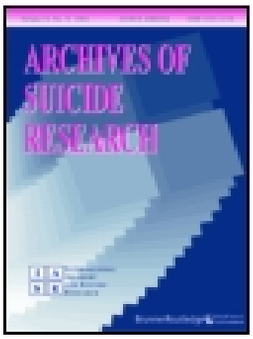

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ABSTRACT

The purpose of this study was to explore the psychological experiences of emergency department staff in northeastern Sichuan when treating patients with suicide attempts and to provide a theoretical basis for developing appropriate clinical interventions and improving mental health services for suicidal patients. Sixteen emergency department staff members who met recruitment requirements at two hospitals in Nanchong, China, were interviewed using Colizzi descriptive phenomenological analysis. The interviews were in-depth and semi-structured. The qualitative analysis of this study revealed three main themes: (1) aspects of the emotional experience that may be detrimental to helping people in crisis (e.g., sympathy and regret, confusion and bewilderment, worry and stress); (2) aspects of the cognitive experience (e.g., inability to deal with patients' psychological issues and having new perspective on the medical profession); and (3) raising awareness of mental health services. Future reform efforts should consider training medical staff in suicide prevention knowledge and communication skills, using a compassion-centered approach to alleviate the suffering of patients who attempt suicide, using the Safety Screening Scale (PSS-3), providing counselors for patients, developing family-focused interventions, and involving family members in suicide risk prevention and treatment.

KEYWORDS

Emergency department; mental health services; psychological experience; qualitative research; Sichuan; suicide

INTRODUCTION

Suicidal behaviors are a concept that includes suicidal ideation (thoughts), planning for self-harming behaviors, attempting suicide, and, in the worst cases, complete destruction (Ponsoni et al., 2018). Suicide attempt (SA) is an act of self-destructive with the intention of ending one's life (Hajji et al., 2016). People who attempt suicide are at high risk for eventual death by suicide. Notably, more than 10 million people worldwide attempt suicide each year; accordingly, the number of patients treated in emergency departments for suicide attempts is increasing each year in many countries (Jeong, Ko, Choi, & Lee, 2021). The observed trends in suicide occurrence globally did not show associations with specific age groups; however, vulnerability to suicide increased with age, with older adults at the greatest risk of suicide (Awan et al., 2021). Indeed, suicide is a complex (but not yet fully understood) phenomenon that may be determined by the interplay

between various factors, such as neurobiology, personal and familiar history, stressful events (Orsolini et al., 2020), and sociocultural environment. Psychiatric disorders, including borderline personality disorder, schizophrenia, bipolar disorder, and major depressive disorder, are considered important risk factors for causing patients to commit suicide (Fountoulakis, Gonda, & Rihmer, 2011; Narishige, Kawashima, Otaka, Saito, & Okubo, 2014). Meanwhile, suicide is caused by many multifaceted social and cultural factors and is more likely to occur during socioeconomic, family, and personal crisis situations (e.g., death of a loved one, unemployment, etc.) (De Berardis, Martinotti, & Di Giannantonio, 2018).

In China, ~2 million people attempt suicide each year (Wei et al., 2018), and many of them will be taken to the emergency department for immediate physical and psychological intervention to prevent suicidal behavior (Larkin & Beautrais, 2010; Tong, Phillips, Yin, & Lan, 2020).

In addition, we cannot ignore the fact that the suicide rate for people who attempt suicide again one year after getting emergency care is still 50 times higher than that of the general population (Kim & Lee, 2021). Rheinberger et al. conducted an investigation from the patients' perspective to determine why this was happening. They found that patients committed suicide again after discharge from the hospital, which was closely related to their negative experience of treatment in the emergency department (Rheinberger et al., 2022). And some of these negative experiences were with emergency room staff, whose lack of empathy (Rheinberger et al., 2021). Furthermore, the patients who attempted suicide felt that the emergency department staff seemed to be more concerned with their physical recovery and lacked the experience to treat their psychological trauma with psychological therapy (Quinlivan et al., 2021).

From the perspective of medical staff, nurses and doctors in the emergency department believe that the negative attitude toward the life of patients who have attempted suicide affects their mood, resulting in poor medical quality (McGough et al., 2022). Furthermore, the medical staff's empathy for patients is low, owing to a lack of time between medical staff and patients to establish the harmonious relationship required for psychological evaluation, as well as a lack of professional knowledge of mental health to assess patients' risk of future suicide and the ability to intervene in a suicide crisis (Chunduri et al., 2019).

As a result, the experience of first-aid medical personnel in general hospitals in treating attempted suicide patients was psychologically analyzed to provide guidance and suggestions for the clinical development of corresponding intervention measures and improvement of mental health services for suicide patients, so that medical staff experience and patient treatment results could benefit each other (Rassy et al., 2022). A thorough literature search revealed that few articles examined the experience of ED staff in China's general hospitals caring for patients who had attempted suicide. Therefore, the purpose of this study was to explore the psychological experiences of emergency department staff in northeastern Sichuan when treating patients with suicide attempts and to provide a theoretical basis for developing appropriate clinical interventions and improving mental health services for suicidal patients.

MATERIALS AND METHODS

This qualitative study, which used semi-structured interviews and the Colizzi's descriptive phenomenological analysis, was approved by the Ethical Committee of the Affiliated Hospital of North Sichuan Medical College (Grant number: 2021R077F02).

Data Analysis Methods

Descriptive phenomenology is a detailed account of one's daily life experiences as seen through mindful awareness (Vignato, Inman, Patsais, & Conley, 2021). The "lived experience" is not fully explored in everyday life and, as a result, is not freely available. To be more precise, the "lived experience" must be examined from three phenomenological philosophical perspectives: intentionality, essences, and phenomenological reduction (Sousa, 2014). Intentionality is the conscious decision to direct one's thoughts toward objects or content. In other words, intentionality describes reality as it happens as a result of conscious awareness. Essences describe the relationship between something real, something remembered, or something imagined. Phenomenological reduction is the suspension of beliefs about the experience, which occurs through bracketing, or the process of disregarding previous beliefs and assumptions to fully understand the phenomenon without preconceptions (Morrow, Rodriguez, & King, 2015).

Colaizzi's data analysis method is based on Husserl's three philosophical stances and employs eight steps to rigorously examine narrative data to arrive at a comprehensive description of the phenomena of concern (Edward & Welch, 2011). These steps are as follows: (1) reading all text, (2) extracting significant statements related to pain and depression symptoms, (3) creating meanings for each significant statement (Repeat steps 1–3 to clarify participant statements as needed), (4) organizing created meanings into groups of themes, (5) combining results into an exhaustive description of the pain and depression symptoms, and (6) framing the exhaustive description into a statement of identification of its essence (Vignato et al., 2021). All steps may be repeated as many times as necessary to ensure a thorough understanding of the statements and data saturation (Vignato et al., 2021).

Participant Recruitment

We issued a recruitment announcement in two EDs (ED1 and ED2) on December 1, 2021, and stated our research purpose. Both EDs were in the same city and were open to the general public. With 47 medical staff, ED1 is part of the largest local public hospital. ED2 is part of another local public hospital that employs 32 medical personnel. To protect the confidentiality of the participants, the author chose not to reveal the hospital's identity further. The selection criteria were as follows: (1) doctors or nurses who had witnessed, treated, or nursed suicide attempts within the last five years; (2) normal cognitive and language expression ability. Exclusion criteria included: (1) working time in the emergency department for <1 month; (2) advanced training and interns. As of February 28, 2022, only three people had taken the initiative to accept the survey and meet the requirements. To boost the number of interviewees, the research team sought assistance from the head nurses of two hospitals' emergency departments on March 1, 2022, and the two head nurses then mobilized all

emergency department staff to actively cooperate with our interview. We categorized statistics from March 1 to March 3, 2022, based on occupation, gender, age, years of work, highest education level, and number of suicide attempts. Statistics show that 63 employees met the inclusion criteria, but two of them were interns and were thus excluded. Then, using stratified random sampling, we chose 30 medical personnel and solicited their willingness to participate in the interview. Finally, 16 medical personnel agreed to participate in the interview from March 4 to March 7, 2022. There were six men and ten women amongst the participants, as well as nine nurses (numbered N1–N9) and seven doctors (numbered D1–D7). Table 1 summarizes the interview's overall characteristics.

Data Collection Methods

The data was gathered by the researcher through one-on-one in-depth semi-structured interviews. In this study, 16 participants were interviewed in depth, and data collection was halted when it was determined that no new qualitative data was available (Higgs & Cherry, 2009).

Interviews were conducted with all 16 medical staff members in an independent and peaceful office where participants could speak freely. They were informed of the purpose of the interview and their commitment to privacy protection again before the formal interview, and both signed the Informed Consent Form on their own initiative. The interview lasted between 30 and 60 min. After obtaining consent, the interviewer used two mobile phones as video recorders to record the interview to avoid errors and omissions in the data. Open-ended questions were asked during the interview. "How long have you been working in the emergency room?" is one of these questions. "How many suicide attempts have you witnessed?" "Can you speak about your thoughts on mental illness?" "Can you talk about your primary emotions when you receive or care for someone who attempts suicide?" "Do you have any experience with patient suicide prevention?" "Do you perform psychological assessments and interventions on patients in your medical or nursing work?" "How did you accomplish this?" "How important do you believe it is to provide mental health assistance to suicidal patients?" "What factors will influence your ability to provide mental health care to suicidal patients?" "How long have you been working in an emergency room?" The interview questions were not asked in any particular order, but they all had to be answered. The interviewees were given enough time to answer each question individually.

RESULTS

Emotional Experience

Sympathy and Regret

The emergency department medical staff, particularly the nursing staff, expressed sympathy for the patients who attempted suicide, but they also disagreed with the causes of suicide and expressed regret for the suicidal behavior of these suicidal patients.

> "… Patients with malignant tumors, particularly those without family support, are unable to bear the pain of cancer and commit suicide. It's far too pitiful… All we can do is console and care for them…" — N1

TABLE 1. Characteristics of participants ($n = 16$).

Serial number	Age (year)	Gender	Marital status	Technical post title	Highest education qualification	Years on the job (year)	Cases of attempted suicide admitted (cases)	Previous training related to suicide management
N1	31	Female	Married	Supervisor Nurse	Junior College	13	>15	No
N2	24	Male	Singlehood	Primary Nurse	Undergraduate	2	<5	Uncertain
N3	26	Female	Singlehood	Senior Nurse	Master	4	5–15	No
N4	32	Male	Married	Supervisor Nurse	Undergraduate	11	>15	Uncertain
N5	25	Female	Married	Senior Nurse	Undergraduate	5	>15	No
N6	36	Female	Married	Supervisor Nurse	Junior College	19	>15	No
N7	35	Female	Married	Senior Nurse	Junior College	18	>15	No
N8	28	Female	Married	Supervisor Nurse	Undergraduate	7	>15	No
N9	32	Female	Married	Supervisor Nurse	Undergraduate	14	>15	Uncertain
D1	27	Male	Singlehood	Resident Doctor	Master	2	<5	No
D2	54	Male	Married	Senior Doctor	Doctorate	28	>15	Uncertain
D3	40	Male	Married	Associate Senior Doctor	Master	21	>15	No
D4	32	Female	Married	Attending Doctor	Doctorate	3	5–15	Uncertain
D5	38	Male	Married	Attending Doctor	Undergraduate	17	>15	Uncertain
D6	35	Female	Married	Associate Senior Doctor	Doctorate	5	5–15	Yes
D7	31	Female	Singlehood	Resident Doctor	Doctorate	2	<5	Yes

"… Those students who committed suicide by poisoning themselves did so because they failed an exam… It's inexplicable…" — D2

Confusion and Bewilderment

Some medical personnel lack experience dealing with patients who have attempted suicide are confused about their patients' suicide behavior, do not know how to communicate, and do not actively follow up on patients.

"… Some young girls committed suicide after their romantic relationships ended… I'm not sure what she was thinking… I didn't care whether they returned to the hospital after they left… " — N3

"… I don't understand why a child would commit suicide so frequently… I'm completely stumped… I can only try to convince them to live a healthier lifestyle… I didn't keep any of their contact information…" — D1

Worry and Stress

Some interviewees stated that they would feel pressured in the face of patients who had previously committed suicide and refused treatment. Furthermore, medical staff were concerned about the treatment of these patients and considered transferring them to psychological rehabilitation centers.

"… Some patients are depressed, quiet, and refuse to eat or drink… They are at a high risk of committing suicide again… During the ward round, the patient's suicidal behavior may be overlooked… The pressure is too much for us… They are still referred to the mental and psychological clinic after their health has stabilised… I will not follow-up with them…" — N7

"… Some patients demonstrated that they had lost hope in life and were desperate for it… Others who attempted suicide were in a bad mood and were easily moved to cry… I will continue to monitor their suicidal behavior and recommend that they be admitted to mental health facilities… But their families are adamantly opposed, and all I can do is comfort and encourage them. However, I am powerless to intervene…" — D7

Cognitive Experience

Inability to Deal with Patients' Psychological Issues

Because of their lack of knowledge about suicide prevention, the majority of those interviewed stated that they were unable to communicate effectively with patients and provide effective mental health services, such as psychological assessment and intervention in the face of psychological problems in patients who had attempted suicide.

"… The patients are timid and cry easily because they have psychological diseases… I can't communicate with them effectively, and I can't correctly identify suicide symptoms… For fear of stimulating them again, I can only provide psychological comfort…" — N5

"… I lacked a systematic study of suicide prevention… Even if I wanted to communicate with patients, I didn't know where to begin… I lacked communication skills and chose to disregard psychological evaluation and intervention…" — D3

Gain a New Perspective on the Medical Profession

A small number of the medical staff interviewed have a better understanding of their responsibilities and recognize that when dealing with patients who have attempted suicide, they should not only promote their physical recovery but also pay attention to their psychological recovery and have more participation in the medical process.

> "… In the past, I believed that when dealing with these patients, we should first save their lives and then gradually introduce psychotherapy… After meeting many patients who had committed suicide, I gradually realized that saving lives should be accompanied by psychological intervention to ensure full recovery… When dealing with the psychological issues of suicide attempts, our medical staff should no longer play the role of 'powerless,' but rather 'play an important role…" — N6

> "… I used to believe that only medical personnel trained in psychology could intervene in psychological problems… After receiving suicide-related training, I believe I can also play an important role…" — N8

Awareness of Mental Health Services

Some interviewees recognized the importance of suicidal patients' mental health and believed that general hospitals should provide psychological health services, such as suicide ideation assessment, psychological intervention, active referral, and follow-up for patients who attempted suicide. However, the vast majority of respondents stated that providing mental health services to people who attempted suicide presented numerous challenges, such as patients and their families avoiding discussing suicide, a lack of suicide evaluation tools, and a lack of knowledge about the operation process of dealing with patients' psychological diseases.

> "… Many suicidal patients suffer from serious mental illnesses… Because the emergency room is the first line of defence, the hospital should actively intervene in patients' mental health while treating their diseases, as well as make appropriate referrals and follow-up…" — N5

> "… In the case of some patients who recommit suicide, timely psychotherapy and intervention, as well as regular follow-up, are critical…" — D6

> "… Many patients and their families do not want us to talk about suicide in front of them…" — N2

> "… Our hospital's emergency department lacks a suicide assessment scale as well as standardized strategies and processes for dealing with psychological problems associated with attempted suicide… Because the hospital lacks a psychiatric department, it is unable to provide timely consultation or referral for patients… Normally, our workload is too heavy, and we are unable to monitor subsequent changes in patients' conditions…" — D3

DISCUSSION

Thus, the qualitative analysis of this study revealed three core themes that investigated the psychological experiences of medical staff in the emergency department of northeastern Sichuan when caring for people who have attempted suicide: (1) aspects of the emotional experience that may be detrimental to helping people in crisis (e.g., sympathy and regret, confusion and bewilderment, worry and stress); (2) aspects of the cognitive

experience (e.g., inability to deal with patients' psychological issues and having new perspective on the medical profession); and (3) raising awareness of mental health services.

People with psychological diseases who attempt suicide are at higher risk of attempting it again (Bostwick, Pabbati, Geske, & McKean, 2016). Emergency medical personnel are at the front line of clinical treatment for suicidal patients. Timely assessment and intervention of patients at risk for suicide can reduce the risk of a repeat attempt by ~6.59% (Calati & Courtet, 2016). Therefore, the assessment and management of psychological disorders in patients with suicide attempts and the establishment of an effective model of psychological diagnosis and intervention services for patients with suicide attempts are important for the detection, prevention, and reduction of future suicide risk.

Many of the dilemmas that lead patients who attempt suicide into crisis are psychosocial, beyond the control of the emergency department, and incompatible with the physiologically-focused approach to care embraced by emergency department staff. This lack of control is exacerbated by the lack of confidence of emergency department staff in their ability to communicate with their patients, which is understandable given the complexity of the suicide narrative. In this study, some medical staff showed stress and anxiety when dealing with suicidal patients. Such negative emotions can affect the quality of medical care (McGough et al., 2022). Some young healthcare professionals, especially those who are unmarried, lack empathy for patients who commit suicide for emotional reasons. Future research should investigate and evaluate potential education and training programs to better facilitate emergency department staff contact with patients who have attempted suicide. In addition, future reform efforts should consider providing training that includes a compassion-centered approach to alleviating the suffering of patients who attempt suicide and encouraging staff to receive expertise in mental health rehabilitation and suicide crisis management.

Although some emergency department staff are willing to provide mental health services to their patients, there are still some clinical difficulties, such as lack of methods to assess the risk of another suicide attempt, management strategies for psychological problems, and lack of understanding of the treatment process for patients who have attempted suicide. To address these difficulties, Chinese hospital emergency departments can learn from the proven experience of US hospital emergency departments in several ways, such as using the Safety Screening Scale (PSS-3), which can quickly and effectively estimate patients' suicidal ideation and risk in the first two weeks; (Lee, 2019) providing professional counselors to provide one-on-one psychological guidance to patients (Hanratty, Kilicaslan, Wilding, & Castle, 2019); using integrated assessment and management of suicide risk (increased departmental collaboration to improve counseling and referral efficiency); (Brailovskaia et al., 2019) and improving effective follow-up rates for discharged patients (Fuller-Thomson, Baiden, Mahoney, & MacNeil, 2021).

Some respondents in this study indicated that some patients and their families refused to discuss the reasons for suicide. The reasons for this are summarized as follows: On the one hand, the causes of suicide in patients who attempt suicide are directly or indirectly related to the life events mentioned by the family (Arafat, Mohit, Mullick, Kabir, & Khan, 2021); on the other hand, the suicidal behavior of the patient has a negative impact on the family, such as disruption of family relationships, loss of

intimacy, guilt or blame between members, mental stress and other psychological problems (Arafat, Saleem, Edwards, Ali, & Khan, 2022). Nonetheless, a positive family environment with clear and transparent communication may help identify risk factors and prevent suicidal behaviors (Edwards, Patterson, & Griffith, 2021). Unfortunately, in this study, there were communication barriers between health care providers, patients, and families regarding the causes of suicide, which limited the ability of family factors to prevent suicide. When treating suicidal patients, emergency department personnel should consider protective factors already present in the family; develop family-focused interventions; allow family members to participate in suicide risk prevention and treatment; strengthen family functioning; address interpersonal issues; and increase family integration and social support.

CONCLUSION

Emergency medical personnel are at the front line of clinical care for suicidal patients. It is critical to assess and overcome psychological barriers in patients with attempted suicide and to develop an effective model of psychological diagnosis and intervention services for patients with attempted suicide.

However, there are some barriers to the clinical work of medical staff, such as lack of assessment methods for re-attempting suicide risk and management strategies for psychological problems; lack of understanding of the treatment process of patients with suicide attempts; negative emotions; and lack of empathy. Future reform efforts should consider training medical staff in suicide prevention knowledge and communication skills, using a compassion-centered approach to alleviate the suffering of patients who attempt suicide, using the Safety Screening Scale (PSS-3), providing counselors for patients, developing family-focused interventions, and involving family members in suicide risk prevention and treatment.

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ETHICAL APPROVAL

The studies involving human participants were reviewed and approved by the Affiliated Hospital of North Sichuan Medical College (Batch number: 2021R077F02). The participants provided their informed consent to participate in this study.

AUTHOR CONTRIBUTIONS

Xianqun Liu: conceptualization. Qingxiu Chen: methodology. Jiao Liu: validation. Xianqun Liu and Maoqiong Yang: formal analysis. Xianqun Liu, Qingxiu Chen, Maoqiong Yang, Jiao Liu, and Yu Yin: investigation. Maoqiong Yang and Jiao Liu: data curation. Xianqun Liu: writing—original draft. Yu Yin: visualization and supervision. Xianqun Liu and Yu Yin: project administration.

DISCLOSURE STATEMENT

No potential conflict of interest was reported by the author(s).

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DATA AVAILABILITY STATEMENT

The raw data supporting the conclusions of this article will be made available by the authors, upon request, without undue reservation.

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