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Understanding the attitudes of paramedics towards suicidal patients

Razumevanje odnosa reševalcev do pacientov, ki so samomorilno ogroženi

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ABSTRACT

Introduction: Since it is almost impossible to identify every suicidal person, the timely intervention of an emergency medical team is of the most importance for preventing suicide attempts. Yet its success depends not only on timely help, but also on the treatment of the suicidal individual, the quality of which is to a large degree determined by the attitudes of the paramedics to the suicide. Hence, this article addresses the issue of how Slovenian paramedics experience suicidal patients, or in other words, what their attitudes to suicidal patients are when treating them.

Methods: This study is based on a descriptive qualitative method of empirical research, in which inductive analysis has been used. To collect the empirical material, semi-structured interviews with ten paramedics were conducted between December 2012 and January 2013.

Results: Despite their professional conduct in working with suicidal patients, Slovenian paramedics often experience various unpleasant emotions while treating them. Although they show understanding, the paramedics are often caught in dilemma while treating suicidal patients, especially those that refuse help or are aggressive. During the treatment, the paramedics act according to their subjective risk assessment and previous work experience, yet they lack the expertise to work with suicidal patients, particularly communication skills.

Discussion and conclusion: The attitude of the participants to suicidal patients is based primarily on the emotional aspect of their work. The research showed that a negative attitude may appear, but is not permanent. It appears only in certain conditions when caring for patients who are aggressive or threaten others and when the participants have not received help from other services.

IZVLEČEK

Uvod: Ključnega pomena pri preprečevanju samomora je pravočasna intervencija ekipe nujne medicinske pomoči. Kakovost obravnave je v veliki meri determinirana z odnosom reševalcev do samomora. Raziskovalno vprašanje je, kako doživljajo in kakšen odnos imajo člani ekip nujne medicinske pomoči do samomorilno ogroženih.

Metode: Raziskava temelji na kvalitativni metodi, uporabljena je bila deskriptivna tematska analiza. Podatki so bili zbrani s pomočjo polstrukturiranih intervjujev desetih namensko izbranih reševalcev. Analiza empiričnega gradiva je bila izvedena po smernicah utemeljene teorije.

Rezultati: Identificiranih je bilo šest kategorij, ki s pripadajočimi kodami omogočajo razumevanje odnosa v raziskavo vključenih reševalcev do pacientov po poskusu samomora. V raziskavo vključeni reševalci se pri delu s pacienti po poskusu samomora soočajo z različnimi neprijetnimi čustvi. Med obravnavo pacientov, ki so samomorilno ogroženi ali so po poskusu samomora, se soočajo z dilemo, predvsem pri tistih, ki odklanjajo pomoč ali so agresivni. Skušajo jim pomagati na različne načine na podlagi subjektivne ocene ogroženosti ter izkušenj, toda za delo z njimi jim še vedno manjka potrebnega znanja, predvsem s področja komunikacije.

Diskusija in zaključki: Odnos udeležencev raziskave do pacientov, ki so samomorilno ogroženi ali so po poskusu samomora, temelji predvsem na čustveni komponenti njihovega dela. Raziskava pokaže, da se pri udeležencih raziskave pojavlja odklonilen odnos, vendar ta ni trajen, pojavlja se le v določenih pogojih, odvisnih od dejavnikov, kot so: ogrožanje drugih, nasilje pacientov, podpora drugih služb in ostalo.

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Introduction

Suicide is a conscious act that causes one's own death with foreseen certainty (Valetič, 2009). As a social phenomenon, it can be found virtually everywhere in the world, but has a varying incidence in different cultures and societies around the world. While suicide is certainly one of the most intimate acts on which a person can decide, it also presents a major concern and public health problem and a challenge to health policy in countries burdened with high suicide rates (Marušič & Zorko, 2003; Roškar, 2009). The high suicide rate has also been addressed Slovenia, which, after Lithuania, Hungary and Finland, ranks fourth in the number of suicides in the European Union (Bertolote & Fleischmann, 2002). While almost 25 % fewer Slovenes committed suicide than even two decades ago, Slovenia has recorded an increase in the number of suicides since 2010 according to data compiled by the Institute of Public Health (2011). Domestic and foreign experts have attributed this increase to the unfavourable social situation and the decline in the standard of living due to the economic crisis that has engulfed the world in recent years (Groleger, 2009; Stuckler, et al., 2009; Pompili, et al., 2014; Karanikolos, et al., 2013; McDaid, et al., 2013; Korošec Jagodic, et al., 2013). According to the statistics, 436 inhabitants of Slovenia die of suicide every year, of whom 347 are male and 89 are female, with the average age being 57 years (Kalin, 2012). According to the most recent data for 2012, 443 people found themselves in a situation from which they saw no way out, of whom 363 were male and 80 were female. Thus, the suicide rate for 2012 was 21.54 (the number of deaths due to suicide per 100,000 people). However, it should be stressed that a great deal has been done regarding the prevention of suicide in Slovenia, as the suicide rate at the beginning of the last decade was 30 people per 100,000 inhabitants (Vrdelja, 2013).

Because suicide is not a momentary event, but the results of a longer process, there has been an increasing focus on preventing suicide and researching the risk factors in different population groups (Weaver & Wright, 2009; Roškar, 2009). Here, the timely identification of suicidal people and professional assistance is crucial (Marušič & Zorko, 2003; Weaver & Wright, 2009). However, despite preventive measures, it is probably impossible to ever prevent all suicide attempts. It is also true that not every suicide attempt ends in death. Heath-care and nursing professionals in Slovenia and abroad continuously come into contact with a rising number of such patients following attempted murder, where the attitude of nursing professionals to such patients varies (Bregar, 2012). According to different studies, the attitude of nurses to patients following a suicide attempt depends on various factors that affect the quality of health care. The findings show that the attitude of health-care employees to patients who have attempted suicide is most often determined by the following factors: psychiatric training, religious convictions, moral values, level of nursing training, emotional intelligence and work experience (Sun, et al., 2007; Carmona-Navarro & Pichardo-Martínez, 2012).

These socio-cultural factors also determine the relationship of emergency medical teams in the field, who are not only in contact with such patients, but usually offer first aid to the patient after a suicide attempt. Therefore, first-aid is of great importance to patients and also depends on their situation and willingness to participate. Therefore, it is very significant for emergency medical teams to approach the patient, considering their health and willingness to cooperate. Consequently, both doctors and paramedics should have a wealth of knowledge of, and experience in, treating suicidal patients, but they should also be able to take effective action at the site (Kregar, 2012). However, because paramedics often work in difficult conditions, some studies have noted a negative attitude to patients who have attempted suicide especially among members of emergency medical teams. The main reasons for the negative attitude of paramedics to patients following a suicide attempt include the aggressiveness of the patients, difficult working conditions and lack of mental health training (Suokas, et al., 2008; 2009). Studies on attitudes to patients following a suicide attempt use both qualitative and quantitative methods; the latter are more oriented to researching and measuring the prevalence of certain aspects of the attitude or to explaining connections or dependencies between variables. On the other hand, qualitative methods seeks to understand the attitudes of health-care professionals towards patients following suicide attempts (Chan, et al., 2009; Osafo, et al., 2012; Er, et al., 2013).

Purpose and objectives

The attitudes of employees in nursing in different areas of specialisation to various patient conditions can significantly affect the quality of care that patients receive (Ouzouni & Nakakis, 2009; Saunders, et al., 2012). Because, according to some foreign research, the reasons paramedics may have negatives attitudes to patients following a suicide attempt include unbearable working conditions and lack of understanding of the (violent) behaviour of patients that they are trying to help (Suokas, et al., 2008; 2009), the purpose of our study is to verify whether participants in the study (referred to as the participants) had a negative attitude to patients following a suicide attempt and to suicidal patients, and, if yes, what contributes to the emergence of negative attitudes. The aim of this research is to identify and understand whether difficult working conditions and a lack of understanding of patients' behaviour patterns are also contributing factors in

Slovenia. Therefore, the basic research question is what the attitude of paramedics to suicidal patients or patients following a suicide attempt is.

Methods

A qualitative case study was carried out, which means that the research problem was researched, analysed and comprehensively described. We conducted a qualitative analysis of the empirical material. When collecting, managing and analysing empirical material, we followed the guidelines of the grounded theory method described by Mesec (1998), which, according to Polit and Beck (2012) has become an important method for exploring various concepts in nursing. Like Urbanc (2008) in Slovenia, Polit and Beck (2012) also argue that it is a systematic method, as it requires a series of particular working procedures. The analysis of empirical material is analytical, and consists of four stages: definition of coding units, open coding, axial coding and relational encoding (Urbanc, 2008). Mesec (1998) argues that grounded theory is almost the same as inductive theory, because, like the former, it is based on collected and analysed empirical data. It is very useful for displaying, understanding and exploring links between data obtained in a survey, and focuses on new findings. The disadvantage is that the work is very demanding, rigorous and time-consuming (Urbanc, 2008). The objective of a qualitative analysis of data according to the grounded theory method is to show the relationship of people to the problem being investigated (Polit & Beck, 2012); it is not always necessary to draw up a hypothesis, as the objective of this method can be judgments, arguments and explanations of how a problem that we want to study is understood.

Description of the instrument

A semi-structured interview with open questions was used to collect empirical data, which was followed by sub-questions. According to the study's purpose and objective, the participants were asked four questions in the interview:

- How do you understand and feel about a patient following a suicide attempt?
- What do you feel when you are near a suicidal patient who is agitated and might be violent?
- How do you ensure the safety of a suicidal patient and an emergency medical team in practice?
- How do you feel when you offer emergency medical aid when feeling threatened by a patient?

Sample description

We used a purposive sample of nurses working in the ambulance services of pre-hospital emergency medical units from three different Slovenian regions. Diversity of participants was achieved by selecting them from different emergency medical units in the country; half of them were female, while half of the participants had completed tertiary education. All had at least seven years of working experience in emergency units. The tasks and duties of all the interviewees comprise working in primary health care in an emergency medical team within community health centres, which means that they encounter a variety of cases in the field. The crucial criterion for selecting the participants was their past experience with suicidal patients or those who had attempted suicide (at least three experiences with suicidal patients or those who had attempted suicide). The age group of participants varied from 30 to 54 years.

Ten persons were included. In the eighth participant, we began to recognise signs of data saturation, which was finally confirmed in the tenth participant, i.e. while reviewing the interviews, we noticed a repetition of the same data. Therefore, we are satisfied with the amount of data collected, although Marshall and colleagues (2013) highlight that data saturation is a highly subjective concept, varying from one researcher to another, so we need more robust guidelines in this respect with regard to the number of participants interviewed. Based on a review of over 80 qualitative studies using a variety of qualitative methods and techniques, established that the recommended number of interviewees involved in qualitative research using grounded theory is at least between 20 and 30, while adding that researchers have also interviewed a smaller number of participants than in our study.

Course of the study and data processing

Before conducting interviews, we acquired the written consent of the participant to participate in the study and informed each participant individually about the role, content, purpose of the study, and their rights. During the interview, we asked them sub-questions, directing them to the essence of the problem or eliciting specific thoughts, statements, further explanations or understanding. At the end of each interview, a transcript was made immediately, so that we were able to take into account relevant findings and conclusions in the following interview. The interviews were conducted on the mornings of December 2012 and January 2013 at a place and time selected by the participants. All the interviews were conducted at the workplace at the end of work. Interviews lasted approximately between 20 and 30 minutes.

This was followed by data processing. The aim of multiple re-readings was to search for codes through a coding process which links and combines similar events and thoughts in the statements in the empirical material. Using the inductive method, we then combined the codes into categories that are more abstract than the codes. By coding and categorising

words, we looked for the deeper meaning of the data, attempting to answer the research question (Vogrinc, 2008). In our case, during the analysis of empirical material, we searched for the encoded statements, thoughts and opinions of the participants, with which we sought to answer the research question. We found that similar codes were repeated when the participants described their feelings during the treatment of patients following attempted suicide. The codes were combined into more abstract categories with which we tried to explain more transparently and systematically the attitudes of the participants to patients following attempted suicide. The participants' statements were left unchanged, which is permitted in qualitative analysis.

All participants were informed of the confidentiality and security of the data obtained. They were also briefed on the right to refuse participation, which was voluntary and non-binding. They were informed that the interviews would be recorded, to which we had previously obtained their consent. The identity of the participants is protected in accordance with the recommendations and instructions of good practice. All interviews are kept in our archive. We were also careful to ensure that the interviewees did not name any patients during the interviews, thereby ensuring the patients' anonymity and data protection.

Results

In response to our fundamental research question, 'What is the attitude of paramedics to patients who are suicidal or have attempted suicide?', we observed quite early on while re-reading and transcribing the interviews that participants had a particular, sometimes negative attitude to patients following a suicide attempt, because aid is rejected, or because of the resistance of patients or their violent behaviour to paramedics. Therefore, we focused on seeking the causes of the negative attitudes of paramedics. All the participants had encountered several such patients. However, we did not ignore cases that showed a more positive attitude towards patients following a suicide attempt. It is our general finding that these patients are often more demanding when receiving medical care, so paramedics often do not understand them, particularly if they refuse help. The participants described this condition in patients as being in 'an uncontrollable state' and always took care of their own safety first in such cases.

'Our personal safety was, and has been, our primary concern.'

Only after the participants ensured their own safety, did they ensure the safety of the patient. In this respect, they often find themselves in a dilemma of how to act or treat a patient. Because they lack experience with psychiatric patients, they had concerns about using physical restraint or forced hospitalisation.

'Officially, the use of physical restraint has been forbidden for years, meaning various straight jackets, we only use a bandage or a scarf when a patient is aggressive. And, of course we can physically stop the patients as well as we can.'

In their line of work, in case the physician is not present or unreachable they are often forced to take decisions exceeding their competences.

'The main person here is the physician, not the paramedic, so everything we do we do together with the physician. Sometimes we can't get them on the phone, so we must, let's say, do something on our own; call the police, detain the patient, physically obstruct the patient.'

In the study, participants would often report negative attitude to some patients following suicide attempts. The question that we attempted to answer was where this negative attitude comes from or why it appears. We sought to provide the answer by analysing empirical material, merging similar codes into thematic categories to explain or understand negative attitude that appears towards some patients following suicide attempt:

- assessment of the patient's condition;
- emotional aspect of the work;
- the principle of due care;
- the principle of therapeutic communication;
- the principle of safety;
- the principle of cooperation.

The assessment of the patient's condition

We combined the codes of *individuality* and *the level of threat.* Because violent behaviour may appear following suicide attempt, the participants report that use of force while attempting to control violent behaviour makes sense and is necessary. In this respect, they say that timely assessment of the level of threat is important, both regarding aggression towards self and others. With regard to patients where the use of force was necessary, the participants always stress their mixed feelings towards them, particularly regarding the most vulnerable population groups, such as women and children. Consequently, we have established that, as a rule, paramedics approach their patients considering their individual characteristics and level of threat.

'It differs from person to person, we must find a different way for everyone,'

In this respect, they highlight groups of patients where this is a particularly sensitive issue.

'Surely one of the factors to consider is where it is a child, a child or a woman, depending on the ability of the patient.

Perhaps you have concerns when it comes to children not to apply this approach, because, well you're dealing with a child, but otherwise... I don't know... you still use physical force for the benefit of the patient, which is what guides us in such cases.'

Emotional aspect of work

When working with patients who have attempted suicide or are suicidal, the participants mentioned that they experienced various emotions while working with patients, including: *compassion, being affected, sadness, fear, despair, terror, anger, anxiety, stress* and *emotional exhaustion*. These codes can be divided into two sub-categories: promoters of negative attitude – *fear, despair, terror, anger, anxiety, stress and emotional exhaustion* – and promoters empathic attitude – *being affected, understanding, compassion and concern*. The codes reveal that the participants generally feel uneasy when treating patients who have attempted suicide. These feelings are even more pronounced when the patients are children and adolescents (*being affected* and *compassion*).

'Emotions get to you, but definitely I am affected the most, the most when it comes to children.'

These emotions are suppressed if patients persist in their intention, if they are still trying to commit suicide. In such cases, patients often not only refuse any help but also often become violent to participant, as they see the paramedics as an obstacle preventing them to reach their goal. In such cases, participants also reported feeling *fear, desperation* and *insecurity* and described their experience as *stressful*.

'it definitely comes with the job, but you still feel anxiety, fear... erhm... I don't know.'

In such situations they attempt to control their emotions, restrain them, but they are not always successful. Therefore, some events sometimes still act as a burden in their home environment, as they show signs of *emotional exhaustion*.

'It really depends on the situation, well, sometimes something happens and you end up thinking about it at home, but I really try to separate the two, so that I try to leave my problems at work, well, but sometimes something affects you. This is the nature of humans.'

Other participants reported that they found it easier to do their work and take the stress if the knew the reasons or motivations that led patients to commit suicide (*understanding*).

'I always look at the background, because I think about it a lot myself, if something happens to you in life... I don't know... a heavy illness or you experience social distress, then I find it easier to relate to the patient.'

Understanding was always accompanied by the feelings of *compassion*.

'You try somehow, but it affects you to a point, so you, you feel some compassion for them and you somehow try to understand, because this is also what, what people need.'

However, the participants showed no understanding for patients who perform self-inflicting acts on a recurring basis. They saw their behaviour as trying to get attention, which made them *desperate* or *angry* at patients or indifferent.

'I don't share the same feeling when it comes to those who are just trying to get attention.

Perhaps a bit, perhaps a bit when it comes to those who've tried before, because, let's say, we've had patients who attempted to commit suicide every week, just to let out their frustrations, as it were, just, let's say, to get our attention. I feel no empathy for such people.'

Despite the statements the participants did not condemn these patients. The background was always mentioned as an apology or an explanation of why an individual was prompted to act in such a way, which suggests an *understanding* when dealing with patients following a suicide attempt, which is always at the forefront when offering first aid to such patients.

'I believe that I have no right to condemn them (sigh), this is where life can take you.'

'I can say that I haven't been in a situation where I'd condemn them.'

The principle of due care

The principle of due care is reflected in their *care for the patient, taking responsibility, exceeding their competences and the feeling of guilt.* They feel responsible for the patient's safety from the first contact to the moment of delivery, which reflects their concern.

'From the moment that I take him over to the moment when I deliver them to the personnel in the psychiatric clinic, he is under my care and I'm not indifferent to what goes on with him in the mean time.'

According to experience, the participants often assume the whole responsibility for the patients: they often take decisions that exceed their competences.

'The main person here is the physician, not the paramedic, so everything we do we do together with the physician. Sometimes we can't get them on the phone, so we must, let's say, do something on our own; call the police, detain the patient, physically obstruct the patient.'

In case there was any damage incurrent during the attempt to control the patient's dangerous behaviour, they would feel guilty and responsible for the damage.

'The feeling of helplessness or the feeling (cough) of guilt if something happened to her because, essentially, I am responsible for her health, aren't I?'

Principle of therapeutic communication

The typical codes connected to the principle of therapeutic communication are those addressing the lack of communication skills as *doubt in the knowledge*, *need for professional supervision and* on the other side also *lack of time*.

'To use precisely the words 'therapeutic communication', ehm, I believe that we are, we are not very familiar with this here, right? I don't think we've mastered

it, right? As much as we should, this is mostly the responsibility of the physicians, right? Here, even if they come to the clinic this is often done by physicians, but it depends, some are very demanding and it takes a long time, some are less demanding, but I don't believe that health care employees have mastered these skills.'

'But I do think that this is a skill that we associate with physicians more; that the physician does this.'

In cases when patients refuse help, participants believe that one should take the time to focus on the case.

'We've had cases when we were at the patient for two hours, but it didn't amount to anything, we had to physically intervene, which means that the police had to assist us so that we were able to deliver the patient to the psychiatrist.'

The participants also say that a discussion to assess the success of intervention and consequently communication is required every time.

'The team has a discussion, not only with regard to psychiatric, but all types of interventions in order to improve some things and replace others, so we talk.'

The principle of safety

The principle of safety refers to ensuring safety during emergency care. This is generally done based on the assessment of the patient's condition. Codes explaining this category include *insecurity, being careful, safe approach, personal safety, inappropriate coercive measures, extreme measures and urgent measure*. Although the codes show that safety in the field is a broad concept for the participants, it is obvious that, upon arrival, they first pay attention to the surroundings, try to find a safe way to approach the patient, monitor the patient's behaviour and gestures and try to prevent self-inflicted wounds. Herefore, they quickly remove any potentially dangerous objects that are within the reach of the patient who has attempted suicide.

'Yes, essentially, we must be careful if someone is aggressive, which means a danger to himself or others, you must control him somehow.'

They value their own safety above everything else. The safety of the patients and other people present comes second.

'In extreme situations we must call the police so that they can restrain them differently, so that we can come close, because we must also pay attention to our own safety.'

When they assess that they will not be able to ensure safety of everyone present, the ask police for assistance. In extreme situations, when a patient is a threat to himself/herself or others, they believe that such a patient must be hospitalised at any cost.

'Such persons must really receive help or should be even dragged somewhere because you can see that they need psychiatric assistance, that they are not only in a dire situation.

When it comes to forced hospitalisation, we cooperate with the police, because this enables us to approach the patient more safely, particularly where this is evident from medical history.'

When offering medical assistance, the participants also have concerns with regard to using force to control the patient, particularly when it comes to women and children, as they believe that physical restraints are inappropriate in such cases.

'Surely one of the factors to consider is where it is a child, a child or a woman, depending on the ability of the patient.

Perhaps you have concerns when it comes to children not to apply this approach, because, well you're dealing with a child, but otherwise... I don't know... you still use physical force for the benefit of the patient, which is what guides the us in such cases.'

According to the participants, physicals restraints, such as hand-cuffs or straight jackets are not only forbidden by law, but also morally and ethically disputable, and inappropriate. Officially any physical restraints are forbidden out of pshychiatric hospitals and therefore according to participants, they use them rarely and improvise with non-standardised equipment. It has been several years since they stopped using them. Talking with the patient and police presence is often enough for the patient to calm down. In very critical situations, which are rare, the participants still intervene in order to physically stop the patient. However, in such cases there are mostly attempts to physically control the patient who have attempted suicide with the help of the police until the physician authorises and ensures that the patient is calmed down by means of medication.

'It has been a long time since someone was in hand cuffs. We abandoned that, we have restraints and use it if necessary but it has been a lot time since anyone was handcuffed here.'

'Officially, the use of physical restraint has been forbidden for years, meaning various straight jackets, we only use a bandage or a scarf when a patient is aggressive. And, of course we can physically stop the patients as well as we can. So, officially, physical restraints are not used in emergency medical assistance. The only restraint that we can use is chemical substance, we can administer tranquillisers under the supervision of a physician, but nothing else.'

The principle of cooperation

The category of mutual cooperation proves that assistance of other professionals is required in order for the work to be effective. Participants believe that police officers are their most important partners when dealing with suicidal and aggressive patients. The following codes typically appeared in this category:

police response time, police approach, establish procedure, limited expectations. According to participants, in many cases, the police should become involved sooner, when the patient is not completely agitated, uncontrollable or violent. Waiting until violence begins makes forced hospitalisation more risky and unpleasant.

'You'd expect them to respond more often and, I don't know, control the patient sooner... if they came sooner... in stead of waiting so that they are even more agitated then.'

When patients are agitated beyond control or even violent, the emergency team asks the police for assistance, expecting nothing other that the police to phycially control the patient using the professional skills and help them to escort the patient into the ambulance van while treating the patients with respect. The participants are sometimes critical of the approach taken by the police.

'They say that unless a patient is a threat, meaning a physical threat to himself, us, their environment or equipment, they can't do anything. The police only become actively involved when the patient's physical attack has already begun, when it can already be critical. Their explanation is that this is prescribed by law.'

The participants expect very little from the police.

'I only expect this from them, to protect me, the patient and so I am happy with their cooperation within what I expect from them. I expect nothing but to help me get this person from the house, flat, to get him in the ambulance and then to the hospital in a humane, dignified way.'

Discussion

The emotional aspect of the work is the central category in our opinion, determining the attitude of study participants towards patients who have attempted suicide the most. The results show that the attitude of the participants is not stable and varies (both positive and negative attitude towards patients have attempted suicide) and that, in principle, negative, attitude appears only in relation to certain factors that have to do with the patient and the participants. The participants particularly highlight patients who refuse emergency medical care following attempted suicide or who respond aggressively. Display of refusal or even violent behaviour following a suicide attempt is possible, particularly with patients who have impaired perception of reality due to mental illness or abuse of psychoactive substances (Koller, et al., 2002; Modesto-Lowe, et al., 2006). Therefore, we steered the interviews in this direction, as we believe that having an understanding attitude towards these patients is important for forming an attitude which can significantly affect the health care of patients according to some authors (Sun, et al., 2007).

The emotional aspect of work is divided into two sub-categories. The sub-category of *promoters of empathy* includes codes which promote greater understanding or empathy towards patients who have attempted suicide. The other sub-category is *promoters of negative attitude* and includes the codes explaining it.

The assessment of patient's condition affects the attitude. If they feel empathy, the participants try to understand patients who have attempted suicide and their background, which definitely affects their attitude towards the patients and their commitment to provide assistance (Sayumporn, et al., 2012). According to some studies, it is easier to develop a more positive attitude towards patients with whom it is easier to empathise (the participants consider these to be women and children), while the attitude is more negative to those towards whom we are unable to feel empathy. Studies mainly mention patients with recurring suicidal tendencies and self-inflicting behaviour, which are generally viewed upon more negatively, even possibly leading to inappropriate health care (McAllister, et al., 2002). Participants also report different attitude towards patients who have attempted suicide if they have recurring suicidal tendencies or frequent self-inflicting behaviour: during analysis of empirical material statements such as: *'those who have done this before…', '… who attempted suicide every week …', '… let out their frustrations' and 'to get our attention'*, which made the participants experience emotions such as *desperation, fear, anger*. We believe that these are *promoters of negative attitude*. Nevertheless, some participants mention *'no right to condemn them…'*. Therefore, we can assume that with regard to these patients who have attempted suicide, whose behaviour promotes negative attitude, the participant still act according to the *principle of due care*.

According to our study, lack of therapeutic communication skills (*the principle of therapeutic communication)* and the feeling of safety (*the principle of safety*) promote a negative attitude of participants towards patients who have attempted suicide as they can lead to negative emotions, *stress* and *emotional burn-out*. Some authors argue that providing assistance can be stressful for nurses and can lead to emotional burn-out without appropriate support of the working environment (Selič, 2010; Bregar, et al., 2011). In such cases, it is possible for the paramedics to develop defence mechanisms, establishing a distance towards some patients, which can negatively affect further relationship (Regehr, et al., 2002) and may lead to less appropriate or negative attitude towards patients who have attempted suicide.

The participants believe that they lack the skills to communicate with patients who have attempted suicide, who may resist help and can become aggressive, which is confirmed by statements such as *'…'therapeutic communication', we are not very familiar with this' and 'I don't think we've mastered it'*. The participants attribute greater therapeutic

communication skills to physicians, which also testifies to strict division of authority, which is not always the most effective working method. In this respect, Bregar (2012) argues that 'today, nursing interventions regarding suicidal patients are dominated by other influential groups in the health care system, which prevents a more independent role of the providers of nursing care.' Participants see communication with such patients more demanding, requiring additional skills. According to their experience, communication with more demanding patients can take longer (*'We've had cases when we were at the patient for two hours'*), but there is not always enough time. Patients who have attempted suicide typically require more attention and time for good communication that focuses on the problems of the patient. In this respect, communication skills possessed by nurses working with these patients are important (Sun, et al., 2005). Qualitative research conducted abroad examined the lack of skills with regard to nurses working in emergency units. The participants believed that they particularly require additional training in mental heath care, where communication skills are very significant (Kerrison & Chapman, 2007).

According to the participants, ensuring safety (*the principle of safety)* is among the most important interventions, not only in terms of ensuring physical safety of the patient, but also in terms of the need to constantly monitor the surroundings. The principle of safety is very much intertwined with the *principle of due care*, as the participants are aware that they are required to provide urgent medical assistance both to patients displaying aggression towards themselves and/or others. This is despite the fact that, according to their statements (*because we must also pay attention to our own safety*), their safety may be compromised. Even foreign authors (Kerrison & Chapman, 2007) confirm our statements that the safety in emergency nursing care when treating patients with mental issues, may often be viewed as compromised. Therefore, emergency nurses can dislike providing medical care to such patients described. Due to the lack of knowledge in this area, the behaviour of some employees may even increase the patient's tension, which may lead to aggression towards others. The participants have also expressed doubts with regard to appropriate medical treatment of suicidal patients. They recognise ambiguous descriptions regarding the permissible use of physical restraint with aggressive patients as a weakness, because legislation only defines permissible use in psychiatry (Zakon o duševnem zdravju/Mental Health Act, 2008). When prompt action is required in legally ambiguous cases in order to ensure the safety of the patient and staff, this can be a source of unpleasant emotions and stress (*promoters of negative attitude*), which may again lead to negative attitude of the participants towards patients who have attempted suicide.

The principle of safety is intertwined with *the principle of cooperation*, which means that when participants assess that they cannot ensure an environment safe enough for themselves and the patient, they ask police for assistance, *'In an urgent situation we must call the police so that they can restrain them differently…'*. Police cooperation is mostly required with forced hospitalisations, where physical restraint is also needed. The participants often encounter the issue of legality of using physical restraint, as the legislation has not defined their use outside psychiatric institutions (Zakon o duševnem zdravju/Mental Health Act, 2008). If police assistance is timely and effective, participants have a greater sense of safety and are more satisfied with the interventions, which in turn may affect their attitude towards patients who have attempted suicide, refuse assistance and may also be violent.

Study limitations

In order to be impartial to the findings of the conducted study, we should note the limitations of the research. The principle investigator is also employed in an emergency medical unit, which may have affected the conduct of interviews as well as analysis because of her own feelings and expectations regarding this issue. In her long career, she has herself perceived the problematic attitudes towards the patients presented in the study, and, as a woman, felt threatened during their medical treatment. However, personal involvement of the investigator in the issue is not problematic in qualitative studies, as it is even recommended that they know the issue well. The investigator personally knows some study participants. Only nursing employees were included in the study. Statements of medical professionals would also be interesting, as their responsibility makes it likely that they perceive their work with suicidal patients or those who have attempted suicide differently. Finally, while these results cannot be generalised, some can provide a starting point for further research.

Conclusion

When analysing empirical material we focused on the attitude of study participants who have experience in resistance, refusal of assistance or violence from patients who have attempted suicide. In order to clarify the attitude of the participants towards these patients, we identified some categories, with the central one being the emotional aspect, as the latter can, in our opinion, best explain the attitude towards patients following a suicide attempt. It is necessary to understand that the emotional aspect of this work depends on several factors that are intertwined and complex.

In conclusion, we wish to stress that it does not make sense to use the categories of positive and negative

attitudes, because the attitude varied from positive to negative and vice versa. It would make much greater sense to see or discuss the attitude towards patients as a continuous process where values or quality moves in different directions due to different factors that depend on study participants as individuals, the physical environment and society. We believe that the analysis has shown that negative attitude of participants towards patients who have attempted suicide is more often linked to the factors that emerge from within: the participants feel threatened, they do not have normal working conditions, they state that they lack knowledge to work with the patients who have attempted suicide and sometimes they are not able to face what they encounter during their work, etc. It is interesting that no participant mentioned religious belief as a reason for negative attitude.

It is our conclusion that due to the lack of psychiatric knowledge study participants approach patients who have attempted suicide too subjectively and that their understanding (even empathy) and approach to the patients is based solely on subjective views that are rooted in social and cultural norms.

The findings of qualitative study conducted among paramedics should also undergo quantitative analysis and provide appropriate support to the employees of emergency units. Guidelines should be drawn up and training on aspects of suicide should be organised, focusing on communication skills. In addition, legislation should be updated so as to formalise procedures and provide legal protection for both the patients and providers of nursing care, particularly regarding physical restraint of patients, where non-standard equipment continues to be used.

Slovenian translation/Prevod v slovenščino

Uvod

Samomor je zavestno dejanje, ki s predvideno gotovostjo povzroči smrt storilca (Valetič, 2009). Kot družbeni pojav ga najdemo tako rekoč povsod po svetu, a z različno pojavnostjo v različnih kulturah in družbah širom sveta. Vendar ob tem, da je samomor zagotovo eno najbolj intimnih dejanj, za katerega se lahko človek odloči, po drugi strani predstavlja ne samo velik in zaskrbljujoč javnozdravstveni problem, ampak tudi izziv za zdravstveno politiko držav, obremenjenih z visokim količnikom samomorov (Marušič & Zorko, 2003; Roškar, 2009). Z visokim količnikom samomorov se je ukvarjala tudi Slovenija, ki se je takoj za Litvo, Madžarsko in Finsko uvrščala na četrto mesto po številu samomorov v Evropski uniji (Bertolote & Fleischmann, 2002). Čeprav naredi samomor skoraj ena četrtina manj Slovencev kot na primer še pred dvema desetletjema, od leta 2010 v Sloveniji po podatkih Inštituta za varovanje zdravja (2011) ponovno beležimo porast števila samomorov. Domači in tuji strokovnjaki ta porast pripisujejo neugodnim družbenim razmeram in padcu življenjskega standarda zaradi gospodarske krize, ki je zajela svet v zadnjih nekaj letih (Groleger, 2009; Stuckler, et al., 2009; Karanikolos, et al., 2013; McDaid, et al., 2013; Korošec Jagodic, et al., 2013; Pompili, et al., 2014). Po podatkih v Sloveniji tako v zadnjem času zaradi samomora letno umre približno 436 prebivalcev, od tega 347 moških in 89 žensk, njihova starost pa je v povprečju 57 let (Kalin, 2012). Novejši podatki za leto 2012 govorijo o 443 osebah, ki so se znašle v brezizhodni situaciji, 363 moških in 80 ženskah. Tako je za leto 2012 samomorilni količnik znašal 21,54 (število umrlih zaradi samomora na 100.000 prebivalcev). V Sloveniji vseeno lahko poudarimo, da smo pri preventivi samomora naredili veliko, saj je samomorilni količnik v začetku prejšnjega desetletja znašal kar 30 oseb, umrlih zaradi samomora, na 100.000 prebivalcev (Vrdelja, 2013).

Ker samomor največkrat ni trenutni dogodek, ampak rezultat dlje časa trajajočega procesa, se vse več pozornosti namenja preprečevanju samomorov in raziskovanju dejavnikov tveganja v različnih skupinah prebivalstva (Weaver & Wright, 2009; Roškar, 2009). Pri tem sta ključni pravočasna identifikacija samomorilno ogroženih in strokovna pomoč (Marušič & Zorko, 2003; Weaver & Wright, 2009). Toda kljub preventivnim ukrepom najverjetneje ne bomo nikoli mogli preprečiti vseh poskusov samomora. Hkrati tudi drži, da se vsi poskusi samomora ne končajo s smrtnim izidom, zato se v zdravstvu in tudi v zdravstveni negi tako pri nas kot v tujini stalno in vse več srečujemo z velikim številom pacientov po poskusu samomora, do slednjih pa zaposleni v zdravstveni negi ne gojijo homogenega odnosa (Bregar, 2012). Kot so razkrile različne raziskave, je odnos zaposlenih v zdravstveni negi do pacientov po poskusu samomora odvisen od raznoraznih dejavnikov, ki vplivajo na kakovost njihove zdravstvene obravnave. Raziskovalci so tako dognali, da odnos zaposlenih do pacientov po poskusu samomora največkrat določajo naslednji dejavniki: znanje zaposlenih s področja psihiatrije, verska prepričanja, moralne vrednote, stopnja izobrazbe, čustvena inteligenca in pretekle delovne izkušnje (Sun, et al., 2007; Carmona-Navarro & Pichardo-Martínez, 2012).

Našteti družbeno-kulturni dejavniki določajo tudi odnos reševalcev v ekipah nujne medicinske pomoči, ki na terenu niso le pogosto v stiku, ampak običajno tudi prva pomoč pacientu po poskusu samomora. Za ekipo nujne medicinske pomoči je zato velikega pomena ustrezen pristop k pacientu glede na njegovo pripravljenost k sodelovanju. Posledično morajo tako zdravniki kot reševalci posedovati veliko znanja in izkušenj s področja obravnave samomorilno ogroženega pacienta in ob enem znati tudi učinkovito ukrepati na mestu dogodka (Kregar, 2012). Toda ker

reševalci pogosto delajo v težkih pogojih na terenu, so nekatere raziskave zaznale negativen odnos do pacientov po poskusu samomora zlasti med zaposlenimi v ekipah nujne medicinske pomoči. Poglavitni razlogi za negativen odnos reševalcev do pacientov po poskusu samomora so npr. nasilnost pacientov po poskusu samomora, težki delovni pogoji, pomanjkljiva izobrazba s področja psihiatrije ipd. (Suokas, et al., 2008; 2009). Odnos do pacientov po poskusu samomorase raziskuje s pomočjo kvalitativnih in kvantitativnih metod, od katerih so slednje usmerjene bolj k raziskovanju oziroma merjenju pogostosti pojavnosti določenih komponent odnosa ali pa skušajo razložiti povezave ali odvisnosti med posameznimi spremenljivkami; s kvalitativnimi metodami pa se bolj odkriva razumevanje odnosa zaposlenih v zdravstvenem varstvu do pacientov po poskusu samomora (Chan, et al., 2009; Osafo, et al., 2012; Er, et al., 2013).

Namen in cilji

Odnos zaposlenih v zdravstveni negi na različnih področjih do raznih stanj pacientov lahko bistveno vpliva na kakovost zdravstvene nege, ki jo pacienti prejemajo (Ouzouni & Nakakis, 2009; Saunders, et al., 2012). Ker nekatere tuje raziskave kažejo, da imajo lahko reševalci negativen odnos do pacientov po poskusu samomora, med drugim zaradi nemogočih delovnih pogojev in nerazumevanja (nasilnega) vedenja pacientov, ki jim skušajo pomagati (Suokas, et al., 2008; 2009), je namen naše raziskave preveriti, ali udeleženci raziskave (v nadaljevanju udeleženci) gojijo negativen odnos do pacientov po poskusu samomora in do pacientov, ki so samomorilno ogroženi, in če to drži, preveriti tudi, kateri dejavniki prispevajo k pojavu negativnega odnosa. Cilj te raziskave je ugotoviti in razumeti, ali so mogoče težki delovni pogoji na terenu in nerazumevanje vedenjskih vzorcev pacientov tudi pri udeležencih vzrok za pojav negativnega odnosa reševalcev do pacientov po poskusu samomora. Zastavili smo si temeljno raziskovalno vprašanje, kakšen je odnos reševalcev do pacientov, ki so samomorilno ogroženi, oz. do pacientov po poskusu samomora.

Metode

Izvedena je bila kvalitativna raziskava primera – raziskal se je dotičen raziskovalni problem, se analiziral in celovito opisal. Izvedli smo kvalitativno analizo empiričnega gradiva. Pri zbiranju, urejanju in analizi empiričnega gradiva smo upoštevali smernice, ki veljajo za metodo utemeljene teorije po Mesec (1998), za katero Polit in Beck (2012) pravita, da je v zdravstveni negi postala pomembna metoda za raziskovanje različnih pojavov. Tako kot pri nas Urbanc (2008) tudi Polit in Beck (2012) pravita, da gre za sistematično metodo, saj predpisuje vrsto nujnih postopkov dela. Značilnost take analize empiričnega gradiva je analitični proces dela, ki ga sestavljajo štiri faze: določitev enot kodiranja, odprto kodiranje, osno kodiranje in odnosno kodiranje (Urbanc, 2008). Mesec (1998) pravi, da je utemeljena teorija v osnovi enaka induktivni teoriji, saj temelji na zbranem in analiziranem empiričnem gradivu kot slednja. Zelo dobra je za prikazovanje, razumevanje in raziskovanje povezav med podatki, ki jih dobimo v raziskavi, in je usmerjena v odkrivanje novega. Slaba stran je, da je delo zelo zahtevno, natančno in zamudno (Urbanc, 2008). Cilj kvalitativne analize empiričnega gradiva po metodi utemeljene teorije je prikazati odnose ljudi do problema, ki ga raziskujemo (Polit & Beck, 2012). Pri tem ni nujno, da vedno pridemo do teorije, ampak so lahko cilj te metode dela tudi sodbe, trditve in razlage razumevanja problema, ki ga želimo raziskati.

Opis instrumenta

Za zbiranje empiričnega gradiva smo uporabili polstrukturirani intervju z odprtimi vprašanji, ki so jim sledila podvprašanja. Z ozirom na namen in cilje te raziskave smo udeležencem v intervjuju zastavili štiri vprašanja:

- Kakšno je vaše razumevanje in kakšni so vaši občutki do pacienta po poskusu samomora?
- Kaj občutite ob pacientu, ki je samomorilno ogrožen, agitiran in lahko tudi nasilen?
- Kako v praksi varnost zagotovite pacientu, ki je samomorilno ogrožen, in kako ekipi nujne medicinske pomoči?
- Kaj občutite pri nudenju nujne medicinske pomoči, kadar se ob pacientu počutite ogroženi?

Opis vzorca

Uporabili smo namenski vzorec, v katerega so bili vključeni aktivno zaposleni izvajalci zdravstvene nege na reševalnih postajah prehospitalnih enot nujne medicinske pomoči iz treh slovenskih regij. Raznolikost med udeleženci smo dosegli tako, da smo izbrali udeležence iz različnih enot nujne medicinske pomoči v državi, tudi po starosti je bila skupina udeležencev raznolika, od 30 do 54 let, polovica udeležencev je bila ženskega spola, polovica v raziskavo zajetih udeležencev je imela visokošolsko izobrazbo, vsi so imeli že najmanj sedem let delovnih izkušenj v enotah nujne medicinske pomoči. Dela in naloge vseh intervjuvanih oseb obsegajo delo v primarnem zdravstvenem varstvu, intervjuvane osebe delajo v enotah nujne medicinske pomoči v okviru zdravstvenih domov, kar pomeni, da se na terenu srečujejo z različnimi oblikami obravnav. Ključno merilo za izbiro udeležencev so bile pretekle izkušnje s pacienti, ki so samomorilno ogroženi ali so po poskusu samomora (vsaj tri izkušnje s pacientom, ki je samomorilno ogrožen ali po poskusu samomora).

V raziskavo smo vključili deset oseb. Pri osmem udeležencu smo že začeli prepoznavati znake zasičenosti podatkov, kar smo dokončno potrdili pri desetem udeležencu. To pomeni, da smo pri pregledu intervjujev že zaznali ponavljanje podatkov. Tako smo se zadovoljili s količino zbranih podatkov, čeprav Marshall in sodelavci (2013) opozarjajo, da je zasičenost podatkov lahko od raziskovalca do raziskovalca zelo subjektivno ocenjen podatek ter da na tem področju potrebujemo trdnejše smernice o številu v intervjuje vključenih udeležencev. Na podlagi več kot 80 pregledanih kvalitativnih raziskav, pri katerih so bile uporabljene različne kvalitativne metode in tehnike, so namreč ugotovili, da je priporočeno število vključenih intervjuvancev v kvalitativnih raziskavah, kjer se uporablja utemeljena teorija, najmanj od 20–30 udeležencev, vendar dodajajo, da so raziskovalci intervjuvali tudi manjše število udeležencev kot v naši raziskavi.

Opis poteka raziskave in obdelave podatkov

Pred izvedbo intervjujev smo si s pisnim zaprosilom pridobili soglasje udeležencev za sodelovanje in vsakega udeleženca posebej seznanili z vlogo, vsebino, namenom in pravicami v raziskavi. Med samim intervjujem smo jim zastavljali podvprašanja, s katerimi smo udeležence usmerjali k bistvu problema ali hoteli določene misli, izjave še dodatno raziskati oziroma razumeti. Po koncu vsakega intervjujasmo le-tega takoj prepisali, tako da smo pri naslednjem intervjuju lahko upoštevali določena spoznanja in ugotovitve na podlagi že izvedenih intervjujev. Intervjuje smo opravili v dopoldanskem času decembra 2012 in januarja 2013 na kraju in ob času po želji udeležencev. Pri vseh je bil intervju opravljen na njihovem delovnem mestu po zaključku delovnika. Intervjuji so trajali približno 20 do 30 minut.

Sledila je obdelava podatkov. Cilj našega večkratnega branja je bilo iskanje kod skozi proces kodiranja, kar pomeni, da smo v empiričnem gradivu povezovali in združevali podobne si dogodke in misli v izjavah intervjuvancev. Nato smo z induktivno metodo kode združili v kategorije, ki so bolj abstraktne od kod. S kodiranjem in kategoriziranjem besed smo iskali globlji pomen podatkov in tako skušali odgovoriti na raziskovalno vprašanje (Vogrinc, 2008). V našem primeru smo pri analizi empiričnega gradiva iskali oziroma kodirali izjave, misli in mnenja udeležencev, s katerimi smo iskali odgovor na raziskovalno vprašanje. Dognali smo, da se ponavljajo podobne kode, s katerimi so udeleženci opisovali svoja občutenja med obravnavo pacientov po poskusu samomora. Kode smo združili v bolj abstraktne kategorije, s katerimi smo skušali razložiti odnos udeležencev do pacientov po poskusu samomora na bolj pregleden in sistematičen način. Izjave udeležencev smo pustili nespremenjene, kar je pri kvalitativni analizi dopuščeno.

Vse udeležence smo seznanili z zaupnostjo in varovanjem pridobljenih podatkov. Seznanili smo jih tudi o pravici do odklonitve sodelovanja, ki je prostovoljno in neobvezujoče. Seznanjeni so bili, da se bo pogovor snemal, za kar smo si prav tako predhodno pridobili dovoljenje intervjuvanih oseb. Identiteta udeležencev je zaščitena v skladu s priporočili in navodili dobre prakse. Vse intervjuje hranimo v svojem arhivu. Prav tako smo pazili, da intervjuvane osebe med intervjuji niso nikogar od pacientov poimensko imenovale. Poskrbeli smo torej tudi za anonimnost in varstvo podatkov pacientov.

Rezultati

Kot odgovor na naše temeljno raziskovalno vprašanje: »Kakšen je odnos reševalcev do pacientov, ki so samomorilno ogroženi, ali do pacientov po poskusu samomora?« lahko rečemo, da smo že kaj kmalu po začetku, med sprotnim branjem in prepisovanjem intervjujev zaznali, da udeleženci gojijo poseben, občasno odklonilen odnos do pacientov po poskusu samomora zaradi odklanjanja in upiranja slednjih ali njihovega nasilnega vedenja do reševalcev. Zaradi tega smo se še pred zaključkom intervjujev začeli osredotočati na iskanje vzrokov odklonilnega odnosa reševalcev do teh pacientov. Vsi udeleženci so se v svoji praksi z opisanimi pacienti že večkrat srečali. Vendar pa moramo na tem mestu poudariti, da pri tem nismo prezrli tudi tistih primerov, ki prikazujejo tudi bolj pozitiven odnos do pacientov po poskusu samomora. Splošna ugotovitev je, da so opisani pacienti med obravnavo in nudenjem medicinske pomoči običajno bolj zahtevni in zato pogosteje podvrženi nerazumevanju reševalcev, še posebej, če odklanjajo pomoč. Takšno stanje so udeleženci običajno opisovali kot »neobvladljivo stanje pacienta« in v teh primerih so vedno najprej poskrbeli za lastno varnost:

»Na prvem mestu pa nam je oziroma bi nam naj bila naša lastna varnost, tako.«

Šele ko so udeleženci poskrbeli za lastno varnost, so poskrbeli za varnost pacienta. Pri tem so se velikokrat znašli v dilemi, kako ukrepati oziroma ravnati s pacientom. Ker nimajo izkušenj s pacienti s področja psihiatrije, so imeli pomisleke na primer o uporabi fizičnih ovirnic ali prisilni hospitalizaciji:

»Ovirnice se uradno ne sme uporabljati že vrsto let, se pravi, kot razne jopiče za zadrževanje, pa seveda pri agresivnih pacientih; kvečjemu kak povoj, ruto, pa seveda fizično oviranje pacienta, kot pač sami znamo.«

Pri svojem delu so v odsotnosti ali nedosegljivosti zdravnika velikokrat prisiljeni sprejemati tudi odločitve, ki presegajo njihove kompetence:

»Nosilec dejavnosti pri nas je zdravnik, ni reševalec. In potem tudi vse, kar delamo, delamo z zdravnikom. Včasih ga ne moreš dobit ne na telefon, in moramo delat, po domače povedano, na svojo pest – klicat policijo, pa bom rekel, pridržanje pacienta, fizično oviranje.«

V raziskavi so torej udeleženci navajali odklonilen odnos do nekaterih pacientov po poskusu samomora. Vprašanje, ki se nam je zastavljalo, je: od kod izvira odklonilen odnos oziroma zakaj se pojavlja. Odgovor na vprašanje smo iskali preko analize empiričnega gradiva, kjer smo posamezne med seboj podobne kode združevali v tematske kategorije, s katerimi lahko pojasnimo oziroma razumemo odklonilen odnos, ki se pojavlja do nekaterih pacientov po poskusu samomora:

- ocena pacientovega stanja;
- čustvena komponenta dela;
- načelo dolžnega ravnanja;
- načelo terapevtske komunikacije;
- načelo varnosti;
- načelo sodelovanja.

Ocena pacientovega stanja

Pod to kategorijo smo združili kodi *individualnost* in *merilo ogroženosti.* Ker se pri določenih pacientih po poskusu samomora lahko pojavi tudi nasilno vedenje, udeleženci pravijo, da je uporaba sile pri obvladovanju nasilnega vedenja pacientov smiselna in potrebna. Pri tem navajajo, da je potrebna pravočasna ocena ogroženosti, tako avtoagresivnosti kot heteroagresivnosti. Pri pacientih, kjer je potrebna uporaba sile, udeleženci vedno izpostavljajo svoje mešane občutke, in sicer zlasti pri najbolj ranljivih skupinah prebivalstva, kot so otroci in ženske. Posledično lahko ugotovimo, da reševalci praviloma obravnavajo paciente glede na njihove individualne značilnosti in merilo ogroženosti:

»*Od človeka do človeka različno in je treba za vsakega posebej znati kako pa kaj.*«

Pri tem izpostavljajo skupine pacientov, katerih obravnava je še posebej občutljiva:

»*Sigurno je merilo tudi otrok, otrok ali ženska ali odvisno od kapacitete tega pacienta. Mogoče je pri otrocih, je nek pomislek od zadaj, da jih ne uporabljaš, ker vseeno, je otrok, ne. Drugače pa, ne vem, vseeno delaš tudi z uporabo teh prisilnih sredstev v dobro pacienta in je to nekako vodilo teh primerov.*«

Čustvena komponenta dela

Pri delu s pacienti, ki so po poskusu samomora ali so samomorilno ogroženi, so udeleženci omenjali različna čustva, s katerimi se srečujejo med delom s pacienti, kot so na primer: *sočutje, prizadetost, žalost, strah, obup, groza, jeza, tesnoba, stres* in *čustvena izčrpanost*. Izpostavljene kode lahko razdelimo v dve podkategoriji, in sicer na *spodbujevalce odklonilnega odnosa*: *strah, obup, groza, jeza, tesnoba, stres* in *čustvena izčrpanost*; ter drugo podkategorijo, tj. *spodbujevalce empatičnega odnosa*, kamor lahko uvrstimo: *prizadetost, razumevanje, sočutje* in *zaskrbljenost*. Iz kod je razvidno, da se udeleženci med obravnavo pacientov po poskusu samomora praviloma počutijo neprijetno. Ta čustva so še bolj izrazita, kadar so pacienti otroci in mladostniki (*prizadetost* in *sočutje*):

»*Čustva delajo po svoje, ampak najbolj sigurno pa gane, me gane pri otrocih.*«

Ta čustva stopijo v ozadje, če pacienti vztrajajo pri svoji nameri, se pravi, če še naprej skušajo storiti samomor. V takem primeru lahko pacienti po poskusu samomora običajno ne samo odklanjajo vsakršno pomoč, ampak pogosto postanejo tudi nasilni do udeležencev, saj jih vidijo kot oviro za dosego svojega cilja. Udeleženci so ob takih primerih navajali tudi občutek *strahu* in *obupa* ter negotovosti in opisovali doživetje kot *stresno*:

»*Ja, k službi spada, vsekakor. Samo vseeno pa takrat občutiš nekakšno tesnobo, strah, ne vem.*«

V takih situacijah poskušajo nadzorovati svoja čustva, jih obvladati, a jim to ne uspeva vedno, zato so občasno z določenimi dogodki obremenjeni tudi v domačem okolju. Posledično kažejo znake *čustvene izčrpanosti*:

»*Čisto odvisno od situacije. No, včasih se zgodi kakšen dogodek, da doma tudi razmišljaš, sicer pa res to probam ločit. No, tako da probam pustit v službi. No, je pa kdaj kakšna stvar, ki se te dotakne pač, to smo ljudje.*«

Sicer pa so udeleženci navajali, da so lažje opravljali svoje delo in prenašali stres, če so poznali vzroke oziroma vzgibe, ki so vodili paciente v poskus samomora (*razumevanje*):

»*Vedno gledam ozadje, ker razmišljam dosti o tem sama. Če se ti zgodi v življenju, ne vem, ali težka bolezen ali socialne stiske, takrat se mi zdi, da se tudi lažje poistovetim s tem pacientom.*«

Pri udeležencih so *razumevanje* vedno spremljali občutki *sočustvovanja*:

»*Poskušaš nekako. Vendarle se te dotakne do te mere, da …, da le malo sočustvuješ z njimi in poskušaš nekako ga razumet, sej v bistvu to tudi …, to tudi ljudje rabijo.*«

Po drugi strani pa so udeleženci kazali manj ali nič razumevanja do pacientov, ki so usmerjeni v ponavljajoča se samopoškodbena dejanja. Njihovo početje so si razlagali kot zbujanje pozornosti, zaradi česar so bili *obupani* ali *jezni* nad pacienti po poskusu samomora ali do njih kazali indiferenten odnos:

»*Nimam pa takega enakega občutka do tistih, ki nekako skušajo pozornost vzbujat. Mogoče za kanček. Mogoče pri tistih, ki so povratniki, ki je večkrat že. Zaradi tega, ker imamo …, recimo, nekatere paciente smo imeli, ki so delali tedensko samomor, samo zaradi tega, da so, bom rekel, izživljali svoje frustracije. Da so, bom rekel, v nas zbujali pozornost. Do tistih pač ne čutim več empatije.*«

Kljub temu v izjavah udeležencev ni možno zaznati obtoževanja teh pacientov, udeleženci so namreč vedno izpostavljali ozadje kot opravičilo ali razlago,

zakaj se posameznik sploh odloča za takšna dejanja. Slednje kaže na to, da je *razumevanje* pri obravnavi pacienta po poskusu samomora pri nudenju prve pomoči udeležencev vedno v ospredju:

»Jaz mislim, da nimam pravice bit obtožujoča do teh. Pač, samo življenje jih pripelje do te faze.«

»Nisem še bila v situaciji, bom rekla, da bi jih ravno obtoževala.«

Načelo dolžnega ravnanja

Načelo dolžnega ravnanja udeležencev se kaže v njihovi *skrbi do pacienta, prevzemanju odgovornosti*, *preseganju kompetenc* in *občutku krivde.* Čutijo se odgovorne za varnost pacienta od prvega stika z njim do predaje pacienta, kar kaže na njihovo skrb:

»Od trenutka, ko ga prevzamem, do trenutka, ko ga predam osebju psihiatrične bolnišnice, je pač moja skrb in mi ni ›vse glih‹, kaj se v tem času dogaja z njim.«

Po svojih izkušnjah med potekom celotne obravnave pogosto prevzemajo vso odgovornost za paciente nase – velikokrat sprejemajo odločitve, ki v bistvu presegajo njihove kompetence:

»Nosilec dejavnosti pri nas je zdravnik, ni reševalec. In potem tudi vse, kar delamo, delamo z zdravnikom. Včasih ga ne moreš dobit ne na telefon, in moramo delat, po domače povedano, na svojo pest – klicat policijo, pa, bom rekel, pridržanje pacienta, fizično oviranje.«

V primeru, da bi med poskusom obvladovanja nevarnega vedenja pacient utrpel kakršnokoli škodo, bi imeli občutek lastne krivde, počutili bi se odgovorne in krive za nastalo škodo:

»Občutek nemoči oziroma občutek … krivde, če bi se njej kaj zgodilo – ker v končni fazi sem jaz odgovoren za njeno zdravje, a ne?«

Načelo terapevtske komunikacije

Za načelo terapevtske komunikacije so značilne kode, ki govorijo o pomanjkanju znanja o komunikaciji: *pomanjkanje časa za komunikacijo, čas komunikacije, dvom v znanje, nujna strokovna supervizija.*

»Da bi prav rekla terapevtsko komunikacijo, …, mislim, da ta izraz pri nas ni prav preveč domač, a ne? Mislim, da je ne obvladamo, a ne, tako kot bi jo morali. Zdaj pač večinoma to izvajajo zdravniki, a ne? Saj pri nas velikokrat, no, tudi če pridejo v ambulanto taki ljudje, pač zdravniki izvajajo. Je pa čisto odvisno, eni so zelo zahtevni, dolgo traja, eni malo manj. Mislim pa, da te komunikacije, ne vem, zdravstveni delavci ne obvladamo.«

»Drugače pa mislim, da to tehniko bolj pripisujemo zdravniku. No, da zdravnik te stvari pač izvede.«

Za primere, ko pacienti zavračajo pomoč, udeleženci intervjujev trdijo, da si je potrebno vzeti čas in se jim posebej posvetiti:

»Smo pa že imeli tudi primere, kosmo dve uri bili pri pacientu. Pa na koncu nismo iztržili nič drugega, kot da smo morali fizično poseč. Se pravi, da je morala pomoči policija, da smo pacienta prepeljali do psihiatra.«

Prav tako udeleženci navajajo, da je po vsaki intervenciji potreben pogovor med člani tima, ki ocenijo uspešnost intervencije in s tem tudi komunikacije:

»Ekipa se pogovori, ne samo pri psihiatričnih, tudi pri ostalih intervencijah, predvsem z namenom, da bi nekatere stvari izboljšali, kakšno slabšo odpravili in tako se pogovarjamo.«

Načelo varnosti

Kategorija varnosti se nanaša na zagotavljanje varnosti pri nujnem posredovanju. Varnost reševalci praviloma zagotovijo glede na oceno stanja pacienta. Kode, ki pojasnjujejo to kategorijo, so *negotovost, previdnost, varen pristop, osebna varnost, neprimerna prisilna sredstva, zadnji ukrep* in *nujni ukrep*. Čeprav kode namigujejo, da je varnost na mestu dogodka za udeležence širok pojem, je očitno, da so pri posredovanju ob prihodu vedno kot prvo pozorni na okolico: iščejo varen pristop do ogroženega pacienta, spremljajo obnašanje in gibe pacienta med obravnavo in skušajo preprečiti samopoškodbe, zato iz bližine pacienta po poskusu samomora hitro odstranijo vse potencialno nevarne predmete:

»Ja, ja, v glavnem, treba je pazit, da če je človek agresiven, to se pravi, nevaren sebi ali drugim, da ga na nek način pač obvladaš.«

Najbolj pomembna jim je lastna varnost in šele nato varnost pacienta ter ostalih prisotnih v okolici:

»V skrajni sili moramo poklicat policijo, da ga pač umirijo na drugačen način, da mu pač se lahko približamo, ker mi moramo tudi pazit prvotno na svojo varnost.«

Vedno, ko presodijo, da ne bodo mogli zagotoviti varnosti vsem prisotnim, zaprosijo za asistenco policije. V skrajnih primerih, ko pacient ogroža sebe ali druge, so mnenja, da je takšnega pacienta za vsako ceno potrebno hospitalizirati:

»Takemu človeku pa mislim, da je treba sploh pomagat oziroma ga kar na silo nekam odvleč, ker vidiš pa, da res rabi eno psihiatrično pomoč, da ni to samo njegova stiska. Za prisilno hospitalizacijo sodelujemo s policijo, ki nam omogoča še bolj varen pristop do pacienta, posebej, kadar je to z anamneze razvidno.«

Pri nudenju nujne medicinske pomoči, zlasti otrokom in ženskam, se udeleženci srečujejo tudi s pomisleki glede uporabe sile pri obvladovanju pacienta, saj ovirnice štejejo za neprimerno prisilno sredstvo:

»Sigurno je merilo tudi otrok, otrok ali ženska ali odvisno od kapacitete tega pacienta.

Mogoče pri otrocih je nek pomislek od zadaj, da jih

ne uporabljaš, ker vseeno je otrok, ne? Drugače pa, ne vem, vseeno delaš tudi z uporabo teh prisilnih sredstev v dobro pacienta in je to nekako vodilo teh primerov.«

Sicer pa so ovirnice, kot so lisice in prisilni jopič, v praksi ne le zakonsko prepovedane, ampak jih je po mnenju intervjuvancev tudi neprimerno ter moralno in etično sporno uporabljati. Že kar nekaj let je minilo, odkar se je opustila uporaba le-teh. Da se pacient umiri, včasih popolnoma zadostuje že pogovor in prisotnost policije. V res kritičnih situacijah, ki so sicer zelo redke, pa so udeleženci povedali, da v praksi vseeno izvajajo fizično oviranje pacienta, vendar gre pri tem običajno le za fizično obvladovanje pacientov po poskusu samomora s pomočjo policije, dokler zdravnik ne odredi in poskrbi za umiritev pacienta s pomočjo medikamentoznega varnostnega ukrepa:

»Že zelo dolgo je primer, da je bil vklenjen takšen človek, in potem te, te načine smo nekako opustili. Mi zdravstveni delavci imamo ovirnice, in če je to potrebno, uporabljamo njo, njo uporabljamo. Tule že zelo dolgo tega, kar smo uporabil te lisice.«

»Ovirnice se uradno ne sme uporabljati že vrsto let, se pravi, kot razne jopiče za zadrževanje, pa seveda pri agresivnih pacientih, kvečjemu kak povoj, ruto, pa seveda fizično oviranje pacienta, kot pač sami znamo pa kako lahko. Tako da uradno se v medicinski nujni pomoči ne uporablja ovirnic. Edino, kjer je tudi ovirnica, kemična ovirnica, ki seveda pod nadzorom zdravnika lahko damo pomirjevala ali karkoli, ostalo pa ne.«

Načelo sodelovanja

Medsebojno sodelovanje je kategorija, ki dokazuje, da je za potek učinkovitega dela potrebna tudi pomoč drugih strokovnjakov. Udeleženci štejejo na primer policiste za njim najpomembnejše sodelavce pri obravnavi pacienta, ki je samomorilno ogrožen ali lahko tudi nasilen. Za to kategorijo so bile značilne zlasti naslednje kode: *odzivni čas policistov, pristop policistov, utečen postopek dela, omejena pričakovanja*. Po mnenju udeležencev bi se policija marsikdaj morala v posredovanje vključiti že prej, ko pacient še ni povsem agitiran, neobvladljiv ali nasilen, kajti s čakanjem do začetka nasilja je izvedba prisilne hospitalizacije mnogo bolj rizična in neprijetnejša:

»Bi pričakoval, da se večkrat odzovejo in bi tudi, ne vem, mogoče pacienta lahko prej obvladali, če bi prej pristopili, kot pa, da se čaka, da je potem še mogoče bolj agitiran.«

Kadar so pacienti neobvladljivi, agitirani ali celo nasilni, udeleženci pravijo, da ekipa nujne medicinske pomoči za pomoč zaprosi policijo, od katere ne pričakuje nič drugega, kot da jim pacienta dostojanstveno, s spoštovanjem in profesionalnim znanjem fizično obvlada in jim ga pomaga pospremiti v rešilni avto. Do pristopa policistov so udeleženci občasno kritični:

»Prvi njihov je zakon tak: dokler pacient ne ogroža čisto fizično sam sebe, nas, ali okolice ali inventarja, se pravi, tudi oni ne morejo nič poseč. Policisti se v aktivno posredovanje vključijo šele, ko se fizični napad pacienta že prične, kar je včasih že zelo kritično. Njihova obrazložitev je, da jim tako veleva zakon.«

Hkrati pa imajo intervjuvanci od policistov le malo pričakovanj:

»Od njih pa pravzaprav jaz pričakujem samo to, čisto prvi, prvo varovanje mene, pacienta in tako, da sem z njihovim sodelovanjem zadovoljen v tistih mejah, kot od njih pričakujem. Jaz od njega ne pričakujem nič drugega, kot da mi pomaga varno spraviti tega človeka iz hiše, iz stanovanja, da ga potem na en človeški način, dostojanstven način brez prisile velike spravimo v reševalno vozilo in potem do bolnice.«

Diskusija

Čustvena komponenta dela je tista kategorija, za katero mislimo, da je osrednja in da najbolj opredeli odnos udeležencev raziskave do pacientov po poskusu samomora. Iz rezultatov je razvidno, da je odnos udeležencev nestabilen oziroma spremenljiv (do pacientov po poskusu samomora lahko gojijo tako pozitiven kot negativen odnos) in da se načeloma odklonilen, negativen odnos pojavlja le v povezavi z nekaterimi dejavniki, ki jih lahko umestimo na stran pacienta ali na stran udeležence. V prvi vrsti pa udeleženci izpostavljajo paciente po poskusu samomora, ki nujno medicinsko pomoč odklanjajo ali pa so lahko tudi nasilni do nudenja prve pomoči. Pojavnost odklonilnega in lahko tudi nasilnega vedenja je pri pacientih po poskusu samomora možna predvsem pri tistih, pri katerih je presoja stvarnosti motena zaradi duševne bolezni ali zlorabe psihoaktivnih snovi (Koller, et al., 2002; Modesto-Lowe, et al., 2006). Tako smo intervjuje usmerjali zlasti v to smer, saj menimo, da je razumevanje udeležencev do teh pacientov pomembno za oblikovanje odnosa, za katerega tudi nekateri avtorji pravijo, da lahko bistveno vpliva na zdravstveno nego, ki so je pacienti deležni v procesu zdravstvene obravnave (Sun, et al., 2007).

Čustveno komponento dela smo razdelili na dve podkategoriji. V podkategorijo *spodbujevalci empatičnega odnosa* smo uvrstili kode, ki pri udeležencih raziskave spodbujajo bolj razumevajoč oziroma empatičen odnos do pacientov po poskusu samomora, v podkategorijo *spodbujevalci odklonilnega odnosa* pa kode, ki pojasnjujejo odklonilen odnos.

Ocena pacientovega stanja je pri oblikovanju odnosa pomembna. Pri empatičnem odnosu udeleženci skušajo razumeti paciente po poskusu samomora in njihovo ozadje, kar vsekakor vpliva na njihov odnos do pacientov in na njihovo zavzetost za nudenje pomoči (Sayumporn, et al., 2012). Nekatere raziskave dokazujejo, da do pacientov, do katerih

lažje izrazimo empatijo (udeleženci uvrščajo v to skupino ženske in otroke), lahko razvijemo pozitivnejši odnos kot do tistih, do katerih le-te ne zmoremo izraziti, odnos do le-teh je negativnejši. V raziskavah avtorji v teh primerih omenjajo predvsem paciente s ponavljajočimi se samomorilnimi težnjami ali namernimi samopoškodbenimi vedenji, do katerih na splošno vlada negativen odnos, kar lahko pripelje tudi do neprimerne zdravstvene nege teh pacientov (McAllister, et al., 2002). Tudi udeleženci navajajo drugačno razumevanje pacientov po poskusu samomora, ki imajo ponavljajoče samomorilne težnje ali pogosta samopoškodbena vedenja, kar smo pri analizi empiričnega gradiva zaznali skozi med seboj podobne opise kot: »*pri tistih,ki so povratniki*«, »*ki so delali tedensko samomor*«, »*izživljali svoje frustracije*« in »*zbujali pozornost*«. Udeleženci pravijo, da se v takih primerih pojavijo čustva, kot so *obup, strah, jeza* – zakatere menimo, da so *spodbujevalci odklonilnega odnosa*. Ker pa kljub temu nekateri v raziskavi izražajo tudi mnenja kot: »*nimam pravice bit' obtožujoča*«, lahko predvidevamo, da udeleženci tudi pri teh pacientih po poskusu samomora, ki s svojim vedenjem spodbujajo odklonilen odnos, ravnajo po *načelu dolžnega ravnanja*.

Pomanjkanje znanja terapevtske komunikacije (*načelo terapevtske komunikacije)* in pomanjkanje občutka varnosti (*načelo varnosti*) v naši raziskavi spodbujata odklonilen odnos udeležencev oziroma negativen odnos do pacientov po poskusu samomora, saj sta lahko vir neprijetnih čustev in *stresa* ter *čustvene izčrpanosti*. Tudi nekateri drugi avtorji trdijo, da je lahko nudenje pomoči za zaposlene v zdravstveni negi stresno, kar lahko ob neprimerni podpori delovnega okolja vodi v čustveno izgorelost (Selič, 2010; Bregar, et al., 2011). V teh primerih je možno, da reševalci razvijejo zaščitne mehanizme, da vzpostavijo do določenih pacientov distanco, kar pa lahko negativno vpliva na nadaljnji odnos do le-teh (Regehr, et al., 2002) – lahko torej vodi do manj primernega oziroma odklonilnega odnosa do pacientov po poskusu samomora.

Udeleženci raziskave pogrešajo znanja iz komunikacije s pacientom po poskusu samomora, ki se lahko upira pomoči in je posledično lahko tudi nasilen, kar nam potrjujejo opisi kot npr.: »*s terapevtsko komunikacijo /…/ ni prav preveč domač*«, »*mislim, da je ne obvladamo*« in »*mislim pa, da te komunikacije, ne vem, zdravstveni delavci ne obvladamo*«. Pri tem udeleženci znanja iz terapevtske komunikacije pripisujejo bolj zdravnikom, kar govori tudi o ostro ločenih pristojnostih, kar pa ni vedno najbolj učinkovita oblika dela. Bregar (2012) v tej zvezi pravi, da so »danes intervencije zdravstvene nege samomorilno ogroženih pacientov pod prevlado drugih vplivnih skupin v zdravstvenem varstvu, kar preprečuje avtonomnejšo vlogo izvajalcev zdravstvene nege«. Udeleženci zaznavajo, da je komunikacija s temi pacienti zahtevnejša in da potrebujejo dodatna znanja. Po njihovih izkušnjah je komunikacija z zahtevnejšimi pacienti tudi dolgotrajnejša: »*Smo pa že imeli tudi primere, ko smo dve uri bili pri pacientu,*« na terenu pa ni vedno na razpolago dovolj časa. Značilno za paciente po poskusu samomora je, da potrebujejo več pozornosti in časa za kakovostno komunikacijo, ki je usmerjena v njegove težave. Pri tem so pomembne komunikacijske veščine, ki jih imajo izvajalci zdravstvene nege za delo s temi pacienti (Sun, et al., 2005). Tudi v tujih okoljih so s kvalitativnimi metodami raziskovali pomanjkanje znanj zaposlenih v zdravstveni negi na področju urgentnih enot. Udeleženci so menili, da potrebujejo dodatna znanja prav s področja psihiatrije, kjer so komunikacijske veščine zelo pomembne (Kerrison & Chapman, 2007).

Zagotavljanje varnosti (*načelo varnosti*), kar ne pomeni samo zagotavljanje fizične varnosti pacienta, ampak tudi nenehno ocenjevanje okolice, je po mnenju udeležencev raziskave ena izmed najpomembnejših intervencij. Načelo varnosti se močno prepleta z načelom *dolžnega ravnanja*, saj se pri pacientih, kjer je prisotna tako avtoagresija kot heteroagresija, udeleženci zavedajo, da morajo po načelu dolžnosti nuditi strokovno nujno medicinsko pomoč, čeprav je po njihovih izjavah sodeč, njihova varnost lahko tudi ogrožena: »*mu pač se lahko približamo, ker moramo tudi pazit prvotno na svojo varnost*«. Tudi tuji avtorji (Kerrison & Chapman, 2007) potrjujejo naše trditve, da je varnost zaposlenih v zdravstveni negi na področju urgence pri obravnavi pacientov z duševno motnjo, pogosto ogrožena. Zaposleni v zdravstveni negi na področju urgence imajo zato lahko tudi odpor do zdravstvene oskrbe opisanih pacientov. Zaradi pomanjkanja znanja na tem področju lahko nekateri zaposleni s svojim vedenjem celo zvečajo napetost pacientov, kar lahko vodi naprej v heteroagresijo. Svoje dvome pa izražajo tudi pri ustrezni zdravstveni obravnavi pacientov, ki so samomorilno ogroženi. Udeleženci raziskave vidijo veliko pomanjkljivost pri nedorečenosti uporabe fizičnega oviranja pacientov, ki izkazujejo nasilno vedenje, saj je le-to med področji zdravstvene obravnave pravno urejeno le za psihiatrijo (Zakon o duševnem zdravju, 2008). V teh pravno nedorečenih primerih, ko je potrebno hitro ukrepanje, tako za zagotavljanje varnosti pacienta in osebja, je lahko to vir neprijetnih čustev in stresa (*spodbujevalci odklonilnega odnosa),* kar lahko zopet vodi v odklonilen odnos udeležencev do pacientov po poskusu samomora.

Načelo varnosti se prepleta z *načelom sodelovanja*, kar pomeni, da ko udeleženci presodijo, da ne morejo poskrbeti za dovolj varno okolje tako zase kot za pacienta, za pomoč prosijo policijo: »*V skrajni sili moramo poklicat policijo, da ga pač umirijo na drugačen način /…/.*« Sodelovanje policije je po izjavah potrebno predvsem pri prisilnih hospitalizacijah, kjer so po izjavah udeležencev potrebne tudi fizične ovirnice. Udeleženci se pri tem srečujejo z vprašanjem

legalnosti uporabe fizičnih ovirnic, katerih uporaba izven psihiatričnih zavodov zakonsko ni opredeljena (Zakon o duševnem zdravju, 2008). V kolikor je pomoč policije pravočasna in učinkovita, imajo udeleženci raziskave večji občutek varnosti in so z intervencijami bolj zadovoljni, kar zopet lahko vpliva na odnos do pacientov po poskusu samomora, ki sodo pomoči odklonilni in lahko tudi nasilni.

Omejitve raziskave

Omeniti moramo nekatere omejitve glede nepristranskosti do nekaterih ugotovitev izvedene raziskave. Tudi nosilka raziskave je zaposlena v enoti nujne medicinske pomoči in je s svojimi občutki in pričakovanji glede izpostavljene problematike lahko imela vpliv na izvedbo intervjujev ter na njihovo analizo. Tudi sama je pri dolgoletni praksi zaznavala problematičnost odnosa do v raziskavi izpostavljenih pacientov inkot ženska zaznavala občutek lastne ogroženosti pri njihovi zdravstveni obravnavi. Z nekaterimi udeleženci raziskave se raziskovalka pozna osebno. Sicer pa za kvalitativne raziskave ni ovira, če je raziskovalec v problematiko osebno vpleten, celo priporočljivo je, da je z njo dobro seznanjen. V raziskavo so bili vključeni samo zaposleni v zdravstveni negi, zanimivi bi bili tudi pogledi zaposlenih v medicini, ki verjetno zaradi svoje odgovornosti drugače dojemajo delo s pacienti, ki so samomorilno ogroženi ali po poizkusu samomora. Nenazadnje teh rezultatov ne moremo posplošiti, nekatere ugotovitve pa so lahko izhodišče za nadaljnje raziskovanje.

Zaključek

Pri analizi empiričnega gradiva smo posebno pozornost posvetili predvsem odnosu udeležencev raziskave do pacientov po poskusu samomora v primerih, ko so med opravljanjem svojega dela naleteli na njihov odpor, odklanjanje pomoči ali nasilje. Za pojasnitev odnosa udeležencev do teh pacientov smo identificirali nekatere kategorije, med katerimi je čustvena komponenta dela po našem mnenju najbolj osrednja in s katero lahko najbolj pojasnimo odnos do pacientov po poskusu samomora. Potrebno je razumeti, da je čustvena komponenta dela odvisna od kar nekaj dejavnikov, ki se med seboj prepletajo, njihovo razumevanje pa je kompleksno.

V zaključku bi želeli tudi poudariti, da pri delu udeležencev ni smiselno operirati s kategorijama pozitiven oz. negativen odnos, kajti odnos vsakega je po našem mnenju spremenljiv: zdaj je pozitiven, zdaj negativen. Bilo bi torej bolj smiselno govoriti oz. si zamisliti ta odnos do pacientov po poskusu samomora kot neki kontinuum, na katerem se vrednost oz. kakovost odnosa pomika sem ter tja z ozirom na različne dejavnike, ki izvirajo iz udeleženca raziskave kot posameznika oz. iz fizične okolice ali družbe kot okolice. Analiza gradiva je po našem mnenju pokazala, da negativen oz. odklonilen odnos udeležencev do pacientov po poskusu samomora srečamo pogosteje pri dejavnikih, ki izvirajo iz njih samih: počutijo se ogroženi, nimajo normalnih delovnih pogojev, ocenjujejo, da nimajo vseh potrebnih znanj za delo s pacienti po poskusu samomora,včasih pa se tudi ne znajo soočati s tem, kar vidijo pri delu, ipd. Kot zanimivost naj omenimo, da noben udeleženec ekipe nujne medicinske pomoči kot razloga za odklonilen odnos ne navaja verskega prepričanja.

Naš sklep je, da udeleženci raziskave zaradi neznanja oz. nepoznavanja psihiatrije k pacientom po poskusu samomora pristopajo preveč subjektivno in da njihovo razumevanje (tudi empatija) in pristop k pacientom po poskusu samomora temeljita izključno na subjektivnih predstavah, ki izvirajo iz družbeno-kulturnih norm.

Ugotovitve kvalitativne raziskave, ki smo jo izvedli med reševalci, bi bilo potrebno tudi kvantitativno oceniti ter na podlagi tega nuditi ustrezno podporo zaposlenim v ekipah nujne medicinske pomoči. Potrebna bi bila priprava nekaterih strokovnih smernic, predvsem iz izobraževalnih vsebin s področja samomorilnosti s poudarkom na znanju in veščinah iz komunikacije. Potrebna bi bila dopolnitev nekaterih pravnih dokumentov, s katerimi bi formalizirali postopke in pravno zaščitili tako paciente kot izvajalce zdravstvene obravnave, in sicer zlasti pri fizičnem omejevanju pacientov, kjer se še danes marsikje uporabljajo nestandardizirani pripomočki.

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