Szelei Antonia
Health Promotion Teacher and Teacher of Adult Education
Social Gerontologist, Graduate nurse, Teacher
Kodolanyi Janos University
Oroshaza, Hungary
szeleiantonia@gmail.com

APPEARANCE OF SUICIDAL THOUGHTS AMONG THOSE LIVING IN THE ELDERLY CARE SYSTEM

Introduction.

Attitudes towards suicide varied by age and culture; sometimes it was completely accepted and sometimes it was forbidden.(Böszörményi, 1991).

Suicide is not always an individual act, with historically famous twin Antonius and Cleopatra. In our country, suicide has always been a negative act. If it happened in the family, the family was ashamed and secret. Outstanding figure in modern suicide research, French sociologist Durkheim, who developed the sociological theory of suicide.(Durkheim, 1988). In his book Suicide, he describes the social factors that played a role in committing suicide. In his view, the condition of the individual's spiritual balance is that his needs and desires are in harmony with one another. All kinds of social changes (both improvement and deterioration) lead to the breakdown of equilibrium and the relaxation of norms. Other researchers highlight infantilism as the cause of suicide, the infantile relationship scheme.(Buda, 1997). The point of this is that the attitude towards the other person is like that of children, an unequal relationship; spiritual dependence on another; expresses the problem not verbally but with mood states and behaviors; expectations are dominated by expectations rather than reciprocity. As a result, your relationships (friends, family, partners, co-workers) end in failure, your life is neurotic and you fail. In Hungary, despite the data of representative surveys, the proportion of suicide attempts and completed suicides among the whole population is decreasing (Osváth, 2009), is still a major health problem. Based on its complex etiology, prevention and care also require a multidisciplinary approach, but the difficulty of prevention, recognition and treatment derives from this complexity. According to both everyday and scientific terms, a person commits suicide who ends his or her own life.

Discussion and Results

Attempts to commit suicide are when one intentionally dies and destroys one's body, but does not die as a result. It follows from the three defining characteristics of suicide that an attempt may fail due to four circumstances or a combination of these:

1.- The intention of dying is not strong enough or not clear,

2. - The suicide method is not, or is not effective enough,

3. - The suicide act is defective or inadequate,

4.- Before death, external help - usually accompanied or followed by medical intervention - prevents, stops or eliminates damage to the body. (Buda, 1971, 1980). Since suicide and intent to commit suicide require consciousness, suicide can be considered a specific human phenomenon. (There is no qualitative difference between animal and animal self-killing.) (Kulcsár, 1935; Buda, 1971; Catanzaro, 1980).

The most important risk factors are: The presence of risk factors increases the likelihood of suicide attempts in an individual's life. Therefore, it is important to know what causes, or life events, may lead to an attempt to self-extinguish life.

It is noteworthy if the individual has already had a previous suicide attempt, or has had suicide attempts in his or her family, or completed suicide.

Depression, bipolar disorder, schizophrenia, and personality disorder are also risk factors. Aging, loneliness, loneliness, negative life events, and possibly crisis accumulations can also lead to hopelessness in life and the emergence of suicidal thoughts. Physical illness (especially if incurable), fear of vulnerability, and unbearable pain can lead to the loss of meaning of life and the patient's feeling of redemption. Different drug addictions and alcoholism also increase the likelihood of suicidal thoughts and attempts. Men are 3x more likely to die, while women are 4x more likely to die. Mortality rates are higher with age.

In suicide research, it is very common to observe that a patient attempting or committing death on an invited visit to a medical office, often a psychiatric clinic, for a longer or shorter period of time and asking for help directly or indirectly. According to several authors, about 40-60% of the patients who had been in a specialist clinic in the year before the suicide occurred.(M. Robins et al., 1959; Kovács et al., 1976). According to communication theories, suicidal intention is a message, a cry for help. This is described by Farberow and Shneidman (1961) in their analysis of the "cry for help" phenomenon. Wasserman (1985, 1986) observes that self-destructive intention is mediated by the important other person, the environment.

"Cry for help" and preszycidal syndrome theories: The concept of cry for help or communication signal, first described by Farberow and Shneidman (1961), means that any communication that is taken should be taken as an indication of psychological intervention that indicates suicidal thoughts or intentions. The purpose of this communication is twofold. On the one hand, he warns that there is trouble and, on the other hand, he asks the individual to help his environment to change the intolerable situation, thereby moving him, giving him

action to communicate. The indifference of the environment can further push the individual towards self-willed death. While cry for help is early on in suicidal tendencies, preszicidal syndrome is the terminal phase. The concept comes from Ringel (1976). By this he meant a constellation of every kind of suicide or serious attempt.

There are several prerequisites for an action to occur: External factors alone are not enough to commit suicide. The narrowing of individual possibilities results from a particular intrapsychic perception and presupposes a deterioration of the mental structure. Situational narrowing, combined with dynamic narrowing, directs the individual to suicide. When weighing between life and death, dynamic narrowing can lead to a disorder in which the individual chooses to die for life. Thought processes are defined by walking in a constant, repetitive circle.Behavior loses its diversity, its nuances. Affective narrowing plays an important role. The time factor is lost. The person becomes the victim of their own mood. Increases internal insecurity, anxiety. Gradual isolation and narrowing make it difficult to respond to tensions arising from conflicts. The first comprehensive psychoanalytic theory of suicide comes from Freud. In his work, Grief and Melancholy, published in 1916, he does not merely take the case description, but gives a completely novel approach to the mechanism of suicide. "Suicide in depressed people, he writes, is initially directed at a close person, after losing his anger turns to himself." Freud says we kill somebody in every suicide; all suicides are also murder. We kill (in a symbolic way) the loved one with whom we have identified ourselves but whose love we have lost. This allows for suicide as a hate reaction. The more the individual suppresses outward aggression, the more severe the more aggressive the individual's self-ideal will be. "In melancholy," Freud writes, "I give up because I feel hated, chased, instead of love. Following Freud, almost all psychoanalytic authors emphasize a deeper or more differentiated aspect of this psychoanalytic theory, adopting the basic premise, which consists of:

1. - suicide is a reaction to loss of things (not only to the physical loss of an important person, but also to the psychic experience of disappointment);
2. - feels the object irreplaceable;
3. - interprets the loss of objects as a threatening process.

Almost all psychiatric diseases are associated with an increased suicide risk, with the highest risk being seen in bipolar disorder and unipolar major depression. Retrospective and prospective follow-up studies have consistently shown that suicidal behavior (completed suicide, attempted suicide) and suicidal ideation in affective patients is seen in 75-80% of patients with severe major depression and 10-15% with dysphoric mania, but is rarely seen in euphoric mania and after recovery from depression or dysphoric mania. (Hawton et al. 2005, Valtonen et al. 2005, 2008, Sokero et al. 2006, Rihmer 2007, Tondo et al. 2008). It follows that suicidal risk in an affective patient is a condition- and severity-dependent phenomenon and that early identification and effective treatment of specific affective episodes is an effective means of suicidal prevention. (Akiskal 2007, Rihmer 2007). However, the overwhelming majority (about 80-85%) of depressed patients die of non-suicide, and about 80% of them die. 50% never attempt suicide, so not only the depression itself, but also the specific clinical features of depression, as well as other psychiatric-medical (comorbid psychiatric and physical illnesses), psychosocial (life events) and psychological, personality (aggressive), and protective factors also play an important role. (Mann et al. 1999, Tondo et al. 2003, Hawton et al. 2005, Balázs et al. 2006, Rihmer 2007).

Depression and suicide in old age: In most countries, elderly people are most likely to end their lives voluntarily in relation to the population (Lovestone and Howard 1996, Agbayewa et al. 1998, Lawrence et al. 2000, WHO 2007, Schmidtke et al. 2008). In Hungary, according to the 2009 data and age group comparisons, not only in relative terms, but in absolute terms, the majority of completed suicides were committed by people over 64 years of age. According to CSO data, 3269 people committed suicide in Hungary in 2000, while in 2010, 2492 people died. Six people a day end their lives in Hungary with their own hands and this number can be multiplied by the number of suicide attempts. Territorial inequality is observed, with one third as many suicides in western counties as in southern, south-eastern regions. (source: KSH 2010). In the elderly, completed suicidia is three to seven times more common among adolescents than among adolescents (Diekstra and Gulbinat 1993, Gulbinat 1996). Male suicide remains prevalent in suicide in old age, but the gender gap is much smaller. According to the 2009 Central Statistical Yearbook, "only" 2.5 times more men committed suicide in the age group 65 and over, while among those younger than 65 there were four times as many men as women. Many factors are responsible for the high suicide rate in the elderly (Canetto, 1995; Cattel and Jolley, 1995). As people get older, more and more diseases attack them, they lose more friends and relatives, they are less able to influence their own lives, and their social esteem and status fades. As a result of these unpleasant experiences, they are gradually overwhelmed by the feeling of hopelessness, loneliness, depression, and the inevitability of the end, increasing the likelihood of committing suicide (Canetto, 1995; McIntosh, 1995; Osgood, 1987). In one study, 44% of people attempting to commit suicide justified their actions by fear of being placed in an elderly home (Loebel et al., 1991). The suicide rate of survivors is extremely high (Li, 1995; McIntosh, 1995, 1992). The danger is greatest in the first year of mourning, but it must be reckoned with later.Older people are much more willing to give up life than any other age group, and therefore have the highest number of completed suicides (McIntosh, 1992).

Risk factors for suicide in old age include: Biological predisposition, associated psychiatric and

somatic diseases, and psychosocial factors all play a role in the suicide of the elderly to varying degrees.There is an increased risk of suicide in family history of depression, substance abuse, and suicide or attempted suicide.

Depression was the most significant predictor, which was found in retrospective psychological studies in 54-87% of cases, followed by substance use (3-43%), followed by anxiety disorders and schizophrenia (Yeates and Thompson 2008).

Depression is the most common psychiatric illness in old age, with suicide being the most serious complication. Several case-control studies have confirmed that existing affective disease significantly increases the risk of suicide (Chiu et al. 2004, Waern et al. 2002, Beautrais 2002). Retrospective psychological studies show significant differences in substance use. The incidence ranges from 3% to 43%, which may reflect ethnic and cultural differences (Yeates and Thompson 2008). In the elderly, the frequency of substance dependence may increase, often due to the causal role of psychosocial factors (eg loneliness, boredom) and, when they occur, the risk of suicide increases. It is not easy to judge this by the patients' bagicking behavior. Research has shown that 60% of people committing suicide are alcohol-dependent (Suokas and Lonnqvist, 1995; Hirschfeld and Davidson, 1988). The data suggest that alcohol consumption plays a crucial role in suicide (Wasserman, 1992). Many professionals believe that alcohol's inhibitory effect contributes to suicidal thinking, but that people who fear the consequences of it (Patel et al., 1972), while others believe that alcohol, by letting go of the aggressive drive, it dampens the individual's inhibitions and resistance to aggression. (Whitlock and Broadhurst, 1969). In drunkenness, people's judgment and conflict resolution abilities continue to decline (Rogers, 1992). Case studies, with one exception (Harwood et al. 2001), did not find dementia a risk factor for suicide (Yeates and Thompson 2008).

In the initial stages of cognitive decline, there may be an increased risk that the patient may notice the first symptoms but these are not yet apparent to the environment. Typical personality disorders are not detectable in suicides in the elderly, but it is common experience that they become richer with age, have coping mechanisms that are impaired, and are more difficult to incorporate into psychotherapy. Harwood et al. (2001) found anankastic and anxiety features to be more prevalent in older adults who committed suicide, but their extent did not meet the diagnostic criteria for personality disorder. Hopelessness in all age groups, including the elderly, is a predictor of suicidal risk (Hill et al. 1988, Ross et al. 1990). Szántó et al. (1998) point out that despite the significant improvement in depression, the residual symptom often remains a feeling of hopelessness in elderly patients who have previously committed suicide, so that they remain high-risk and maintain complex psychosociotherapy should help these patients find meaning and purpose in their lives. With age, the incidence of chronic somatic diseases increases. The relationship between various physical illnesses and suicide is mediated by depression, since chronic somatic disorders are often associated with depression. According to the literature, there is an increased risk of suicide in HIV / AIDS, Huntington's chorea, multiple sclerosis, epilepsy, peptic ulcer, chronic heart, lung and kidney disease, SLE and prostate disease (Harris and Barraclough 1997, Kutcher and Chehil 2007). Tumors are also more common in the elderly. Lung, stomach, oral and pharyngeal, and then laryngeal cancers are most frequently sequenced, with older white men predominantly (Misono et al. 2008). Most suicide attempts are caused by depressing illnesses with severe pain. (Lester, 1992; Allebeck and Bolund, 1991). For such patients, death seems inevitable. They feel they have to endure themselves in the shortest possible time because the pain and suffering they are experiencing is beyond their tolerance. Not only physical disorders, but also the medications used to treat them can cause depression and thus indirectly increase the risk of suicide (eg beta-blockers, seroids, benzodiazepines, barbiturates, L-dopa, digoxin, reserpine, haloperidol, Gottfries and Karlsson 1997). It is a common experience that the condition of elderly patients is improved by reducing the number of medicines they take. Not only because of side effects and drug interactions, but also for suicidal prevention, we prescribe only the most necessary medications for our patients and eliminate home pharmacies.

Psychosocial factors, life events: Among the life-cycle changes, retirement and its negative consequences are notable, which, in the case of men in particular, entails not only material loss but also a loss of social prestige. Retirement is a major stress factor. Suddenly, the number of social relationships may be significantly reduced, and instead of regular - often excessive - daily activities, the feeling of emptiness, boredom and superfluity may occur. New lifestyles require adequate adaptive skills, but inadequate cooperative mechanisms often lead to psychosomatic illnesses, e.g. hypertension. Family relationships are loosening, children are living independent family lives, and parents are increasingly less likely to visit. Parenting can easily be transformed into "childlike", especially when moving away from their old, customary home or living space to their child's home. The feeling of dependence can strengthen the sense of superfluity, the remainder will break the rest of their social relationships, "social loneliness" and isolation can easily be the basis for depression. The loss of objects (death of a close relative, divorce) can lead not only to loneliness and bereavement, but also to crisis, depression and serobus, which increases the risk of suicide. Older people living alone are significantly more likely to commit suicide than those living in a family or community (Barraclough 1971, Wanta et al. 2009, Kutcher and Chehil 2007). Older people give less warning to their environment, but it is also true that the environment is less alert to them (Carney et al. 1994).

Methods of committing: In Hungary, hanging is the

most common form of suicide leading to death, while suicide-related suicide is relatively rare among women (CSO 2009), while in the US, 57% of men and 32% of women firearms offense based on 2004 figures (CDC 2007). This rate is even higher among people over 65, with more than two-thirds (72%) giving their lives in this way (CDC 2007). Weapon use is on the rise, especially among older women. Between 1979 and 1992, this method increased by 24% in women over 65 (from 1.7 to 2.1 / 100,000) and became the second most common method after drug-related suicides (Adamek and Kaplan 1996).

Protective factors for suicide: Of the many suicide risk factors, relatively few are known to be protective for suicidal behavior. Good family and social support, pregnancy and postpartum periods, large numbers of children, active (non-formal) religiosity, and suppressing or dying suicidal methods. limiting their accessibility (from less toxic psychotropic drugs to adequate barriers at railway stations, bridges, etc.) and stricter arms, alcohol and drug strategies have been shown to be protective (Marzuk et al. 1997, Drevic et al. 2004, Driver and Abed 2004, Rih , Godwin and Jamison 2007). Fortunately, suicidal behavior is rare in the population, and much more common among psychiatric patients, many of whom seek different levels of health care in the weeks or months leading up to the suicide (Tondo et al. 2003, Rihmer 2005, 2007). This underlines the role of health professionals in recognizing and caring for those at risk of suicide. However, since trained medical staff can only help those who seek help, public information (written and electronic) on depression and suicide prevention is also very important. It is not enough to know how to cure depression, it is also necessary to arrange for the patient to go to the doctor and receive appropriate treatment (Kalmár 2003, 2009).

Prevention options: The issue of prevention began to come to the fore in the mid-1950s. More than one-third of suicide-related elderly people visit their doctor within one week, but most often give only an indirect, hard-to-recognize indication of their intention (Yeates and Thompson 2008). Some suicidal ideation is feared by some GPs (Stoppe et al. 1999), although it is a mistake that the question of intention would provoke a suicide attempt. On the contrary, the patient can ventilate and be relieved to share his or her fears, bad thoughts, with a professional. There is no need to fear the use of antidepressants in the treatment of elderly depressed patients. The ideal suicide prevention strategy would be to regularly assess the somatic and psychological condition of the elderly with their GP, to receive appropriate psychosocial support and to be provided with a Tele-help, Tele-Check Service in the event of a somatic or psychological crisis; this is not a utopia, but an option that is already realistic in some countries (De Leo et al. 2002). Suicide prevention programs and telephone emergency services consider people who are suicidal to be in crisis, unable to cope with their stress, feeling hopeless and immutable, threatened and hurt. Accordingly, the approach of the programs follows the rules of crisis intervention: they help people at risk to assess their situation in a sober and systematic way, to make appropriate decisions and to act more effectively in order to overcome the crisis. (Frankish, 1994).

Conclusions: Suicide as an existing problem should not be treated as a taboo subject. All regrettable events of all ages. We cannot condemn anyone who has had thoughts of suicide or an attempt. Everyone lives their own lives and struggles with the difficulties and crises that accompany their lives. Suicide, a trauma that is difficult to process in the life of a family, causes a major crisis. The family, the environment of the individual and the professionals play an important role in processing the loss. Seek professional help in dealing with trauma and crisis. Don't be ashamed to ask for help. Unprocessed losses can have consequences. There is a need for professionals (Psychologists, Psychiatrists, Mental Hygienists, Social Gerontologists, Social Workers, Doctors and Nurses, etc.) who know and recognize the causes of suicide, to take part in prevention, to participate effectively in crisis intervention. I find it important to recognize cry for help as a phenomenon, to recognize it when the other person needs help. Dare to ask for help and give! Timely identification and treatment of depressed persons is also essential for prevention. Reducing the loneliness, vulnerability and superfluity of the elderly is of paramount importance to those living in the elderly care system. Do not let the elderly become lonely, because loneliness, a feeling of loneliness, slowly drains the oxygen of the flame of life, and may lose the meaning of life. I consider it important to maintain loving relationships for the rest of their lives. Ensure continuous contact with family and friends. Providing joyful activities, hobbies and useful activities among those living in the elderly care system. Spiritual comfort, the opportunity to practice religion at home. Prevention of isolation, confinement and loneliness is also a priority. Every human being is unique and unrepeatable, every human being is valuable, and we treat people as values at the end of their lives. Let's learn to accept each other's decisions and let go of whoever wants to go.

Keywords: suicide, depression, incurable disease, loneliness, cry for help, self-destructive behavior, invited death, old age,

Reference

1. Bagdy, E .: The Relationship between Crisis Care-Intervention Method-Specific Psychotherapy (Manuscript)
2. Bakó T., (1996) Deep in the Stack. Book about the crisis. Cserépfalvi, Budapest
3. Bakó T., (1992) Suicide Attempt to commit suicide, Data and Facts. Animula, Budapest.
4. Bakó T., (1992) Without Secrets - Psychological Investigations of Suicide, Cserépfalvi Edition, Budapest.
5. Buda, B. (1997) Suicide. Medical and social studies. Animula, Budapest.
6. Caplan G.: Mastery of Stress: Psychosocial Aspects. Am. J. Psych. 138, 4, 1981.
7. Farberow N.L.: The Cry for Help. McGraw-Hill, New York, 1981.

8. Farberow N.L.: Suicide: Past, Present and Perspectives. Suicide Research/Psychiatria Fennica Suppl. 1976.
9. Fekete Fekete, Osváth P. (2004) Suicide. From inheritance to culture. Pro Pannonia, Pécs.
10. Kalmár S. Németh A. Zoltán Rihmer (ed.) (2012) Suicide risk analysis, treatment, prevention by the medical eye, Medicina Könyvkiadó Zrt. Budapest.
11. Kézdi B .: Culture of Suicide, Sign S.O.S. LIFE Telephone Service, Pécs, 1992.
12. Kopp, M. (2008) Hungarian state of mind. Empowerment and Quality of Life in Today's Hungarian Society, Semmelweis Publishing House, Budapest
13. Perczel Forintos, D., Sallai, J. and Rózsa, S. (2001): Cognitive background factors in suicidal behavior - Experiences of using the Hopelessness Scale in Depressed Patients: Psychiatria Hungarica, (6). 632-643.
14. Perczel Forintos, D. (2008): Suicide Prevention and Problem Solving (ed.) Psychiatria Hungarica XXIII. Vol. 2008/1 thematic issue
15. Perczel Forintos, D., Poós, J. (2008): The Way out of Race - Problem Solving Training in Preventing Suicide Risk (Review Study). Psychiatria Hungarica XXIII. Vol. 2008/1, 4-22. She.
16. Poós, J., Annus, R., and Perczel Forintos, D. (2008): Examination of problem-solving ability in psychiatric patients. Psychiatria Hungarica XXIII. Vol. 2008/1, 42-56. She.
17. Popper, P. (1999) Does it hurt to die? Saxum Bt. Kaposvár Printing House Ltd.
18. Rajna P., Tariska P .: Neuropsychiatry in the elderly. (2000) B + V Publishing and Publishing Ltd.
19. Rihmer Z. (2007): Suicide risk in mood disorders. Curr. Opin. Psychiat 2007, 20: 17-22.
20. Rihmer Z, Fekete S. (2009): Suicide. In. Hungarian Handbook of Psychiatry (ed. Füredi, Németh A, Tariska P.), 4th revised and expanded edition, Medicina Publishing House, Budapest, 2009. pp. 670-678.
21. Rihmer Z. (2011): Lithium treatment and the risk of suicide in affective disorders. Eur Psych Rev 2011; 4: 48-51.
22. Ronald J. Comer. (2000): Diseases of the Soul Psychopathology Osiris Publishing House, Budapest.
23. Shneidman E .: Definition of Suicide. Wiley and Sons, New York, 1985.
24. Simkó, A., Frater, R., and Tariska, P. (eds.): Current Problems in Gerontopsychiatry (1994) Print-X Publisher. Budapest.
25. Spar. J.E., La Rue, A .: Geriatric Psychiatry. (2003) Soul at Home Publisher. Budapest.
26. Székács, B. (ed.): Geriatrics. Medicine for old age. (2005) Semmelweis Publisher. Budapest.
27. Tringer, L. (2005): The Textbook of Psychiatry. Medicina Publishing House, Budapest.
28. Zonda, T., and Veres, E. (2004) Suicide Development in Hungary (1970-2000). Addictologica Hungarica, Volume 3, No.1., P. 7-23.
29. Zonda, T., (1995) Is the Hungarian a suicidal people? Endens Foundation, Budapest.

Сідун Лариса Юріївна
ст. викладач кафедри теорії та практики перекладу
ДВНЗ «Ужгородський національний університет»
мУжгород, Україна
larisa.sdn@gmail.com

РЕАЛІЗАЦІЯ ПРИНЦИПУ ПОЛІКУЛЬТУРНОСТІ В УМОВАХ БАГАТОНАЦІОНАЛЬНОЇ ДЕРЖАВИ

Україна є багатонаціональною державою, тому питання міжетнічних відносин відносяться до найбільш актуальних. У вирішенні питань міжетнічних відносин важливе значення має дотримання принципу полікультурності, зокрема, це стосується освітніх проблем національних меншин. Цей принцип як один із провідних принципів виховання громадянина зазначається в «Концепції громадянського виховання особистості в умовах розвитку української державності». Його реалізація означає, що в процесі громадянського виховання мають створюватись умови для формування особистості, вихованої в національній культурі і водночас відкритої іншим культурам, ідеям і цінностям. Тільки така особистість, наголошується в Концепції, здатна зберегти свою національну ідентичність, оскільки глибоко усвідомлює національну культуру як невід'ємну складову світової культури [1, с. 8].

Основні завдання полікультурної освіти визначені в рекомендаціях Міністерства освіти і науки України до концепції полікультурної освіти в Україні: забезпечення законних прав, задоволення освітніх і культурних потреб національних (етнічних), мовних, культурних меншин; формування в молодих громадян України всіх національностей повноцінних уявлень про етнічне й мовно-культурне різноманіття сучасного українського суспільства та внесок різних етнічних груп і народів-сусідів у нашу історію й культуру, знань про мови й культури великих і малих народів, що населяють Україну, переконаності в цінності культурного різноманіття та плюралізму; виховання в представників усіх національностей взаємного розуміння, поваги й толерантності, здатності до міжетнічного й міжкультурного діалогу, віри в необ-