p < 0.001$ ), level of independence in the performance of the activities of daily living ( $p < 0.001$ ), incidence rate of chronic pain ( $p = 0.002$ ), social integration ( $p = 0.016$ ), suicidal thoughts ( $p < 0.001$ ) and incidence rate of comorbidity of somatic illnesses and psychological disorders ( $p < 0.001$ ).

**Discussion and conclusion:** Results of the study point to the share of enduring personality changes patients living at home in which the condition remains largely unrecognized, untreated and shadowed by other mental and physical health issues. Community nurses play a crucial role in timely recognition and detection of the changes and the patients' referral to multidisciplinary treatment. A national research project conducted by community nurses is needed to highlight the prevalence, treatment and good practice in the delivery of pertinent services.

### IZVLEČEK

**Uvod:** Med motnje osebnosti in vedenja odraslih uvrščamo trajne osebnostne spremembe, ki jih ni mogoče pripisati možganski poškodbi ali bolezni. Travmatične izkušnje lahko povzročijo osebnostno ranljivost. Namen raziskave je ugotoviti značilnost trajnih osebnostnih sprememb, dejavnike tveganja ter kakovost življenja pacientov v domačem okolju.

**Metode:** Terenska raziskava temelji na kvantitativni metodi dela. Podatki so bili zbrani z anketiranjem 606 pacientov (18,56 %) na območju osrednjeslovenske regije, starih od 20 do 92 let. Uporabili smo strukturirani vprašalnik. Podatki so bili obdelani z opisno statistiko, preizkusom  $\chi^2$ , razvrščanjem v skupine in diskriminantno analizo.

**Rezultati:** Trajne osebnostne spremembe so prisotne pri 9 % ( $n = 53$ ) pacientov, ki so starejši in manj izobraženi. Le četrtina ( $n = 10$ ) se jih zdravi pri psihiatru. Med skupinama pacientov, ki imajo oziroma nimajo trajnih osebnostnih sprememb, so prisotne statistično značilne razlike glede izkušenj s travmatičnim dogodkom ( $p < 0,001$ ), stopnje samostojnosti pri izvajanju življenjskih aktivnosti ( $p < 0,001$ ), incidence kronične bolečine ( $p = 0,002$ ), socialnega vključevanja ( $p = 0,016$ ), samomorilnih misli ( $p < 0,001$ ) in incidence zdravstvenih težav ( $p < 0,001$ ).

**Diskusija in zaključek:** Rezultati opozarjajo na delež pacientov s trajnimi osebnostnimi spremembami, ki so nezdravljene in skrite v ozadju duševnih in telesnih zdravstvenih težav. Potrebno je pravočasno odkrivanje, napotitev in multidisciplinarni pristop, pri čemer je vloga patronažnih medicinskih sester pomembna. Nadaljnji raziskovalni izziv bi bil nacionalni projekt.

## Introduction

The World Health Organisation (WHO) constitution states that there is no health without mental health (Promoting Mental Health, 2005). Mental health is a state of well-being in which individuals realize their own intellectual and emotional abilities, can work productively and are able to feel and function well, be resilient in the face of life's challenges and make a contribution to their community (Jeriček Klanšček, et al., 2010; Resolucija o nacionalnem programu duševnega zdravja, 2011). Globally, mental disorders are one of the ten most common causes of functional limitations with severe social and economic ramifications (Resolucija o nacionalnem programu duševnega zdravja, 2011). It is estimated that 450 million of people out of the total population suffer from some type of mental disorder and that one in three persons experiences this problem at least once in a lifetime (Dernovšek & Šprah, 2008). The most common reasons for seeking first medical help on the primary level of health care in Slovenia and other European countries are depression, anxiety disorders, acute stress reaction and adjustment disorders (Jeriček Klanšček, et al., 2010). Compromised mental health may have detrimental effect on chronic diseases, rehabilitation and increase the demand for medical services (Annells, et al., 2011). Enduring personality changes (EPC) are defined as severe disturbances in the personality and behavioural tendencies of the individual; not directly resulting from disease, damage, or other insult to the brain, or from another psychiatric disorder.

EPC are classified as:

- EPC after catastrophic experience, such as violence or abuse (Teicher, et al., 2002; Teicher, et al., 2006), torture, persecution, war trauma (Maddern, 2004; Beltran, et al., 2009; Te Brake, et al., 2009), natural and human-instigated disasters (Cook & O'Donnell, 2005, cited in Karner, 2008),
- EPC after psychiatric illness,
- Other EPC – chronic pain personality syndrome,
- EPC, unspecified (The ICD-10 classification of mental and behavioural disorders, 1992; 1993).

The experience of traumatic events in childhood is associated with long-term health effects. Early exposure to traumatic stress, in the form of abuse or neglect, presents a major risk factor for a cascade of neurobiological reactions leading to permanent changes in brain development, later psychopathology and behavioural disorders (Teicher, et al., 2002; Teicher, et al., 2006) as well as compromised physical health. Experiences of traumatic events in childhood have been shown to have long-term consequences for health in adulthood (Mulvihill, 2005). Schore (2002) reports that 60 % of men and 50 % of women experience a traumatic event at some point in their lives. The experience of trauma can often result in a wide range of psychosocial

and psychiatric disturbances and complex psychiatric comorbidity. It has been shown that the prevalence of suicide attempts, suicidal behaviour, suicidal ideation and increased morbidity is elevated among people who have experienced traumatic events (Krysinska, et al., 2009). The study conducted in Slovenia by Sedmak and colleagues (2006) established that 23.7 % out of the 1006 respondents had experienced family abuse and violence, of which 73 % happened in their childhood. Selič and colleagues (2008) report that 30 % of the population studied (509 patients in the Republic of Slovenia) confirmed their past experience with both physical and psychological violence and abuse. Bronisch (1996, cited in Židanik, 2003) claims that one third of the persons that completed suicide had suffered from some type of personality disorder. Traumatic experience can cause personality vulnerabilities with cognitive, emotional and behavioural problems which are manifested as a hostile or mistrustful attitude towards the world, social withdrawal, feelings of emptiness or hopelessness, a chronic feeling of being 'on edge', as if constantly threatened, and estrangement (The ICD-10 classification of mental and behavioural disorders, 1992; 1993; Maddern, 2004; Mulvihill, 2005; Adams, 2006; Daud, et al., 2008; Karner, 2008; Beltran, et al., 2009; Seides, 2010). Personality disorders are very common and present one of the greatest challenges in the field of health care (Židanik, 2003), and remain one of the least explained psychiatric categories (Benedik, 2004).

The literature review reveals that the nature and the incidence of EPC in the Republic of Slovenia and abroad has not been the object of direct investigation. EPC may present a special problem in community nursing as they may hinder or interfere with the process of nursing care, the treatment, rehabilitation and social integration of patients (Annells, et al., 2011).

### *Aims and objectives*

The aim of the study was to establish the nature and the incidence of EPC as well as their impact on the quality of life of the affected individuals, their social relations and social integration.

Based on theoretical rationale, seven hypotheses were proposed:

H1: At least one fourth of the adult patients cared for by community nurses in their homes are diagnosed with EPC.

H2: There is a statistically significantly higher prevalence of EPC in patients with a history of traumatic victimisation as compared to those without this experience.

H3: There are statistically significant differences in the level of dependence in the performance of daily living activities between patients with EPC and those without EPC.

H4: There is a statistically significantly higher incidence of EPC in patients experiencing chronic pain as compared to those without this symptom.

H5: There are statistically significant differences in social functioning (social inclusion, society memberships) between patients with EPC and those without EPC.

H6: There are statistically significantly higher suicidal tendencies in patients with EPC as compared to those without EPC.

H7: There is a statistically significantly higher incidence of comorbid psychological and physical disorders in patients with EPC as compared to those without EPC.

## Methods

The field research conducted is based on a non-experimental quantitative method.

### *The description of the research instrument*

The questionnaire was developed on the basis of specific EPC criteria, not attributable to brain damage and disease (The ICD-10 classification of mental and behavioural disorders, 1992; 1993), publications on personality disorders (Benedik, 2004), EPC (Leeuw, et al., 2005; Daud, et al., 2008), social relations and interactions (Kobentar, 2003), and a standardised detailed assessment of posttraumatic stress (Briere, 2001). The survey was conducted via a written structured questionnaire including 20 questions (open-ended, closed-ended and half-closed-ended questions). The survey used dichotomous and multiple-choice questions where the respondents selected an answer from a list of choices. In some instances the respondents evaluated the statements on a Likert 5 point frequency scale where the number one indicated the absence of opinion/behaviour and the number 5 the enduring presence or strongly expressed. Prior to performance of a full-scale research project, a preliminary pilot study was carried out on 30 members of the relevant population in order to evaluate the content and comprehensibility of the questions, and accompanying instructions. The Cronbach alpha coefficient ( $\alpha = 0.7$ ) showed appropriate internal consistency for each statement (social relations, personal characteristics/personality vulnerability, impact of health status on work/home/relations and activities of daily living), and the reliability of a psychometric instrument.

### *Description of a sample*

Data were collected on a cohort of adult community nursing service users from the Central Slovenia region. The services are organised by the Community Health Centre Ljubljana and provided by five organisational units: Health centre Ljubljana Bežigrad, Health centre

Ljubljana Center, Health centre Ljubljana Moste-Polje, Health centre Ljubljana Šentvid, Health centre Ljubljana Šiška, Health centre Ljubljana Vič-Rudnik. The Community Health Centre covers the health care needs of 280.607 inhabitants of the City Municipality of Ljubljana, on the territory of 275 km<sup>2</sup> (Statistični urad Republike Slovenije, 2012). A purposive sample included 18.56 % of the statistical population (statistics of patient motion by the end of year 2011, with the total of 3265 patients treated) (Inštitut za varovanje zdravja Republike Slovenije, 2012). Included in the study were the patients over 18 years of age, living in their home environment who were visited by community nurses on the day the study was conducted. The participation was voluntary. The total of 820 questionnaires was distributed, among which 38 were invalid. The final sample included 606 participants of whom 182 were men (30 %) and 423 were women (70 %), aged from 20 to 92 years (mean age 62 years;  $s_x = 17.8$ ). Most of the respondents  $n = 181$  (30 %) belonged to the age group from 66 to 80 years and 171 (28 %) were aged between 51 to 65 years. Most of the respondents  $n = 195$  (32 %) completed a 4-year secondary education and 149 (25 %) of the participants had earned higher professional or university degrees. Half of the participants  $n = 302$  live in urban areas, 195 (32 %) in the suburbs, and 108 (18 %) in the village. Nearly half of the respondents  $n = 291$  (48%) are married and 128 (21 %) are widowed. Most of the respondents  $n = 220$  (36 %) share their lives with their spouse or a partner, 134 (22 %) participants live by themselves, 123 (20 %) participants live with their spouse or partner and relatives, and 115 (19 %) of them live with their relatives. Only 13 (2 %) respondents share their living facility with their roommates.

### *The description of the research procedure and data analysis*

Prior to questionnaire distribution, an ethics approval of research was granted by the Republic of Slovenia National Medical Ethical Committee (No. 92, August 24, 2012) and a permission of the Community Health Centre was obtained to carry out the survey among the patients for the purposes of Master thesis research (No. 511, August 10, 2012).

The invited respondents were informed of confidentiality and anonymity protection, the intended use of the data collected as well as of the possibility to decline their participation. A written informed consent was prospectively obtained from the addressees as to their voluntary participation. Detailed written instructions were provided along with the questionnaire on how to fill out the questionnaire. The questionnaires and the stamped envelopes with return post address were distributed to patients after the preventive and/or curative nursing services had been delivered. The respondents returned the completed

questionnaires in closed envelopes to the community nurses within an agreed period of time. Community nurses collected the file folders within the agreed period of time at community nursing administrative bases. The survey was conducted from September 10, 2012 until December 14, 2012.

Multivariate method of discriminant analysis was used to discriminate between the two groups of respondents in terms of independent performance of the activities of daily living, social relations, suicidal thoughts and additional disorders (or diseases) co-occurring with the primary disease. The discriminant analysis was used to explore the relationship between the descriptive (dependent) variable and independent numerical variables. To determine the differences between the respondents with or without EPC as regards the necessity of psychiatric treatment, the Kullback 2l test (likelihood ratio) was used as an alternative to  $\chi^2$  test for which the necessary conditions were not given (Field, 2006). A 5 % difference and a  $p < 0.05$  were considered to be statistically significant. For the statistical analysis, the Statistical Package for the Social Sciences version 18.0 (SPSS Inc., Chicago, IL) was utilised.

The basic statistical parameters of descriptive statistics were calculated for each variable. Hierarchical cluster analysis was employed in grouping the respondents in regards to the presence of EPC. Ward's method was used to determine the distance between the clusters.

The Squared Euclidean distance was applied as a measure of distance between the variables which were standardised before grouping.

## Results

Results of the study show that 91 % of the respondents do not suffer from EPC and the rest (9 %) are inflicted by the disease. A high majority of the respondents (91.8 %) were properly classified. There is a statistically significant difference between the two groups in relation to the respondents' age ( $\chi^2 = 12.504$ ,  $p = 0.014$ ) and education ( $\chi^2 = 23.950$ ,  $p < 0.001$ ). Enduring personality changes are present in 62 % of the respondents aged over 65 years, with complete or incomplete primary education (43 %).

Among respondents with the experience of at least one traumatic event (64 %), 13 % suffer from EPC. In the respondents with no history of trauma, EPC was identified in 3 %. There are statistically significant differences ( $\chi^2 = 9.304$ ,  $p = 0.002$ ) regarding the gender of people exposed to a traumatic event, 74 % were male and 61 % female. The chi-squared value ( $\chi^2$ ) is 14.589 and is statistically significant. It can be concluded that traumatic experience is a determining factor in the development of EPC. A history with violence, abuse and neglect in their childhood was confirmed by 20 % of the respondents.

The patients with EPC have more difficulties to independently perform the activities of daily living and the differences between the groups are statistically significant. Gender-wise, no statistically significant differences in this respect were observed between male and female respondents (dressing, undressing:  $t = -0.121$ ,  $p = 0.904$ ; lying/sitting down and getting out of a bed or chair:  $t = 0.964$ ,  $p = 0.336$ ; taking a bath or a shower:  $t = 0.858$ ,  $p = 0.391$ ; walking, mobility:  $t = 0.721$ ,  $p = 0.471$ ) (Table 1).

Differences were established between the groups in regards to the presence of chronic pain. Of the respondents suffering from chronic pain (pain in the neck, lower back, headache, migraine, pain in the joints), 11 % present with EPC and only 3 % of those without chronic pain. The chi-squared value  $\chi^2 = 10.000$  and is statistically significant ( $p = 0.002$ ). It can be concluded that there is a correlation between chronic pain and the presence of EPC.

Nine out of the twelve variables (75 %) concerning problems in social functioning and performance were identified to be statistically significantly related to EPC. The social relations of patients with EPC are less frequent as compared to those without this condition (Table 2).

The variable 'I think it would be better if I were dead or that I intentionally and seriously harmed myself' has a statistically significant impact on group differentiation (Wilks  $\lambda = 0.861$ ,  $p < 0.001$ ).

Results of the study confirm that EPC patients generally manifest more health problems ( $\bar{x} = 6.13$ ,  $s_x = 2.650$ ) than those without this condition ( $\bar{x} = 3.81$ ,

Table 1: *The difference between the groups of subjects with (n = 52) or without EPC (n = 507) in regards to the activities of daily living*

Tabela 1: *Razlika za skupini preiskovancev, ki imajo (n = 52) oziroma nimajo TOS (n = 507) glede na dnevne aktivnosti*

Statements/Trditve	Wilks $\lambda$	F	df1	df2	p
Dressing/undressing	0.945	32.570	1	557	<0.001
Lying down/sitting down and getting out of bed or chair	0.955	26.458	1	557	<0.001
Taking a bath or shower	0.934	39.042	1	557	<0.001
Walking/movability	0.944	33.104	1	557	<0.001

Legend/Legenda: Wilks  $\lambda$  – value of Wilk's Lambda/vrednost Wilksove Lambde; F – test values/vrednost testa; df1 – discriminant function 1/prva diskriminantna funkcija; df2 – discriminant function 2/druga diskriminantna funkcija; p – statistical significance at 0.05 or less/statistično značilna razlika pri 0,05 ali manj

Table 2: *The difference between the groups of subjects with (n = 52) or without EPC (n = 507) in regards to social functioning and performance*

Tabela 2: *Razlika za skupini preiskovancev, ki imajo (n = 52) oziroma nimajo TOS (n = 507) glede na socialne stike*

Statements/Trditve	Wilks $\lambda$	F	df1	df2	p
I maintain contacts with family members.	0.992	4.226	1	557	0.040
I maintain contacts with relatives.	0.992	4.487	1	557	0.035
I maintain contacts with friends.	0.987	7.407	1	557	0.007
I maintain contacts with neighbours.	0.997	1.879	1	557	0.171
I look forward to having contacts with people.	0.985	8.226	1	557	0.004
I am a member of an organised social group (choir, Association of Pensioners, Red Cross, sports club, Association of Resistance Fighters, etc.).	1.000	0.028	1	557	0.867
I invite people for a visit.	0.991	5.130	1	557	0.024
I offer my family members a financial support.	0.992	4.258	1	557	0.040
I travel to other places.	0.955	26.546	1	557	<0.001
I can really listen to other people.	0.963	21.551	1	557	<0.001
I attend meetings, events...	0.984	9.282	1	557	0.002
When I am ill, my family members and relatives help me.	0.995	2.591	1	557	0.108

Legend/Legenda: Wilks  $\lambda$  – value of Wilk's Lambda/vrednost Wilksove Lambde; F – test values/vrednost testa; df1 – discriminant function 1/prva diskriminantna funkcija; df2 – discriminant function 2/druga diskriminantna funkcija; p – statistical significance at 0.05 or less/statistično značilna razlika pri 0,05 ali manj

Table 3: *The difference between the average values of the two groups of subjects with (n = 52) or without EPC (n = 507)*

Tabela 3: *Razlika med povprečji dveh vzorcev za skupini preiskovancev, ki imajo (n = 52) oziroma nimajo TOS (n = 507)*

Statements/Trditve	Wilks $\lambda$	F	df1	df2	p
I think it would be better if I were dead or that I intentionally and seriously harmed myself	0.861	89.840	1	557	<0.001

Legend/Legenda: Wilks  $\lambda$  – value of Wilk's Lambda/vrednost Wilksove Lambde; F – test values/vrednost testa; df1 – discriminant function 1/prva diskriminantna funkcija; df2 – discriminant function 2/druga diskriminantna funkcija; p – statistical significance at 0.05 or less/statistično značilna razlika pri 0,05 ali manj

$s_x = 2.353$ ). The difference between the two groups is statistically significant (Wilks  $\lambda = 0.925$ ,  $p < 0.001$ ) (Table 3).

## Discussion

The first hypothesis proposing that EPC are present in at least one quarter of the respondents was not confirmed. It was determined that EPC, classified as personality disorders of the advanced age, are present in only 10 % of the respondents. The study produced results which corroborate the findings of Marlowe and Sugerman (cited in Židanik, 2003) suggesting a 2 % – 13 % incidence of EPC among the general population. In contrast, Kaplan (cited in Židanik, 2003) found the EPC incidence ranged from 15.5 % to 32 % EPC. Židanik (2003) reported a high percentage of people with potential personality disorders (41.2 %) in Maribor region. Community epidemiological surveys estimate that as many as 25 % of the adult population in the United States meet the criteria for mental disorder (Kessler, et al., 2005) and that one family out of five is inflicted with a mental disease (Medline Plus, 2009). The present study shows that the respondents with EPC are generally older, which could also be

attributed to the fact that the sample included a high percentage of older adults with relatively low levels of education.

EPC along with lower educational achievement and aging may complicate the nursing process and interfere with social relations, learning of social skills and cognitive behavioural therapy techniques (Magoteaux & Bonnavier, 2009). Results of the study confirmed the hypothesis that the respondents without EPC maintain better social relations compared to those who suffer from this condition. This fact can be explained by the personal vulnerability of EPC patients whose inflexible and maladaptive behaviour leads to impairment in their interpersonal, social, and occupational functioning (The ICD-10 classification of mental and behavioural disorders, 1992). As a consequence, stigmatisation and discrimination create and further reinforce their social isolation (Resolucija o nacionalnem programu duševnega zdravja, 2011). Experts observe that mental status may be associated with increased rates of somatic complaints and general medical conditions, and vice versa. Patients with chronic diseases often develop other comorbid psychiatric conditions, depression being the most common (Annells, et al., 2011; Inštitut za varovanje zdravja Republike Slovenije, 2010). Elderly

adults with a history of traumatic event are at a greater risk to develop chronic diseases, compromised physical functioning, gastritis, angina pectoris and arthritis (Pietrzak, et al., 2012). A good half of the respondents in the current study reported having problems with neck and back pain, and a quarter of them presented with headache and migraines. Our results are comparable to the findings of Lew and colleagues (2009) which confirm that the most common chronic pain locations were the back and head. The data gathered support the hypothesis that the patients with chronic pain score higher on a measure of EPC than the respondents without chronic pain. The result is not surprising as chronic pain augments a person's suffering and personal vulnerability (Ščavničar, 2004). Literature review conducted by several researchers confirmed the detrimental effects of fragile mental health on the development of chronic diseases. Poor mental health also hinders medical rehabilitation process and increases the demand for medical services (Annells, et al., 2011). The following hypothesis tested whether EPC more commonly co-occur with other health issues than in the respondents without EPC. The results confirmed the hypothesis that the average incidence of comorbidity is more common in patients with EPC than in those without them. The differences among genders are statistically significant. Women reported higher rates of several physical health conditions than men. The hypothesis that suicidal ideation is more frequent in patients with EPC than in other respondents was confirmed. This finding is very important, especially in view of the data retrieved by retrospective studies which observe that one out of three suicide victims had some type of EPC (Židanik, 2003). A history of traumatic event was reported by a significant majority of the male (75 %) and a good half of female study participants. The findings of the current study accord with the earlier observations (Schore, 2002) which suggest that 60 % of men and 50 % of women have experienced some traumatic event. A little less than 50 % of the respondents reported a history of catastrophic/traumatic experience involving a serious injury, experience of coercive behaviour, life-threatening situations or seeing another person injured or killed. One fifth of the respondents reported experiencing traumatic life events, such as violence, psychological, physical and/or sexual abuse and neglect. These results accord with the findings of the public opinion research on family violence (Sedmak, et al., 2006), which was conducted on a representative sample of 1006 adult Slovenian citizens. The evidence gathered is in agreement with the hypothesis that EPC are more common in individuals with a history of traumatic event (The ICD-10 classification of mental and behavioural disorders, 1992). There is an association between prolonged traumatization and personality impairments, psychopathology and lifelong maladaptive behaviours. Prolonged torture experiences or extreme early trauma exposure is reflected in impaired personality formation

which enhances the development of cognitive, affective and behavioural vulnerabilities (Daud, et al., 2008; Rick & Douglas, 2007). Mulvihill (2005) documented a strong relationship between childhood trauma and psychological difficulties and physical illness in later life. The results produced by the current study corroborate these findings. In the performance of the activities of daily living, the respondents with EPC need most assistance with walking or movability while they are more independent in other activities, i.e. dressing and undressing. A little less than one fifth of the respondents need help and support of another person or assistive devices, some of them had their homes adapted to suit their changing needs. The hypothesis that there are statistically significant differences in the level of independence between patients with and without EPC was confirmed. This finding could be also attributable to the fact that the sample involved a large proportion of the elderly adults. A good half of the respondents seek medical care of general practitioners and more than one third of family doctors and various specialists. A surprisingly small number of patients with EPC (25 %) are treated by psychiatrists. This finding leans towards a conclusion that EPC in the study participants often remain unrecognised, untreated and hidden behind other mental diseases and physical conditions, which accords with the results of the literature review (Židanik, 2003; Benedik, 2004, Magoteaux & Bonnavier, 2009). The scarcity of psychiatric treatment may be explained in part by the EPC sufferers' considerable personal distress and social disruption, disabling them to seek appropriate medical help. In light of the above research, community nurses play a crucial role in recognizing a personality disorder, and provide the adequate treatment based on partnership and mutual trust, the necessary support and health education of patients and their families (Maddern, 2004; McAllister, 2010; Annells, et al., 2011).

The current study and the literature review results indicate that EPC patients share certain clusters of traits: late adulthood (age 65 and beyond), low educational attainment (primary school), a history of traumatic event (four-fifths), the comorbidity of psychiatric disorders and physical conditions, chronic pains, suicidal ideation, difficulty in performing daily activities, poor social integration, weak social network and ties, low rate of psychiatric treatment (10 out of 53), non-recognition and absence of treatment of EPC symptoms which are hidden behind the decoys of other mental and physical disorders.

The findings of the study do not necessarily reflect the real number of occurrences of EPC among the residents of the Central Slovenia region. Caution must be applied in the interpretation of the data gathered which, however, provide a valuable insight into the health status of the population studied. The most worrisome are the responses concerning suicidal behaviour and social isolation. Though the results

might not be transferable to the entire Slovenian population, they have important implications for the community nursing practice to timely detect and recognise the symptoms of EPC in patients cared for in their home settings.

Community nurses should have the knowledge, training and experience to refer the patients to multidisciplinary treatment and ensure the persons living with EPC the highest quality of life possible. Another issue emerging from these findings relates to the community nurses' responsibility to gain additional knowledge on personality and psychopathology, especially enduring personality changes, in order to offer appropriate care to this patient population. As several questions remain unanswered, further studies on the current topic are recommended on a national level.

## Conclusion

As community nurses visit people in their own homes on a continuous basis, they are often the first care providers who can identify the healthcare needs of patients and families. A patient's positive experience of the first community nurse visit largely impacts the quality of therapeutic relationship and patient outcomes. The EPC patients' lack of control and their decreased judgement and insight into their situation impede the treatment process. Creating a relationship, which is central to nursing work, requires not just communication skills but therapeutic engagement, perseverance, patience and dialogue. It is also of importance that nurses recognise specific risk groups within their community in order to plan nursing interventions in their homes, improve service integration and patient access to primary care and specialist medical services. The nurse's role moves beyond an illness-care role to that of diminishing stigmatisation, discrimination and social exclusion of people diagnosed with mental disorders which adversely affect their quality of life. Nurses can improve the patients' sense of well-being in life by health promotion, timely recognition of the disease, psychosocial evaluation, referral, support and multidisciplinary approach to treatment and rehabilitation as well as social integration.

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*Slovenian translation/Prevod v slovenščino*

## Uvod

Ni zdravja brez duševnega zdravja, je stališče, ki ga promovira Svetovna zdravstvena organizacija (Promoting Mental Health, 2005). Duševno zdravje omogoča posamezniku udeleževanje njegovih umskih in čustvenih zmognosti ter mu omogoča, da najde in izpolni svojo vlogo v poklicnem, družbenem in zasebnem življenju (Jeriček Klanšček, et al., 2010;

Resolucija o nacionalnem programu duševnega zdravja, 2011). Duševne motnje spadajo med 10 vzrokov oviranosti v svetu s hudimi družbenimi in gospodarskimi posledicami (Resolucija o nacionalnem programu duševnega zdravja, 2011). Na svetu ima težave zaradi duševnega zdravja 450 milijonov ljudi, vsak tretji izmed nas naj bi jih imel vsaj enkrat v življenju (Dernovšek & Šprah, 2008). Najpogostejši vzroki za prve obiske zdravstvenega varstva v Republiki Sloveniji in v Evropi na primarni ravni so depresija, anksiozne motnje, odzivi na hud stres in prilagoditvene motnje (Jeriček Klanšček, et al., 2010). Slabše duševno zdravstveno stanje ima škodljive učinke na kronične bolezni, okrevanje in večjo uporabo zdravstvenih storitev (Annells, et al., 2011). Med motnje osebnosti in vedenja odraslih uvrščamo skupino trajnih osebnostnih sprememb (TOS). Med skupino TOS, ki jih ni mogoče pripisati možganski poškodbi ali bolezni, štejemo:

- TOS po katastrofični izkušnji: nasilje, zloraba (Teicher, et al., 2002; Teicher, et al., 2006), mučenje, preganjanje, vojne travme (Maddern, 2004; Beltran, et al., 2009; Te Brake, et al., 2009) naravne, umetne nesreče (Cook & O'Donnell, 2005, cited in Karner, 2008),
- TOS po duševni bolezni,
- druge TOS — sindrom kronične bolečine,
- TOS, ki je neopredeljena (The ICD-10 classification of mental and behavioural disorders, 1992; 1993).

Otroci so še posebej občutljivi na zgodnji stres, nasilje in zlorabo, ki povzročata vrsto nevrobioloških reakcij, te pa lahko vodijo v trajne spremembe v razvoju možganov, duševne in vedenjske motnje (Teicher, et al., 2002; Teicher, et al., 2006) ter telesne težave v kasnejšem življenju (Mulvihill, 2005). Schore (2002) navaja, da kar 60 % moških in 50 % žensk izkusi travmatični dogodek vsaj enkrat v življenju. Žrtve travmatičnih izkušenj pogosto trpijo zaradi visoke stopnje zdravstvene obolevnosti (zlasti na račun duševnih motenj), invalidnosti in povečane ravni umrljivosti, vključno s povečanim tveganjem za samomorilne misli, poskuse in samomore (Krysinska, et al., 2009). Sedmak in sodelavci (2006) so na vzorcu 1006 oseb v Sloveniji ugotovili, da je nasilje in zlorabo v družini izkusilo 23,7 % odraslih oseb, od tega 73 % v otroštvu. Selič in sodelavci (2008) so ugotovili na vzorcu 509 pacientov v Republik Sloveniji, da je 30 % oseb potrdilo izkušnjo z nasiljem (telesno, duševno). Bronisch (1996, cited in Židanik, 2003) trdi, da je ena tretjina ljudi, ki je napravila samomor imela eno od osebnostnih motenj. Travmatične izkušnje lahko povzročijo osebnostno ranljivost s kognitivnimi, čustvenimi in vedenjskimi težavami, ki se kažejo kot sovražen ali nezaupljiv odnos do sveta, socialni umik, občutek praznine, brezup, odtujenost, kronični občutek »biti na robu«, kot biti nenehno ogrožen (The ICD-10 classification of mental and behavioural disorders, 1992; 1993; Maddern, 2004; Mulvihill,

2005; Adams, 2006; Daud, et al., 2008, Karner, 2008; Beltran, et al., 2009; Seides, 2010). Osebnostne motnje so zelo razširjene in predstavljajo enega večjih izzivov na področju zdravstvene oskrbe (Židanik, 2003) in eno najbolj nejasnih kategorij osebnostnih motenj v psihiatriji (Benedik, 2004).

S pregledom literature smo ugotovili, da TOS pri osebah v Sloveniji niso bile neposredno predmet raziskovanja, pa tudi v tujini se temu vprašanju posveča bolj malo raziskav. TOS predstavljajo večji izziv na področju patronažne zdravstvene nege, saj lahko zapletejo in otežijo proces zdravstvene nege, rehabilitacijo in socialno integracijo pacientov (Annells, et al., 2011).

### *Namen in cilj*

Poleg pogostosti in značilnosti TOS smo ugotavljali vpliv na kakovost življenja, povezanega z zdravjem, s socialnimi odnosi ter integracijo v socialni mreži. Na podlagi teoretičnih izhodišč smo oblikovali sedem raziskovalnih hipotez:

H1: Pri odraslih pacientih, ki so obravnavani v patronažnem varstvu, so vsaj pri četrtini prisotne značilnosti TOS.

H2: Pri pacientih, ki so bili izpostavljeni travmatičnemu dogodku, je prisotna statistično pomembno višja prevalenca TOS kot pri pacientih, ki niso imeli izkušnje s travmatičnim dogodkom.

H3: Med pacienti s TOS in tistimi, ki jih nimajo, obstajajo statistično pomembne razlike glede stopnje samostojnosti pri izvajanju življenjskih aktivnosti.

H4: Pri pacientih s kronično bolečino je incidenca TOS statistično pomembno višja kot pri pacientih, pri katerih kronična bolečina ni prisotna.

H5: Med pacienti s TOS in tistimi, ki jih nimajo, obstajajo statistično pomembne razlike v socialnem vključevanju (socialni stiki in vključenost v združenja).

H6: Pri pacientih s TOS je statistično pomembna višja incidenca samomorilnih misli kot pri pacientih brez TOS.

H7: Pri pacientih s TOS je statistično pomembna višja incidenca drugih duševnih in telesnih težav kot pri pacientih brez TOS.

### **Metode**

Terenska raziskava temelji na neeksperimentalni kvantitativni raziskovalni metodi.

#### *Opis instrumenta*

Vprašalnik smo razvili na podlagi značilnostnih kriterijev za TOS, ki jih ni mogoče pripisati možganski poškodbi ali bolezni (The ICD-10 classification of mental and behavioural disorders, 1992; 1993), literature o motnjah osebnosti (Benedik, 2004), o trajnih

osebnostnih spremembah (Leeuw, et al., 2005; Daud, et al., 2008), o socialnih odnosih (Kobentar, 2003) in na osnovi standardiziranega vprašalnika o oceni izpostavljenosti travmatičnim dogodkom in simptomov posttravmatičnega stresa (Briere, 2001). Tehnika anketiranja je potekala v obliki strukturiranega pisnega vprašalnika. Sestavljen je bil iz 20 vprašanj (zaprtega, polodprtega, odprtega tipa). Vseboval je dihotomna vprašanja in vprašanja izbirnega tipa s ponujenimi možnimi odgovori. Pri nekaterih vprašanjih so se lahko preiskovanci opredelili po Likertovi lestvici, kjer je število 1 pomenilo odsotnost določenega mnenja/vedenja, število 5 pa njegovo stalno prisotnost oz. izredno močno izraženo. Pred izvedbo raziskave smo vprašalnik pilotno testirali pri tridesetih preiskovancih. Vsebinsko veljavnost smo preverili s pilotnim preizkusom vprašalnika glede vsebine, razumljivosti vprašanj in ustreznosti navodil. Vsi preverjeni sklopi pilotne raziskave (socialni stiki, osebnostne značilnosti/ranljivosti, vpliv zdravstvenega stanja na delo/dom/odnose in dnevne aktivnosti) vprašalnika imajo vrednost Cronbachovega koeficienta večjo od  $\alpha = 0,7$ , torej so vsi sklopi vprašalnika dovolj zanesljivi.

#### *Opis vzorca*

Populacijo predstavljajo osebe v odrasli dobi, ki so uporabniki storitev patronažnih varstev Zdravstvenega doma (ZD) v Ljubljani, na območju osrednjeslovenske regije, kamor je vključenih pet javnih primarnih ZD v Ljubljani: ZD Ljubljana Bežigrad, ZD Ljubljana Center, ZD Ljubljana Moste - Polje, ZD Ljubljana Šentvid, ZD Ljubljana Šiška in ZD Ljubljana Vič - Rudnik. Patronažno varstvo ZD Ljubljana pokriva področje Mestne občine Ljubljana, v kateri živi 280.607 ljudi, področje pa predstavlja 275 km<sup>2</sup> (Statistični urad RS, 2012). Namenski vzorec je zajemal 18,56 % oseb statistične množice (statistika gibanja pacientov ob koncu leta 2011, obravnavanih 3265 pacientov) (Inštitut za varovanje zdravja Republike Slovenije, 2012). V vzorec preiskovancev so bile vključene osebe v domačem okolju, ki so bile stare 18 let in več ter so bile na dan izvedbe raziskave naključno obravnavane na patronažnem obisku in so prostovoljno pristale na sodelovanje v raziskavi. Končni vzorec predstavlja 606 oseb. Razdeljenih je bilo 820 vprašalnikov, izločenih 38 neveljavnih. Od 606 preiskovancev je bilo 182 moških (30 %) in 423 žensk (70 %), starih od 20 do 92 let, povprečna starost pa je bila 62 let ( $s_x = 17,8$ ). Največ preiskovancev, 181 (30 %), je bilo starih od 66 do 80 let, sledi 171 preiskovancev (28 %), starih od 51 do 65 let. Največ preiskovancev, 195 (32 %), ima dokončano 4-letno srednjo šolo, sledi 149 preiskovancev (25 %) z višjo, visoko ali univerzitetno izobrazbo. Polovica preiskovancev ( $n = 302$ ) živi v mestu, 195 (32 %) v predmestju, 108 (18 %) pa na vasi. 291 preiskovancev (48 %) je poročenih, sledijo ovdoveli 128 (21 %). Največ, 220 (36 %), jih živi z zakoncem oz. partnerjem,



134 (22 %) jih živi samih, 123 (20 %) s partnerjem in svojci, 115 (19 %) pa s svojci. Najmanj, 13 (2 %), jih živi s sostanovalci.

### Opis poteka raziskave in obdelave podatkov

Pred razdelitvijo vprašalnika med paciente na domu smo pridobili Soglasje o etični sprejemljivosti raziskave pri Komisiji Republike Slovenije za medicinsko etiko (št. 92, 24. 08. 2012) ter Soglasje zavoda ZD Ljubljana za izvedbo anketiranja pacientov v okviru magistrskega dela (št. 511, 10. 8. 2012). Preiskovance smo k sodelovanju v raziskavi povabili s pojasnilom, da lahko sodelovanje odklonijo, da je anonimno, ter jim predstavili predvideni namen rezultatov. Pripravljenost sodelovanja v raziskavi so potrdili s podpisom. Vprašalniki so bili skupaj s pisnimi navodili za izpolnjevanje preiskovancem razdeljeni v pisemskih ovojnica na domu po opravljenih preventivnih in kurativnih patronažnih obiskih. Izpolnjene in v pisemski ovojnici zaprte vprašalnike so vrnili patronažnim medicinskim sestram. Le-te so vprašalnike v zbirnih mapah zbrale v dogovorjenem roku na sedežu patronažnih služb. Izvedba anketiranja je potekala od 10. 9. 2012 do 14. 12. 2012.

S pomočjo multivariantne metode diskriminantne analize smo pridobili elemente samostojnosti izvajanja življenjskih aktivnosti, socialnih stikov, samomorilnih misli in število zdravstvenih težav, ki diskriminirajo med obema skupinama. Z diskriminantno analizo smo proučevali odvisnost med opisno (odvisno) spremenljivko in neodvisnimi številskimi spremenljivkami. Za preverjanje razlik med preiskovanci s TOS glede obiskovanja psihiatra smo zaradi neizpolnenih pogojev za izvedbo preizkusa  $\chi^2$  uporabili Kullbackov preizkus  $2\hat{I}$  (»likelihood ratio«), ki predstavlja alternativo preizkusu  $\chi^2$  (Field, 2006). Za statistično pomembne smo upoštevali razlike na ravni 5% in manjšega tveganja ( $p \leq 0,05$ ).

Pri analizi zbranih podatkov smo uporabili statistično programsko orodje SPSS 18.0 (SPSS Inc., Chicago, IL). Za posamezne spremenljivke smo izračunali osnovne statistične parametre opisne statistike. Pri združevanju preiskovancev v skupine

glede na TOS smo uporabili multivariantno analizo hierarhičnega združevanja v skupine. Za izračun razdalje med skupinama smo uporabili Wardovo metodo. Kot mero različnosti smo uporabili kvadrat evklidske razdalje, spremenljivke pa smo pred razvrščanjem standardizirali.

### Rezultati

Med vsemi preiskovanci jih je bilo v skupino brez TOS uvrščenih 91 %, v skupino s TOS pa 9 %. Pravilno uvrščenih je bilo 91,8 % preiskovancev. Skupini preiskovancev se statistično značilno razlikujeta glede na starost ( $\chi^2 = 12,504$ ,  $p = 0,014$ ) in izobrazbo ( $\chi^2 = 23,950$ ,  $p < 0,001$ ). TOS so prisotne pri 62 % preiskovancih, ki so starejši od 65 let in imajo osnovnošolsko izobrazbo ali nižjo (43 %).

Vsaj en travmatični dogodek je doživelo 64 % preiskovancev. Med preiskovanci, ki niso doživeli travmatičnega dogodka, je 3 % takih, ki imajo TOS. Med preiskovanci, ki so doživeli vsaj en travmatični dogodek, pa jih ima 13 % izražene TOS. Travmatični dogodek je doživelo več moških (74 %) kot žensk (61 %), razlike so statistično značilne ( $\chi^2 = 9,304$ ,  $p = 0,002$ ). Vrednost testa  $\chi^2$  je 14,589 in je statistično značilna ( $p < 0,001$ ), torej obstajajo razlike v prisotnosti TOS glede na izkušnjo travmatičnega dogodka. Izkušnjo z nasiljem, zlorabo in zanemarjenjem v otroštvu je potrdilo 20 % preiskovancev.

Pacienti, ki imajo prisotne TOS, težje izvajajo dnevne aktivnosti samostojno, razlike med skupinama so statistično značilne. Statistično značilnih razlik med spoloma nismo našli (oblačenje, slačenje:  $t = -0,121$ ,  $p = 0,904$ ; leganje/sedanje in vstajanje:  $t = 0,964$ ,  $p = 0,336$ ; kopanje, tuširanje:  $t = 0,858$ ,  $p = 0,391$ ; hoja, pomičnost:  $t = 0,721$ ,  $p = 0,471$ ) (Tabela 1).

Med tistimi, ki nimajo kroničnih bolečin (bolečine v vratu ali križu; glavobol, migrena; bolečine v sklepih), ima TOS 3 % preiskovancev, med tistimi s kroničnimi bolečinami pa 11 %. Vrednost preizkusa  $\chi^2$  je 10,000 in je statistično značilen ( $p = 0,002$ ), torej med skupinama preiskovancev obstajajo razlike glede pojavnosti TOS.

Devet spremenljivk od 12 (75 %) o socialnih stikih statistično značilno vpliva na razlikovanje med

Tabela 1: Razlika za skupini preiskovancev, ki imajo ( $n = 52$ ) oziroma nimajo TOS ( $n = 507$ ) glede na dnevne aktivnosti

Table 1: The difference between the groups of subjects with ( $n = 52$ ) or without EPC ( $n = 507$ ) in regards to the activities of daily living

Trditve/ Statements	Wilks $\lambda$	F	df1	df2	p
Oblačenje, slačenje	0,945	32,570	1	557	<0,001
Leganje/sedanje in vstajanje s postelje ali s stola	0,955	26,458	1	557	<0,001
Kopanje, tuširanje	0,934	39,042	1	557	<0,001
Hoja, pomičnost	0,944	33,104	1	557	<0,001

Legenda/Legend: Wilks  $\lambda$  – vrednost Wilksove Lambde/value of Wilk's Lambda; F – vrednost testa/test values; df1 – prva diskriminantna funkcija/discriminant function 1; df2 – druga diskriminantna funkcija/discriminant function 2; p – statistično značilna razlika pri 0,05 ali manj/statistical significance at 0.05 or less

Tabela 2: Razlika za skupini preiskovancev, ki imajo ( $n = 52$ ) oziroma nimajo TOS ( $n = 507$ ) glede na socialne stike  
 Table 2: The difference between the groups of subjects with ( $n = 52$ ) or without EPC ( $n = 507$ ) in regards to social functioning and performance

Trditve/Statements	Wilks $\lambda$	F	df1	df2	p
Vzdržujem stike z družinskimi člani.	0,992	4,226	1	557	0,040
Vzdržujem stike s sorodniki.	0,992	4,487	1	557	0,035
Vzdržujem stike s prijatelji.	0,987	7,407	1	557	0,007
Vzdržujem stike s sosedi.	0,997	1,879	1	557	0,171
Veselim se stikov z ljudmi.	0,985	8,226	1	557	0,004
Sem član društva (pevski zbor, društvo upokojenecv, Rdeči križ, športno društvo, Zveza borcev ipd.).	1,000	0,028	1	557	0,867
Povabim ljudi na obisk.	0,991	5,130	1	557	0,024
Članom ožje družine finančno in materialno pomagam.	0,992	4,258	1	557	0,040
Potujem v drug kraj.	0,955	26,546	1	557	<0,001
Znam poslušati druge ljudi.	0,963	21,551	1	557	<0,001
Udeležujem se srečanj, prireditev.	0,984	9,282	1	557	0,002
Kadar zbolim, mi člani družine in svojci pomagajo.	0,995	2,591	1	557	0,108

Legenda/Legend: Wilks  $\lambda$  – vrednost Wilksove Lambde/value of Wilk's Lambda; F – vrednost testa/test values; df1 – prva diskriminantna funkcija/discriminant function 1; df2 – druga diskriminantna funkcija/discriminant function 2; p – statistično značilna razlika pri 0,05 ali manj/statistical significance at 0.05 or less

Tabela 3: Razlika med povprečji dveh vzorcev za skupini preiskovancev, ki imajo ( $n = 52$ ) oziroma nimajo TOS ( $n = 507$ )  
 Table 3: The difference between the average values of the two groups of subjects with ( $n = 52$ ) or without EPC ( $n = 507$ )

Trditve/Statements	Wilks $\lambda$	F	df1	df2	p
Razmišljam o tem, da bi bilo bolje, če bi bil mrtev, ali da bi si nekaj hudega naredil.	0,861	89,840	1	557	<0,001

Legenda/Legend: Wilks  $\lambda$  – vrednost Wilksove Lambde/value of Wilk's Lambda; F – vrednost testa/test values; df1 – prva diskriminantna funkcija/discriminant function 1; df2 – druga diskriminantna funkcija/discriminant function 2; p – statistično značilna razlika pri 0,05 ali manj/statistical significance at 0.05 or less

pacienti s TOS in brez njih – slednji imajo pogostejše socialne stike (Tabela 2).

Spremenljivka »Razmišljam o tem, da bi bilo bolje, če bi bil mrtev, ali da bi si nekaj hudega naredil« statistično značilna (Wilks  $\lambda = 0,861$ ,  $p < 0,001$ ) vpliva na razlikovanje med skupinama pacientov.

Glede na število zdravstvenih težav imajo preiskovanci s TOS v povprečju več zdravstvenih težav ( $\bar{x} = 6,13$ ,  $s_x = 2,650$ ) kot tisti, ki nimajo TOS ( $\bar{x} = 3,81$ ,  $s_x = 2,353$ ). Razlika med skupinama je statistično značilna (Wilks  $\lambda = 0,925$ ,  $p < 0,001$ ) (Tabela 3).

## Diskusija

Pri prvi hipotezi smo predvidevali, da so vsaj pri četrtini preiskovancev TOS prisotne, a hipoteze nismo potrdili. Ugotovili smo, da so TOS, ki spadajo med osebnostne motnje v odrasli dobi, prisotne pri desetini preiskovancev. Prišli smo do podobnih ugotovitev kot Marlowe in Sugerma (cited in Židanik, 2003), ki navajata 2–13% pojavnost osebnostnih motenj v splošni populaciji, višji odstotek osebnostnih motenj, med 15,5 in 32 %, pa navaja Kaplan (cited in Židanik, 2003). Židanik (2003) z raziskavo ugotovi zelo visok delež potencialno osebnostno motenih ljudi v

mariborski regiji (41,2 %). Incidenca duševnih bolezni pri odraslih prebivalcih Združenih držav Amerike je ocenjena na eno od štirih oseb (Kessler, et al., 2005) in eno od petih družin (Medline Plus, 2009). Naša raziskava je pokazala, da so preiskovanci s TOS starejši, kar lahko verjetno pripišemo tudi visokemu deležu zajetih starostnikov v vzorcu. Imajo tudi nižjo stopnjo izobrazbe. Nižja stopnja izobrazbe, visoka starost in prisotnost TOS lahko otežijo proces zdravstvene nege in ovirajo socialne interakcije, učenje socialnih veščin in vedenjsko kognitivnih tehnik (Magoteaux & Bonnivier, 2009). Raziskava je pokazala, da imajo preiskovanci, pri katerih TOS niso prisotne, pogostejše socialne stike. Potrdili smo hipotezo, da obstajajo razlike v socialnem vključevanju med pacienti, ki imajo TOS, in tistimi, ki jih nimajo. Ta rezultat je razumljiv glede na to, da so pacienti s TOS osebnostno ranljivi, kar se kaže s težjim prilagajanjem in težavami pri vzpostavljanju ter vzdrževanju medosebnih odnosov (The ICD-10 classification of mental and behavioural disorders, 1992), kar lahko vodi do socialne izključenosti, stigmatizacije in diskriminacije (Resolucija o nacionalnem programu duševnega zdravja, 2011). Strokovnjaki opažajo, da se duševnim boleznim pogosto pridružijo še telesne bolezni in

tudi obratno; kroničnim telesnim boleznim se rade pridružijo različne duševne bolezni, najpogosteje depresija (Annells, et al., 2011; Inštitut za varovanje zdravja Republike Slovenije, 2010). Pri starejših odraslih s travmatično izkušnjo obstaja višja stopnja tveganja za pogostejše telesne zdravstvene težave, kot so kronične bolezni, slabše telesno delovanje, gastritis, angina pectoris in artritis (Pietrzak, et al., 2012). Med različnimi zdravstvenimi težavami je največ preiskovancev v naši raziskavi omenjalo bolečine v hrbtenici ali vratu (več kot polovica), nekaj manj (četrtnina) pa jih je omenjalo glavobole in migrene. Naše ugotovitve lahko primerjamo z ugotovitvami študije Lew in sodelavci (2009), kjer je bila najpogostejša kronična bolečina prav tako locirana na hrbtenici in glavi. Potrdili smo tudi hipotezo, da je med pacienti s kroničnimi bolečinami večji delež tistih s TOS. Rezultat je pričakovan, saj predstavlja kronična bolečina trpečo izkušnjo posameznika in povečuje njegovo osebnostno ranljivost (Ščavničar, 2004). Več raziskovalcev v pregledu literature je ugotovilo škodljive učinke slabšega duševnega zdravstvenega stanja na kronične bolezni, vključno s počasnejšim zdravstvenim okrevanjem in pogostejšo uporabo zdravstvenih storitev (Annells, et al., 2011). Preverjali smo, ali je incidenca zdravstvenih težav pri pacientih s TOS višja. Tudi to hipotezo smo potrdili, saj je raziskava pokazala, da imajo preiskovanci brez TOS v povprečju manj zdravstvenih težav. Razlike glede na spol so statistično značilne, in sicer imajo ženske v povprečju več zdravstvenih težav kot moški. Potrdili smo tudi hipotezo, da pacienti s TOS v pogostejše razmišljajo o samomoru. Ta podatek je zelo pomemben, saj retrospektivne študije ugotavljajo, da je imela ena tretjina ljudi, ki je napravila samomor, eno od osebnostnih motenj (Židanik, 2003). Izkušnje s travmatičnim dogodkom je v raziskavi izrazila več kot polovica preiskovancev, od tega tri četrtine moških in več kot polovica žensk. Naše ugotovitve lahko primerjamo z ugotovitvami študije Schore (2002), ki navaja, da kar 60 % moških in 50 % žensk v svojem življenju izkusi travmatični dogodek. Nekaj manj kot polovica preiskovancev je doživela katastrofično/travmatično izkušnjo, ki je vključevala resno poškodbo njih ali drugih ali grozečo smrt oz. so videli, kako je bil nekdo drug poškodovan ali ubit. Nasilju, zlorabi (psihični, fizični, spolni) in zanemarjenju je bila izpostavljena petina preiskovancev. Do podobnih ugotovitev o nasilju v družinah so prišli Sedmak in sodelavci (2006) z javnomnenjsko raziskavo na reprezentativnem vzorcu 1006 polnoletnih prebivalcev Slovenije. Potrdili smo hipotezo, da je med pacienti, ki so doživeli travmatični dogodek, več tistih, pri katerih so prisotne TOS. Rezultat je razumljiv in potrjuje tudi definiranje značilnosti TOS (The ICD-10 classification of mental and behavioural disorders, 1992). Izpostavljenost ekstremni travmi v zgodnjem otroštvu in/ali dolgotrajni travmatizaciji v

odrasli dobi je primarni dejavnik pri razvoju motenj osebnosti, povezanih z osebnostno ranljivostjo, kot so nasilje, izogibanje in nenavezanost (Daud, et al., 2008; Rick & Douglas, 2007). Mulvihill (2005) trdi, da so travmatične/katastrofične izkušnje v otroštvu povezane tudi z duševnimi in telesnimi težavami v kasnejšem življenju. Enaka spoznanja smo dokazali tudi z našo raziskavo. V povprečju imajo preiskovanci v raziskavi največ težav pri izvajanju življenjskih aktivnostih, kot je hoja oz. pomicnost, najmanj pa z oblačenjem in slačenjem. Manj kot petina jih potrebuje pomoč druge osebe in tehnične pripomočke, nekaj jih ima prilagojeno stanovanje. Preiskovanci, pri katerih so prisotne TOS, so pri opravljanju življenjskih aktivnosti manj samostojni in potrebujejo več pomoči, kar je razumljivo tudi zaradi značilnosti visokega deleža starostnikov v vzorcu. S tem smo potrdili 3. hipotezo. Nekaj več kot polovica preiskovancev se zdravi pri družinskem zdravniku, več kot tretjina pa pri družinskem zdravniku in specialistu, nekaj se jih zdravi pri psihiatru. Presenetil nas je nizek delež preiskovancev s TOS (četrtnina), ki se zdravi pri psihiatru. Ta podatek nam dokazuje, da so TOS pri preiskovancih neprepoznane, nezdravljene in ostajajo skrite v ozadju duševnih in telesnih zdravstvenih težav, kar potrjujejo tudi ugotovitve iz pregleda literature (Židanik, 2003; Benedik, 2004; Magoteaux & Bonnavier, 2009). Vzrok lahko iščemo tudi v tem, da pacienti s TOS niso sposobni samoobvladovanja lastnega položaja in spoznanja, da si morajo poiskati ustrezno strokovno pomoč. Tukaj je vloga patronažnih medicinskih sester izrednega pomena, da prepoznajo osebnostno motnjo in skozi terapevtski odnos, ki temelji na zaupanju, podpori, zdravstveni vzgoji pacienta in svojcev, zagotovijo ustrezne oblike pomoči (Maddern, 2004; McAllister, 2010; Annells, et al., 2011).

Ugotovitve rezultatov in ugotovitve iz pregleda literature kažejo na nekatere skupne značilnosti pacientov, pri katerih so prisotne TOS: so starejši in manj izobraženi (nad 65 let, osnovnošolska izobrazba), štiri petine jih ima izkušnje s travmatičnim dogodkom, pri njih je prisotnih več zdravstvenih težav (duševnih in telesnih), imajo več izkušenj s kroničnimi bolečinami, izraženih več samomorilnih misli, več težav pri izvajanju življenjskih aktivnosti, redkejša socialna stike, so slabše socialno integrirani in imajo slabšo socialno mrežo, le četrtnina pacientov s TOS se zdravi pri psihiatru (od 53 samo 10) in večina TOS pri pacientih je neprepoznanih, nezdravljenih in skritih za duševnimi in telesnimi zdravstvenimi težavami.

Rezultati raziskave ne odražajo nujno tudi realnega stanja populacije v patronažnem varstvu v osrednjeslovenski regiji. Tako ne moremo zagotovo trditi, da imajo vsi pacienti, ki jih je instrument z analizo rezultatov v raziskavi prepoznal kot osebe s TOS, tudi dejansko TOS, vendar pa dobimo vpogled v stanje. Zlasti so zaskrbljujoči odgovori glede samomorilnega

vedenja in socialne izključenosti. Rezultatov raziskave ne moremo posploševati na celotno populacijo v Sloveniji, opozarjajo pa na delež pacientov s TOS, pri katerih so le-te večinoma neprepoznane, nezdravljene in skrite v ozadju duševnih in telesnih zdravstvenih težav. Prek tega rezultati izkazujejo potrebo po usmerjanju pozornosti na pravočasno prepoznavanje, odkrivanje osebnostne patologije v vsakdanji profesionalni praksi patronažne zdravstvene nege v domačem okolju ter potrebo po napotitvi in multidisciplinarnem pristopu obravnave pacientov za doseganje čim višje kakovosti njihovega življenja, pri čemer je vloga patronažnih medicinskih sester zelo pomembna. Rezultati in dodatno znanje o trajnih osebnostnih spremembah, ki ga v šolskih sistemih ni, so lahko podlaga za izboljševanje zdravstvene nege pacientov z duševnimi motnjami na domu. Nadaljnji raziskovalni izziv bi bil nacionalni projekt.

## Zaključek

Zaradi kontinuirane prisotnosti na terenu so patronažne medicinske sestre pogosto prve, ki izvedo za stisko pacientov. Izkušnje kažejo, da je uspeh profesionalnega dela patronažnih medicinskih sester odvisen od kakovosti vzpostavitve prvega stika s pacientom in družino. Pacienti s TOS niso sposobni samoobvladovanja lastnega položaja z uvidom, kar predstavlja težje izhodišče za obravnavo. To dejanje zahteva mnogo vztrajnosti, potrpljenja, pogajanja, predvsem pa spretnosti komunikacije skozi terapevtski odnos. Pomembno je tudi, da medicinska sestra v patronažnem varstvu na svojem terenu pozna rizične skupine prebivalstva in ve, katere dejavnosti so organizirane, da lahko načrtuje zdravstveno nego, usmerja paciente in njihove svojce ter jim pomaga urejati mreže služb in servisne storitve na domu. Ukrepi proti izvorom diskriminacije, stigmatizacije in s tem socialne izključenosti lahko zelo pripomorejo k vsem pobudam za izboljšanje duševnega zdravja prebivalcev. Zdravstveno nego pacientov s težavami v duševnem zdravju, kot so TOS, lahko izboljšamo s promocijo zdravja, pravočasnim prepoznavanjem, psihosocialno oceno, napotitvijo, podporo in multidisciplinarnim pristopom pri zdravljenju, rehabilitaciji in integraciji oseb v socialno mrežo.

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