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Responsibility and compassion in prehospital support to survivors of suicide victim – Professionals' experiences

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1. Introduction

Over 800,000 people throughout the world commit suicide every year [1]. It is estimated that for each person who commits suicide, six or more survivors are affected [2]. As Shneidman pointed out: *"A person's death is not only an ending: it is also a beginning – for the survivors"* [3]. There is a difference for survivors between losing someone by sudden death caused by an accident or disease and the deliberate actions of a person who has committed suicide [4]. The survivors often blame themselves for not preventing the suicide. They may also feel abandoned and betrayed since the deceased made an active decision to end life [5].

1.1. Background

Professionals who the survivors meet are usually Emergency Medical Services (EMS) personnel, police officers and a general practitioner (GP). The first contact is often with the EMS personnel. The police are responsible for investigating deaths that are not due to natural causes [6]. In the majority of Western countries certification of death is the responsibility of a registered physician [7]. In Sweden this is done in most cases in the prehospital stage by a GP.

The structure of the EMS in Europe varies from one country to another. However, in most countries the EMS are staffed by paramedics [8]. In Sweden, ambulances must be staffed by at least one Registered Nurse (RN) [9]. According to general Swedish directives [10], the nurse is allowed to administer drugs and medical treatments without a doctor's order. Medical guidelines exist [11], but there are no guidelines that address prehospital support to the survivors.

Previous studies have either focused on the support of survivors in the event of a sudden death that was not self-inflicted or the provision of support by accident and emergency units for the survivors of suicide victims. Only one study was found that addressed EMS personnel's experiences associated with caring for the survivors of a suicide victim. The situations were considered to be traumatic [12], but the study's focus was not on the professionals' experiences. In conclusion, knowledge is scant and needed about the professionals' prehospital support to the survivors. In order to improve the support for the survivors after suicide, there is a need is to understand the experiences of the involved professionals in the acute situation.

1.2. Aim

The aim was to describe experiences of facing and supporting survivors of suicide victim from the perspectives of EMS personnel, police officers and general practitioners.

1.3. Methods

The study design was descriptive with a qualitative approach using focus group data and inductive content analysis [13].

1.3.1. Setting and sample

The inclusion criteria for participation were professionals belonging as EMS personnel, police officer or GP, and having experience of supporting survivors of suicide victims. All senior officials in the police force, primary medical care systems and the

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Table 1
Socio-demographics of the participants (n = 26).

Demographics	**n (%)**
Female	11 (42)
Male	15 (58)
	Median (**range**)
Age, years	44 (27–65)
Work experience, years	12 (5–40)
Numbers of experiences of meeting survivors	12 (1–50)
Profession	**n (%)**
General practitioner	6 (23)
Frontline police officer	5 (19)
Emergency Medical Services personnel:	15 (58)
Emergency Medical Technician	3 (12)
Registered Nurse	12 (46)

ambulance service in one Swedish county, i.e. 20 workplaces, were asked for permission to recruit staff to participate in focus group discussions (FGDs) during working hours. Six officials declined participation, stating lack of resources as reason. Recruitment was carried out at the remaining 14 workplaces: Emergency Medical Services (n = 3), police force (n = 3) and primary medical care systems (n = 8).

The recruitment was aimed for 30–36 participants [14]. The passive invitation to the professionals implied oral and written information given by the officials, which resulted in 25 professionals contacting the researchers. As a second recruitment strategy, officials were asked to suggest persons that they knew met the inclusion criteria. This resulted in additional 20 professionals. Ten professionals declined participation when the first author contacted them (without stating a reason), leading to 35 included participants. Nine persons declined to participate at the actual time of the FGDs due to high workload, and lack of time, which finally resulted in 26 participating professionals. See Table 1 for socio-demographics of the participants. The frequency of suicide in this county were 48 suicide during 2015 [15].

1.3.2. Data collection

FGDs were chosen for data collection as they enabled participants to elaborate on this sensitive subject and to interact within the group [14]. Each FGD had 4–6 participants (one was a GP, two or three were EMS personnel and one or two were police officers). The FGDs were conducted March-April 2014, five at a medical centre and one at a research centre. The first author was the moderator in the FGDs, backed up by a co-moderator. The main question was: *"Please, describe the support for the survivor/s following a suicide that you have been called to?" Prompts used were: "Please, describe circumstances following a suicide that made it difficult to provide support for the survivors?"; "Based on your experience, what do you feel constitutes good support of survivor/s following a suicide?"* and *"What is the greatest challenge when supporting the survivors?"*. The moderator facilitated the discussion through asking follow-up questions, such as *"Can you describe more about…"* or *"Please, can you tell me what you mean with…"* and ensured that the participants did not digress from the subject. The rule of silence was applied for at least five seconds, and much longer when needed, before asking a new question, thus giving the participants the opportunity to reflect further and to speak [14]. The co-moderator observed the interaction between the group members, noted topic lines that were not followed up, and asked supplementary questions at the end of each FGD. The first FGD was a pilot to test the interview questions and the moderators' roles. The pilot led to the change of a more active role for both the moderator and co-moderator regarding follow-up questions The pilot was still regarded to contribute with rich data and was therefore included in the study, as advocated by Krueger and Casey [14]. The FGDs were audio recorded, lasted 51–77 min each (mean 65 min) and transcribed verbatim by an experienced research secretary.

1.3.3. Data analysis

Data were analysed using content analysis, with an inductive approach according to Elo Kyngäs [13]. The first author listened to all FGDs and read the transcripts several times, to become immersed with the whole. Each participant's statements were then marked to get an overview of the interaction in the FGD. The co-authors also read the transcripts and discussed the content and understanding of the data. Sections of transcripts with redundant content were not re-reviewed by all researchers. The first author noted preliminary codes in the text margins and then the coding was transferred to the N-Vivo software package version 10 to facilitate the further analysis. Codes that shared similar meaning were grouped under higher order headings to sub-categories and then further to generic categories. The first author coded the transcripts and the coding and categorisation were then reviewed in the N-Vivo program by all co-authors and discussed iteratively until consensus was reached. The generic categories were abstracted to main categories, first by the first author and further with the co-authors. These discussions continued when writing up the results, pending between part and the whole, which generated re-categorisations and re-formulations until final agreement. To illustrate the results and increase the trustworthiness, quotations were identified and translated to English by a professional translator.

1.3.4. Ethical considerations

An advisory statement specifying no objections to the study was provided by the Swedish Regional Ethical Review Board of Uppsala (Reg. no. 2014/081). The participants and their managers were informed, orally and in writing, that participation was voluntary and that participants had the right at any time to refrain from further participation without specifying any reasons. Written informed consent was obtained from all participants. The authors were fully aware that the participants could regard the topic of this study as sensitive. Therefore, all participant received a phone number of the Health services for employees in the event that anyone would need further support after the FGD. However, the FGDs may have been cathartic for some as they faced the same kind of situation and also the possibility of reducing pressure on the individual to answer specific questions [16].

1.3.5. Interaction analysis during FGDs

Pertinent analytical questions were used to promote understanding of the interaction during the FGDs [16] and it was noted that the participants generally kept to the subject although on a small number of occasions they talked about death in general. The participants seemed open-minded, committed and curious, asking each other follow-up questions, seemingly to increase their understanding. They seemed to show respect for each other and the situation, i.e. no interruptions, equal allocation of speaking time, no open conflicts, affirmation of feelings expressed as well as supportive and sincere questions. The predominant perception among the participants was that the subject was complex and difficult. On occasions, when opinions differed, participants asked curiously for an explanation or clarification.

2. Results

From the perspectives of the EMS personnel, police officers and GPs in this study supporting survivors after suicide could be experienced as feelings of inadequacy, attempting to shield, personal decision to focus on the survivors and uncertainty about professional responsibility (Fig. 1).

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