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CUPRINS

MOTTO:

Fiecare om care se simte bine e de fapt un bolnav care se neglijează.

*Jules Romains (1885 – 1972)**

Fluierul piciorului este un dispozitiv de găsire a mobilierului pe întuneric.

*Colin Bowles**

Bigamia înseamnă să ai o nevastă în plus. Monogamia e același lucru.

Oscar Wilde

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PREZENTAREA ASOCIAȚIEI BALINT DIN ROMÂNIA

Michael Balint: Psihanalist englez de origine maghiară

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GRUPUL BALINT:
Grup specific alcătuit din cei care se ocupă de bolnavi și care se reunesc sub conducerea a unui sau doi lideri, având ca obiect de studiu relația medic-bolnav prin analiza transferului și contra-transferului între subiecți.

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SOME CONSIDERATIONS ABOUT THE PROBLEM OF SUICIDE

MirceaDehelean, Liana Dehelean, PompiliuDehelean, The University of Medicine and Pharmacy "Victor Babeș" Timișoara

Definition: *Suicideis derived from the Latin word for "self-murder", i.e. sui-cida:*

- *It is "the act of taking ones` own life" (Stedman, 2006) (1)*
- *According to Webster 3rd New International Dictionary (Vol. 3, 1996), (2) suicide is the act or an instance of taking ones` own life, voluntarily and intentionally: self-destruction (self-murder)*
- *But in the "New Encyclopedia Britannica" 15th Edition, volume II (Micropedia), 1992 (3)- a simple word is changed, i.e. "act of voluntarily or intentionally taking ones` own life" and makes a difference. Because this definition does not specify the outcome "it is not customary to distinguish between fatal suicide or attempted (non-fatal) suicide"*
- *In conformity with Sadock, Sadock and Ruiz (2015) (4) suicide is "the act of intentionally causing one`s own death" (completed suicide). "Self-inflicted death is a fatal act representing the persons` wish to die, with explicit or implicit evidence that the person intended to die."*
- *In **UCH** Textbook of Psychiatry, edited by H. Wolf, A. Bateman and D. Sturgeon (**Duckword**, Oxford, 1990) (5) is also stated: suicide is a willful self-inflicted life-threatening which has resulted in death.*
- *So the suicide is "completed" (not only attended unsuccessfully); this term is preferred by many people instead of "committed" ("commit suicide") because the last implies that suicide is "criminal, sinful, morally wrong" (as argued the ethicist physicians or Abrahamic religious) and this problem is controversial (as so many others related).*

PRINCIPAL DISTINCTION BETWEEN TERMS AND CONCEPTS RELATED

HOMICIDE represents the act of killing people (one or more), nevertheless if it refers to itself or other people. In the general acceptation, the suicide is a kind of homicide and is condemned by law (religion, morale, society, culture, a.s.o.). Only few people consider that the 6thCommandment of the Bible (not to kill) refers only to others not to oneself and exemplifies that by the character of Samson.

ASSITED SUICIDE is when one individual helps another bring about their own death, indirectly, via providing other advice or the means that can lead towards their end (Giullota P., Bloom M., 2002).

It is in contrast with EUTHANASIA (gr. *"good death"*), that means compassionately allowing, hastening and causing death to another, and where another person (not only some physicians) takes directly a more active role in bringing about a person's death (Giullota P., Bloom M., 2002) **ATTEMPTED SUICIDE IS THE OPPOSITE TO COMPLETED SUICIDE** and represents non-fatal suicide behavior (e.g. self-injury) with the desire to end ones` life that does not result in death (Krug E. 2002).

PARASUICIDE: - The act of mimicking suicide behavior, sustaining deceitfully the wish to die; -the term is coined by Norman Krietman (1977); - Parasuicide is a claimed suicide attempt that was not intended to succeed. Apparent attempts and suicidal gestures have other aims than that

PHISYCIAN- ASSISTED SUICIDE

The act of a physician, in the case of a terminal, incurable patient, with great and inalienable suffering illness, to provoke directly the death of a patient, after his request (and after the request of his family), with a lethal dose of medication, when the patient is incapable of committing suicide, but is mentally competent, fully informed, therefore making a voluntary choice.

This is a debatable problem:

Arguments:

- it is a human alternative to active euthanasia, in the-matter that the patient maintains more autonomy, remains the actual agent of death; may be less likely to be coerced into that intent.

- the legal right to die.

Arguments:

The distinction is capricious, asthe intent in both cases is to bring about a patient`s death;

Difficulty to discriminate between two patients: which one is more ill or distressed, taking into consideration that one of them cannot complete the act because of problems regarding swallowing, dexterity or strength;

The American Association of Suicidology (1996): In PhysicianAssisted Suicide-death is not:

a. the goal of treatment;

b. intentional;

Several degrees to which a physician may assist the suicidal patient:

providing information or ways of committing suicide;

supplying a prescription for a lethal dose medication means inhaling a lethal dose of CO;

providing a suicide device that the patient can operate;

withdrawing and withholding life-sustaining treatment.

The case of Jack Kevorkian

He helped more than 130 people take their lives. Charged in 1989 with first-degree murder, he was later dismissed because his state, Michigan, had no law against physician-assisted suicide. Finally, he was sent to prison in 1999 and released in 2006.

He was applauded for his courage in easing pain and suffering by his followers, but his opponents considered him a serial-mercy-killer and argued that suicide rarely occurs in absence of psychiatric illness (especially treated depressive disorders). In 1994, the state of Oregon legalized Psychiatry-assisted suicide (*"Death and Dignity act"*). Attorney General John Ashcroft in 2000 attempted to prosecute Oregon doctors but the Supreme Court supported the Oregon Law in 2005.

HISTORICAL PERPECTIVE

Throughout history, suicide was both condemned and praised by various societies.

It is condemned by all Abrahamic (Judaism, Islamic, Christianity) religions. But in the Bible, some people are glorified (i.e. Samson). In Judaism there is permission for singular or collective suicide (Masada), in special circumstances. Some religions believe that the Biblical 6thCommandment (*not to kill*) must be respected *"only for others"*.

Christianity, in its early period, glorified the sacrifices of *"martyrs"* who *"provoked"* their own death (by Crucifixion, a.s.o.). But in 492, the Council of Arles condemned suicide as a *"devils work"*. Thomas D`Aquino (as Saint Augustin in antiquity) considered suicide a sinful behavior, a God offence because of the sanctity of life (a God's gift). But it exists an opposite opinion: suicide is not a greater sin than medical treatment in conformity to some protestant doctrines about non-intervention in God's work with an individual.

Philosophically, there are also opposite beliefs: immorality versus the right of any human being to take decisions concerning his life (David Hume).

Historically, in Ancient Greece, official convicted criminals,if they were nobles and/or famous, were permitted to take their own lives(in the case Socrates, drinking poison).

In ancient Rome, suicide was permitted for escaping from intolerable situations (Petronius, Seneca, defeated generals, a.s.o.). Later, romans attitude towards suicide hardened.

In India, the Brahmans and Jainists tolerated suicide of Indian widows (this practice was highly praised at that time). There were also other attitudes: allowed only by non-violent practice of starvation (Prayopavesa).

The Japanese customs of *seppuku* (Harakiri) or disembowelment was long practiced as a ceremonial rite (compulsory hara-kiri was outlawed in 1863). Noblemen were granted the privilege of punishing themselves in this way for: wrongdoing, to escape the humiliation of failure, in order shame ones` enemies and demonstrate loyalty to the master or emperor.

Buddhist monks and nuns committed sacrificial suicide by burning themselves alive as a social-protest.

Juridically

The most severe punitive legislation against suicide was promulgated by Louis XIV in France, in 1670;

But John Donne approved suicide in special circumstances (Case Samson);

Following the 1789 Criminal Penalty for attempting to commit suicide was abolished in many European Countries (the last one was England in 1961);

But the general status of suicide differs in time, in Europe and the U.S.A.

Nevertheless, the change in the legal status of suicide has had no adverse influence in suicide rates in most of the

countries or regions; the evident decline of the suicide-rates was in wartime.

In the modern society the trend is:

1. The permissiveness
2. Greater tolerance for all deviant behaviors
3. Less moralistic and punitive attitude of societies toward suicide
4. Greater readiness to understand rather than to condemn. The tendency to conceal suicide still persists. The author considers that with the exception of very special situations, suicide must be successfully prevented as much as possible.

PARTICULAR WAYS OF SUICIDE

- **ALTRUISTIC SUICIDE** for the benefit of others: e.g. for Innuits and other arctic-native population, as proof of respect, courage, wisdom, in the case of people of old age, ill, disabled part of the group.
- **PATRIOTIC SUICIDE** e.g. defeated generals (Model) or Japanese *"kamikaze"* pilots;
- **FANATIC SUICIDE, MURDER-SUICIDE** (ideological motivation): e.g. Jihadists (Bomber-suicide): to kill *"the enemies"* is good goal.
- **MIMMETIC SUICIDE, COPY-CAT SYNDROME**: e.g. Werther Syndrome (Bohanna 2012): suicide *"endemic"* in Germany around romantic younger Germans after reading a Goethe novel. It is opposite to *"Papageno Syndrome"* when the tendency of suicide is prevented successfully (mass-media factor) in the opera of Mozart- Magic Flute
- **VICTIM PRECIPITATED HOMICIDE** is the phenomenon of using others to kill oneself by killing other people for this specific goal (his own death). Closely related with Amok (run amok) Malaysian Phenomenon. To kill others is not a goal but a way.
- **EXTENDED SUICIDE** is the extreme form of MURDER-SUICIDE. The individual aims to take the life of others at the same time (difference from serial-killers) with the peculiar motivation of seeing the murdered person as an extension of oneself.
- **MASS SUICIDE** (1978, Jonestown): suicide of 905 members of the Peoples` Temple of Jim Jones, by drinking (mostly) grape Flavored Aid with cyanide. Thousands of Japanese civilians took their own lives at the last day of the battle of Saipan (1944), some by jumping from *"suicide-cliff"* and *"bansai-cliff"*. The list of particular suicide is not exhaustive. Previously authors published an article about *"Paradoxical Suicide"* and intended to continue in this manner this topic in the future.

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THE ROLE OF THE GENERAL PRACTITIONER IN THE PREVENTION OF DEPRESSION-RELATED SUICIDES

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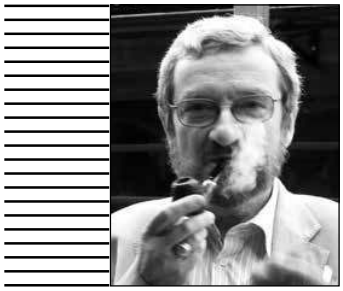
Rezumat: *Comportamentul suicidar este rar întâlnit în comunitatea pacienților, însă este mai frecvent la pacienții psihiatrici, care pot solicita pentru o consultație doctorii lor de familie cu câteva săptămâni sau luni înainte de a comite suicidul. Depresia majoră este diagnosticul psihiatric cel mai frecvent întâlnit la victimele suicidului complet și la cei care încearcă să se sinucidă (56-87%), iar de aceea tratamentul de succes, acut și de lungă durată al depresiei reduce semnificativ riscul de comportament suicidar, chiar în populația cu risc crescut. Deoarece ceva mai mult de jumătate a viitoarelor victime ale suicidului contactează medicii lor generaliști că câteva săptămâni înainte de a-și sfârși viața, medicii de circumscripție joacă un rol important în predicția și prevenirea actului de suicid. Cinci studii comunitare de mare amploare arată că educația medicilor generaliști și de alte specialități pentru recunoașterea depresiei și a farmacoterapiei potrivite, mai ales dacă sunt însoțite de intervenții psiho-sociale și educația publicului pot ameliora identificarea și tratamentul depresiei, ba chiar că numărul de sinucideri și de încercări de suicid este mai redus în zonele deservite de doctorii care au fost special antrenați.*

Abstract: *Suicidal behaviour isa rare event in the community, but it ismore common among psychiatric patients, who may contact their general practitioners few weeks or months before the suicidal event.Major depressive episode is the most common current psychiatric diagnosis among suicide victims and attempters (56-87%), and therefore acute and log-term successful treatment of depression significantly reduces the risk of suicidal behaviour even in this high-risk population. Because more than half of allsuicidal future victims contact their general practitioners within weeks before their death, primary care doctors play an important role in suicide prediction and prevention. Five large-scale community studies showthat education of general practitioners and other medical professionals on the recognition and appropriate pharmacotherapy of depression, particularly in combination with psycho-social interventions and public education improve the identification and treatment of depression and reduces the rate of completed and attempted suicide in the areas served by trained doctors.* ***Keywords:*** *Depression, General Practitioners, primary care, suicide, suicide attempt,suicide prevention.*



1. INTRODUCTION

Major depressive episodes (unipolar and bipolar)are the most common current diagnoses of suicide victims and attempters(Hawton and Heeringen, 2000; Balazs et al., 2003,Mann et al., 2005; Turecki and Brent, 2016). The lifetime, 1-year and point prevalence rates of unipolar major depression in the general population is in average 12%, 7%, and 4% respectively(Rihmer and Angst,2005a; 2005b). In addition, the lifetime, 1-year and current prevalence rates for bipolar (manic-depressive) disorder, including both bipolar Iand bipolar II subtypes in the community are around 4%, 1% and 0.6% respectively (Rihmer and Angst,2005a; 2005b).

Up-to two-thirds of patients with unipolar depression and bipolar disorder have comorbid anxiety disorder(s), and/or substance-use disordersand around one-third of them also have one or more serious medical illness and this comorbid disordersdecrease the chance of diagnosis of depression and increase the risk of suicidal behaviour

(Davidson and Meltzer-Brody, 1999; Hawton and Heeringen, 2000; Wasserman, 2001; Rihmer and Angst, 2005b).

2. PREVALENCE AND RECOGNITION OF DEPRESSIVE DISORDERS IN PRIMARY CARE

Studies consistently show that only 35-50% of all depressed patients in the community seek medical help and the majority of the ones who do consult their general practitioners (GPs) however, are not adequately diagnosed and treated despite the last decades great diagnostic and therapeutic achievements in the field of mood disorders (Lecrubier and Hergueta, 1998; Davidson and Meltzer-Brody, 1999; Berardi et al., 2005; Rihmer and Rutz, 2019). While the point prevalence of DSM-III/DSM-IV or ICD-10 major depression in the primary care practice is around 8-10%, most of depressed patients are not recognised by their GPs. Moreoverthe rate of adequate antidepressant treatment among diagnosed depressives was less than 20% (Spitzer et al., 1994; Szadoczky et al., 1997; Davidson and Meltzer-Brody, 1999; Szadoczky et al., 2004; Berardi et al., 2005; Torzsa et al., 2009a). The WHO Collaborative Study conducted in 1991 on more than 25.000 primary care patients in 14 countries reported that on the whole, approximately 50% of the patients with an ICD-10 diagnosis of major depressive episode were recognised as suffering from some kind of mental disorder by their GPs, but only 15% of major depressives were recognised as having depression, and fewer than half of them were prescribed antidepressants for their depression(Lecrubier and Hergueta, 1998; Lecrubier, 2001).Studies performed 5-10 years later, reported much higher rates of recognition and treatment of depression in primary care (62-85%) and 33-50% of them were treated with antidepressants (Lecrubier, 2001; Berardi et al., 2005) indicating that the situation does appear to be improving as a consequence of steadily increasing awareness of depression.

Around half of depressed patients report painful physical symptoms both in psychiatric and in primary care settings that make the diagnosis of depression more difficult(Garcia-Cebrian et al., 2006). The majority of patients with depression consult their GPs primarily for somatic reasons, either because of their somatic comorbidity or because of the predominant somatic symptoms of their depression(Davidson and Meltzer-Brody, 1999; Lecrubier, 2001; Tylee and Rihmer, 2004). This important, since major depression is frequently associated with chronic physical disorders (cardiovascular diseases, hypertension, stroke, cancer, epilepsy, Parkinson's disease,HIV infection/AIDS, etc.) which further increase the risk of suicidal behaviour. Several factors, relating to both patients and doctors, are likely to affect the recognition of major depression in primary care. Patient factors associated with non-recognition of depression include: comorbid psychiatric (anxiety, substance abuse and personality) disorders, comorbid (mostly chronic) medical disorders, low degree of disability, less severe depressions, predominantly somatic symptom-presentation, male gender, younger or older age, and married marital status(Rihmer and Rutz, 2019). On the other hand, high level disability, lack of comorbid psychiatric and medical disorders, more severe depression, higher number of depressive symptoms, presenting depression predominantly with psychological symptoms (depressed mood, poor concentration, fatigue, psychomotor retardation), middle age-range, female gender and separated or divorced marital status increases the chance of correct identification (Rutz et al., 1995; Rutz et al., 1997; Lecrubier, 1998; Lecrubier, 2001,Szadoczky et al., 2004).

The recognition and management of depression in primary care practice is still far from the optimal(Lecrubier, 2001; Berardi et al., 2005; Rihmer and Rutz, 2019). Physician factors, related to poor recognition of depression are: lack of experience, insufficient or suboptimal knowledge about the symptoms, treatment and good prognosis in treated depression, prejudices about mental illness, lack of postgraduate psychiatric training, insufficient interview-skills, lack of cooperation with psychiatrists, and low level of empathy (Rutz et al., 1997; Lecrubier, 2001). Studies showed that specific organisational interventions and postgraduate training programmes improve the recognition and treatment of depression in primary care (Rutz et al., 1997; Mann et al., 2005; Hegerl et al., 2006; Szanto et al., 2007, Szekely et al, 2013). Short screening-instruments, some of them designed specifically for primary care are also helpful, but they do not replace a well-performed and competent clinical interview(Davidson and Meltzer-Brody, 1999; Lecrubier, 2001; Szadoczky et al., 2004).History of completed suicide among first or second degree relatives could be a good and simple clinical marker for current and lifetime major depressive episode in primary care practice(Torzsa et al., 2009a).

Studies on suicidal behaviour in primary care focuses mainly on unipolar major depressive disorder and less attention is paid to bipolar illness, the point prevalence of which is between 1 and 2 percent in the GP practice (Spitzer et al., 1994; Szadoczky et al., 1997).Because the majority of hypomanic and manic patients later also become depressed (Rihmer and Angst, 2005a), patients with history of hypomania and mania, particularly in the presence of

current depression should be considered as persons at very high risk of suicide.

3. DEPRESSION AND SUICIDAL BEHAVIOUR

Between 10-18 % of adults worldwide report lifetime suicidal ideation and 3-5 % have made at least one suicide attempt lifetime(Kessler et al., 1999; Szadoczky et al., 2000; Nock et al., 2008).Suicidal ideation, suicide attempt and completed suicide are three different, but greatly overlapping features.Prior suicide attempt and current major depression are the two best predictors of future suicide, and the vast majority of suicide attempters/completers come from a population of people with current suicidal ideation, particularly in the presence of untreated major depression(Kessler et al., 1999; Goldney et al., 2003). However, depression, suicide attempt and completed suicide are three different, but greatly overlapping categories:more than one third of suicide victims have at least one previous suicide attempt, and the first suicide attempt significantly increases the risk of completed suicide during the next 10-15 years (Isometsa and Lonnqvist, 1998; Hawton and Heeringen, 2000; Suokas et al., 2001; Wasserman, 2001; Suominen et al., 2004). Although suicidal behaviour is a relatively rare in the primary care practice, given that depression is very common among completed suicides, depression, particularly in combination withpast or current suicidal behaviourshould be taken very seriously even in primary care.

4. CLINICALLY DETECTABLE SUICIDE RISK FACTORS IN PRIMARY CARE

Suicide is avery complex, multi-causal human behaviour with several medical-biological as well as psychosocial and cultural components and it is not the normal response to the levels of stress experienced by most people but it is not the linear consequence of major mental disorders It is also associated with a number of psychiatric-medical (e.g., major mental) disorders, psycho-social (e.g., chronic adverse life situations and acute psycho-social stressors), and demographic (e.g., male gender, old age) suicide risk factors of varying prognostic utility. Although the statistical relationship between the different psycho-social and demographic risk factors and suicidal behaviour is well documented, (Rihmer, 2007; Nock et al., 2008) their predictive value is very weak in individual cases. Because suicidal behaviour is very rare in the absence of current major psychiatric disorders, psychiatric-medical suicide risk factors, particularly current major depression with prior a suicide attempt are the most powerful and clinically explorable predictors of suicidal behaviour, especially in the presence of psycho-social and demographic suicide risk factors (Hawton and Heeringen, 2000; Wasserman, 2001; Balazs et al., 2003; Goldney et al., 2003; Tylee and Rihmer, 2004). A recent cross-national epidemiological survey showed that for lifetime suicide attempts the strongest diagnostic risk factors were mood disorders in high-income countries but impulse control disorders in low- and middle-income countries (Nock et al., 2008). Studies from different countries of the world consistently show that more than 90 % of suicide victims or attempters have at least one (mainly untreated) major mental disorder, most frequently unipolar or bipolar major depressive episodes (56-87%), substance-use disorders (26-55%) and schizophrenia (6-13%). Comorbid anxiety and personality disorder as well as concomitant serious medical disorders are also frequently present, but they are rarely the only or principal current diagnosis among suicide victims (Hawton and Heeringen, 2000; Wasserman, 2001; Balazs et al., 2003). In spite of the fact that more than two-thirds of suicide victims and attempters have current major depressive episode (Hawton and Heeringen, 2000; Wasserman, 2001; Balazs et al., 2003) and up to two-thirds of them contact their GPs within four weeks before the suicidal act (Rihmer et al., 1990; Luoma et al., 2002; Balazs et al., 2003; Fekete et al., 2004), the rate of pharmacotherapy with antidepressants and/or mood stabilisers in depressed suicidal patients is less than 20 % and thus disturbingly low (Rihmer et al., 1990; Henriksson et al., 2001; Balazs et al., 2003).

Considering the very high rate of current major mental disorders among people with suicidal behaviour, in the early 1980's Khuri and Akiskal (1983) considered that much of the putative psycho-social and demographic suicide risk factors were not modifiable in the frame of individual healthcare and they proposed that suicide prevention should focus on the treatable contributory psychiatric disorders involved in such behaviour(Khuri and Akiskal, 1983).

5. DETECTION OF THE SUICIDAL PATIENT IN PRIMARY CARE

Suicidal behaviour (attempt or completed suicide) in major mood disorder patients occur mostly during major depressive episodes (79-89%), less frequently in the frame of dysphoric (mixed) mania (11-20%), but practically never during euphoric mania and euthymia (0-1%)(Isometsa et al., 1994b; Rihmer, 2007). It indicates that suicidal behaviour in mood disorder patients is a state-dependent phenomenon, showing the significant role of recognition and treatment

of depression in suicide prevention (Khuri and Akiskal, 1983; Mann et al., 2005). Since more than half of suicide victims contact their GPs 4 weeks before their death (Isometsa et al., 1995; Luoma et al., 2002; Rihmer and Rutz, 2019), it is very likely that at these visits the vast majority of the patients are clinically depressed, and most of them have one or more comorbid psychiatric and/or medical disorder. The characteristic features of suicidal depression are: agitation, severe anxiety, hopelessness, insomnia, appetite and weight loss, comorbid substance-use disorders and bipolar depression (i.e., depression with past hypomania or mania).Recent psycho-social stressors and acute alcohol use, even in non-alcoholic depressives (Hawton and Heeringen, 2000; Wasserman, 2001; Rihmer, 2007; Nock et al., 2008, Sher et al., 2009), also increase the current risk of suicidal behaviour. However, depression is often masked by secondary alcoholism, particularly in men, and symptoms of suicidal depressed men is often masked by aggressive, impulsive, and abusive behaviour, and that these men are better known to legal and social welfare agencies than to their GPs (Rutz et al., 1995; 1997; Rihmer and Rutz, 2019). The complex interaction between psychiatric, personality, and psycho-social factors in suicidal behaviour is best explained by the stress-diathesis model for suicidal behaviour where the stressors include acute psychiatric disorder and negative life events (*"state"* component), and the diathesis includes aggressive, impulsive and pessimistic personality features (*"trait"* component, Mann et al, 2005). Both hopelessness/pessimism and aggressiveness/impulsiveness may be amenable to cognitive/behavioural therapy and pharmacotherapy, like SSRI antidepressants, lithium and other mood stabilizers. GP contact is quite common before suicide:thirty-four to sixty-six percent of suicide victims visit their GPs 4 weeks before their death, and 20-40 % also do so in the last week, respectively (Isometsa et al., 1995; Luoma et al., 2002; Rihmer and Rutz, 2019) and the rate of GP contact before suicide attempt is in the same magnitude (Fekete et al., 2004). Compared to non-suicidal patients, suicide victims visit their GPs three times more frequently in the last 4 weeks of their life (Isometsa et al., 1994a; Isometsa et al., 1994b; Luoma et al., 2002) and the number of GP visits increases significantly before the suicidal act both among completed suicides and suicide attempters (Michel et al., 1997; Fekete et al., 2004). However, among those with medical contact, the frequency of persons who communicate explicitly their suicidal intention is only around 20%, and it is particularly rare in primary care (11%) and in other (non-psychiatric) specialist settings (6%). One study have found that 18% of the suicide victims visited GPs on the last day of their life, but the topic of suicide was discussed in only 21% of these cases (Isometsa et al., 1995). An extensive literature review shows that about 40% of suicide victims communicate their intention (Pompili et al, 2016).

To discuss the possibility of suicidal behaviour with the patient and family members as a common but preventable complication of acute severe mental disorders is very important, because asking questions about suicidal ideation and past suicide attempts does not trigger suicide (Hawton and Heeringen, 2000; Gould et al., 2005). This is particularly true if such a discussion is accompanied by some sentences explaining that depressive disorders can be successfully treated, and that suicidal intent will vanish after (or even before) the recovery from depression. This is beneficial, as many patients think they are alone or unique in their suicidal ideas. Leaflets, posters, and fliers left in the waiting room indicating the main symptoms and dangers of depressionas well as information on good prognosis of treatmentmay prompt people to ask for help(Rihmer and Rutz, 2019). Short screening instruments, like the Beck Scale for Suicide Ideation (an interview-rated 19-item scale) and the Beck Hopelessness Scale (a 20-item self-reported questionnaire) are useful in clinical practice for detecting actual suicide risk (Hawton and Heeringen, 2000; Wasserman, 2001). Yet, no one screening instrument can replace the optimal doctor-patient relationship, including asking the right questions at the right time, accompanied by a highly professional and empathic atmosphere. Asking simple questions (*"what do you think about the future?"*, *"do you feel that life is not worth living?"*, etc.) can easily facilitate further, more deep and honest discussion on the topic of suicide.

Because the risk of suicide is extremely high a few days and weeks after the discharge from inpatient psychiatric departments(Hawton and Heeringen, 2000; Qin and Nordentoft, 2005) GPs should be alert when a patient discharged from the psychiatric clinic seeks help. As a significant part of depressives stop their medication at the fourth week of the treatment (Lin et al., 1995) aftercare of recently discharged depressive patients is essential for improving compliance and to maintain efficacy. The clinical, psycho-social, and demographic features of the acutely suicidal patient in primary care are listed in Table 1.

6. MANAGEMENT AND PREVENTION OF DEPRESSION-RELATED SUICIDES IN PRIMARY CARE PRACTICE

Unfortunately, we cannot prevent all suicides. However, the majority of depression-related suicides are preventa-

ble, even in primary care. Suicidal behaviour usually does not occur in the very early stages of the depression and this allows enough time to make a precise diagnosis to consult psychiatrists if needed and to start appropriate treatment. Continuing medical education (including specific depression-training) for GPs improve recognition of depression including detection of current suicidal ideation, and increase treatment of depression (Rihmer et al., 1995; Rutz et al., 1997; Hegerl et al., 2006; Henriksson and Isacsson, 2006; Szanto et al., 2007). The five most important studies on this field are: 1.) The pioneering Gotland Study, performed in the early 80's in the last century (Rihmer et al., 1995; Rutz et al., 1997); 2.) the Nuremberg Alliance Against Depression (NAAD) project performed in Germany between 2000 and 2002(Hegerl et al., 2006); 3.) the Swedish Jamtland study performed between 1995 and 2002 (Henriksson and Isacsson, 2006); 4.) theHungarian GP depression-management educational program between 2000 and 2005 implemented in a region of Kiskunhalas where the baseline suicide rate was twice the national average (Szanto et al., 2007); and the Hungarian GP Depression Recognition and Suicide Prevention Program in Szolnok (Torzsa et al., 2009b, Szekely et al, 2013).

The *Swedish Gotland Study* showed that 2 years after the two-days postgraduate educational programme on the diagnosis and treatment of depression for the GPs in 1983 the suicide rate of Gotland decreased by 60%, the prescription of antidepressants increased from 50% to 80% of Swedish average, and the utilization of non-specific medications (benzodiazepines, antipsychotics) decreased by 25% compared to the Swedish average. The number of referrals to psychiatry for depressive disorders decreased by more than 50% and the inpatient care for depression as well as the number of days on sick leave because of depression also decreased by 75% and 50%, respectively. All these changes were in contrast to the earlier trends on Gotland and/or contemporary trends in the rest of Sweden (Rutz et al., 1995; Rutz et al., 1997). Most importantly the rate of depressive suicides among all suicides decreased significantly after the programme (from 42% to 16%, $p<0.01$), indicating that the decline in suicide mortality after the education resulted directly from a robust decrease in depressive suicides particularly among those who used violent suicide methods (Rihmer et al., 1995). However, the decline in depressive suicides after the training was almost entirely the result of a decrease in female depressive suicides, whereas male suicidality was almost unchanged. Few suicidal males were known to the local medical services, although many of them were known to the police and social welfare services. However, the overall favourable effect of the education faded in a few years and repeated education in 1993 and 1995 again led to another marked decrease in suicides, again mainly in females (Rutz et al., 1997).

The *Nuremberg Alliance Against Depression*, a 2-year intervention program was performed in Nuremberg (440.000 inhabitants) at four levels: a) training GPs, b) a public relations campaign, c) cooperation with community facilitators (teachers, priests, local media) and d) support for the self-help activities and for high-risk groups (depressed patients, suicide attempters and their relatives). The results showed that compared to control region (Würzburg, 290.000 inhabitants) a significant reduction in frequency of all suicidal acts (suicides and suicide attempts combined) was observed in the intervention region during the 2-year intervention period (2002 vs 2000, Nuremberg: 24% reduction, Würzburg: 7% increase, $p<0.004$). The reduction in all suicidal acts was most pronounced for violent methods. However, concerning only completed suicides there was no significant difference in the decline of suicide rate between the intervention and control region (Hegerl et al., 2006).

Evaluating the effects of continuing medical education programme (8 seminars between 1995 and 2002) for the GPs on depression in *Jamtland county, Sweden* (136.000 inhabitants) the authors found that compared to pre-intervention period (1970-1994) the mean suicide rate of Jamtland county decreased by 36% in the intervention period (1995-2002) while the mean suicide rate of Sweden decreased *"only"* by 30% during the same time. The use of antidepressants in Jamtland county increased from 25% below the Swedish average to the same level. In line with the greater reduction of suicide rate in Jamtland county the use of antidepressants increased by 161% in this county while the same figure for the whole Sweden was *"only"* 108% (Henriksson and Isacsson, 2006).

As for the *Hungarian GP depression-management educational program*, in the intervention region (region of Kiskunhalas, 73.000 inhabitants) the 5-year preintervention (1996-2000) and postintervention (2001-2005) mean annual suicide rates per 100.0000 population were 59.7 and 49.9 (16% decrease). In the local control region (Kiskunfélegyháza, 54.000 inhabitants) the same figures were 50.4 and 45.1, respectively (11% decrease). In spite of the fact that this difference is mathematically not significant the difference shows in the expected direction

and is in good agreement with the finding that the raise in antidepressant prescription and the rate of antidepressant treated persons increased significantly more in the intervention than in the control region. However, the suicide mortality of subjects seen only by GPs in the last year of their life decreased significantly (by 26%) compared to those who contacted other health-care services (internal medicine, cardiology, rheumatology, psychiatry, pulmonology, etc.) or with no medical contact at ell. Further, the decrease in annual suicide rate was significantly greater in the intervention region (9.8 per 100.000) compared with the county minus intervention region (6.9 per 100.000) and compared with all of Hungary (4.5 per 100.000), (Szanto et al., 2007; Rihmer and Rutz, 2019).

The *Hungarian Depression Recognition and Suicide Prevention Program* in Szolnok started when the Institute of behavioural Science of Semmelweis University joined the European Alliance Against Depression program in 2004. The program was implemented in Szolnok (approx. 80000 inhabitants) in 2005 with the primary aim of educating all local professionals (including GPs, psychiatrists, psychologists, telephone help service providers, pharmacists, teachers, pastors, police officers, family nurses, geriatric care providers etc.) about the recognition of depression and suicide risk and basic intervention methods (Torzsa et al., 2009b). In 2005, the first year of the program, absolute number of suicides decreased by 57%, while in 2006 by 47% compared to the average number in the previous 9 years in the town of Szolnok. On a national level a slight decrease in suicide rates were observed during the same period, however, it did not reach the magnitude observed in Szolnok in any other region. The significant improvement was observable in 2007, the year following the completion of the program, however, in 2008 it returned to the rate observed in previous years (Torzsa et al., 2009b, Szekely et al, 2013).

Although the five major healthcare-based educational programmes, discussed above, were performed in different time-frames and used somewhat different research design the main results show in the same direction indicating that better care of psychiatric (and particularly depressive) patients is one important contributing factor in declining suicide rates of the areas served by trained GPs and other healthcare workers.

It should be noted, however, that improved primary care education in isolation, does not have any significant long-term effect, and only complex educational and organisational interventions that incorporate continuous clinician education, an enhanced role of nurses and social workers, as well as high level of integration between primary and secondary (psychiatric) care (consultation-liaison) are beneficial. GP education should be well-focused, quite short and interactive, include written materials, lectures, seminars, video-demonstrations, and small-group discussions (Rutz et al., 1997;Mann et al., 2005; Hegerl et al., 2006; Szanto et al., 2007, Szekely et al, 2013).

Better management of depression requires not only improved recognition and treatment skills from the doctors, but also good compliance from the patients, since nonadherence to antidepressant therapy is one of the most common causes of treatment failure. About one-third of patients stop taking antidepressants during the first 4 weeks of therapy, and around half of them take them until the end of the third month (Lin et al., 1995). The better side-effect profile and less toxic nature of SSRIs and other new antidepressants, and the recently increasing practice of GPs to prefer these drugs over tricyclic antidepressants is also beneficial for improving the quality of care and reducing the risk of death in the case of overdose. Using simple psycho-educational messages (i.e. why, how, and how-long to take antidepressants and what to do in the case of side effects, to optimise the clinical response) both in oral and written form increases the adherence of patients to antidepressant therapy (Lin et al., 1995, van Os et al, 2002).

Management of depressed patients in primary care should follow international and national guidelines established (van Os et al., 2002). However, since antidepressant monotherapy, unprotected by mood stabilisers in bipolar depression, sometimes induces agitation, excitement (and rarely also auto- and hetero-aggressive behaviour) in the first few days or weeks of treatment, all depressive patients should be carefully checked for bipolarity and followed closely in the first 1-3 weeks of the therapy (Akiskal et al., 2005; Rihmer, 2007). Anxiety, agitation or insomnia should always be controlled with concomitant use of high-potency benzodiazepines, which hasten the clinical response if combined with antidepressants. Regular aftercare with fixed appointments and permanent psychological support are also recommended, particularly for those patients with prior suicide attempts.This is important, since the actual clinical picture immediately after suicide attempt is often misleading, due to the cathartic effect of self-aggression, resulting in a short-lived but sometimes marked improvement of the depression (Jallade et al., 2005). This can also serve as one of the explanations why some healthcare workers misinterpret suicide attempts as manipulative acts.

Acutely suicidal patients usually need inpatient treatment even of involuntary nature. In the case of severe agitation or anxiety prompt anxiolysis with benzodiazepines or with atypical antipsychotics and close observationis highly recommended. After an open discussion with the patient and relatives, involuntary admission is rarely needed. If acute hospitalisation is not indicated, a close observation by family members and removing possible means of suicide (i.e., guns, drugs, pesticides, car key etc.) as well as consultation with a local outpatient psychiatrist is advised. GPs should work in close and permanent collaboration with the local mental health services. Outpatient psychiatric consultation is also helpful in the cases of differential-diagnostic problems, treatment resistance and comorbid substance-use disorder regardless of whether the patient is suicidal or not. If long-term/prophylactic pharmacotherapy is needed (bipolar disorder, recurrent unipolar major depression) the GP may direct the patient to a psychiatrist for optimising the therapy (Hawton and Heeringen, 2000; Wasserman, 2001; Tylee and Rihmer, 2004). The most frequent reasons of outpatient psychiatric consultation and inpatient admission are shown in the Table 2.

Prevention of depression-related suicidal behaviour in primary care is not easy, but it is not impossible.In the majority of the cases GPs are the first to meet depressed patients and should be trained in diagnostics and up to date use of antidepressants and non-pharmacologic interventions. Although specific depression-targeted psychotherapies exceed the frame of primary care, psycho-education and supportive psychotherapy is needed, and it is essential to offer this kind of treatment in primary care settings. Regardless, GPs should have knowledge about the identification and treatment of depression and they also should collaborate withpsychiatric services.

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Table 1. Most characteristic features of acutely suicidal patients in primary care

Clinical features *Primary suicide risk factors*	**Psychosocial features** *Secondary suicide risk factors*	**Demographic features** *Tertiary suicide risk factors*
• Severe depressive episode (agitation, insomnia, anxiety, hopelessness, guilt) • Acute/chronic alcohol/drug problems • Severe comorbid medicaldisorder(s) • Hopelessness, wish to die, suicide ideas, suicide plan, suicide gestures • Recent discharge form in-patient psychiatric department (short hospitalstay, high number of priorhospitalizations, unplanneddischarge) • Impulsive/aggressive personality features • Lacking treatment and/orfamily support	• Acute psycho-social stress-ors (loss-events, major financial problems) • Isolation/divorce, living alone • Gun/poison at home, living in high buildings • Unemployment, permanent adverse life-situatuions	• Male gender (all ages) • Old age (both gen-ders) • Young people (males) • Same-sex orientation Spring/early summer

Table 2. When to refer primary care patients to mental health services?

Outpatient psychiatric care	**Inpatient psychiatric admission**
• Recent suicide attempt/gesture • Differential diagnostic problem • Treatment resistant depression • Comorbid substance abuse/dependence • Noncompliance with the treatment • Severe personality disorder • Hypomanic episode • Newly recognized bipolar disorder	• Current suicidal danger • Very severe depression (psychotic, catatonic,negativistic features) • Manic or hypomanic episode • Acute psychotic states. Severe comorbid medical disorder(s)

FINNS, SISU AND SUICIDE

FÜLÖP GABRIELLA, Budapest-Stocholm

Rezumat: *Finlanda este una dintre țările cele mai de succes din punct de vedere al bunăstării și al educației. În același timp, este o țară a paradoxului. Recent votată „cea mai fericita țară din lume", Finlanda are totodată o rată mare de sinucideri. Comparația socială poate fi o idee relevantă în înțelegerea paradoxului asocierii unei satisfacții depline în viață concomitent curiscul ridicat de suicid în cazul unei populații vulnerabile. Suicidul este un fenomen cu multiple cauze. În Finlanda, cei mai relevanți factori par să fie sănătatea mintală, abuzul de substanțe nocive, în special alcoolul, dar și cultura finlandeză. Conceptul de "sisu" poate oferi o nouă perspectivă în paradoxul finlandez "fericire-suicid".*
Cuvinte cheie*: Finlanda, „sisu", suicid, satisfacția în viață, depresia, cultura.*

Abstract: *Finland is one of the highest-ranking countries relative to well-being and education. However, it is also a country of paradoxes. Recently voted the happiest country in the world, Finland has not with standing a high suicide rate. Social comparison might be an important concept to consider as a potential explanatory factor leading to the paradox of a high life satisfaction but also higher suicide risk for a vulnerable population. Suicide is a multicausal phenomenon. In Finland, the most relevant factors seem to be mental health, substance abuse, and Finnish culture. The concept of "sisu" offers new insight into the Finnish happiness-suicide paradox.*
Keywords*: Finland, "sisu", suicide, life satisfaction, depression, culture.*

THE FINNISH HAPPINESS-SUICIDE PARADOX

Finland is one of the top countries in the world regarding well-being and education. Its extensively studied high-performing education system is the result of decades of educational reform. Its main pillars are the Finnish culture, the welfare society and ethnic characteristics. Decentralized education management and increased school autonomy with well-trained teachers provide continuous quality improvement and enhanced equity, which have been the central themes in the modern Finnish education policies. It is often said that the secret of the Finnish education and welfare system lies in the society itself, all aspects of which rest on flexibility and creativity, as well as a profound respect for human rights (Sahlberg, 2009.).

Interestingly and conversely, studies indicate that Finnish students experience less anxiety and stress compared to other countries (OECD, 2004). Still, Finland has always had a higher-than-average rate of suicide. According to 2019 data, Finland rates 23rd in the world with 15.9 suicides per 100.000 inhabitants (Suicide Rate by Country 2019). After steadily declining ever since 1990, when 1500 persons committed suicide, in 2017 there were 824 suicide cases, 75% of which committed by men.

A specifically relevant problem is that, among the 14 – 25-year-old, suicide is the third cause of death (Wrede-Jantti, 2016). From 2016 onwards Finland experienced a slight increase in suicide rates again (www.stat.fi, 2017). This informationseems to contrast with Finland's recently received status of the world's happiest country, according to the World Happiness Report, measuring subjective well-being (Helliwell et al., 2018). The report includes factors such as economic strength, social support, life expectancy, freedom of choice, generosity, and perceived corruption. All these factors are regarded as highly important and integral parts of Finnish society.

However, these account principally for stability of existence or general life satisfaction, which is not the same as happiness. This is even more prevalent when considering that Finns themselves were not impressed by these results. When, for instance, people were asked how often they experience positive emotions and experiences, Finland ranked much further from the top, on the 36-th place, with Latin-American countries dominating the list (Clifton, 2014). This seems more in accordance with the *Finns' reputation of being emotionally withdrawn and reserved.*

Paradoxically, it seems though, that Finns' aversion to happiness might make them generally happier. Martela (2018) argues that the *Finns' tendency of downplaying their own sense of happiness and display of joy* might in fact be the secret of being more satisfied. Finns are happy to be content with their life conditions. *They are more preoccu-*

pied with equality and equity than ambitions and competitiveness. This is reflected in every aspect of their life from education where the aim is to lift everyone up according to their own potential rather than concentrating on the talented few, to the social system where human dignity is respected above all else and people from the periphery are taken care of by the majority with no questions asked and no preconditions. *Humility is respected and arrogance or ambition is often frowned upon. Finns refrain from showing emotions and are very private. They need a large personal space, where they can better protect their insecurities.* This privacy lets little space for social comparison.

As demonstrated by research, social comparison plays a significant role in life satisfaction. People tend to judge their well-being in comparison to others around them (Dalya et al., 2011). Interestingly, this argument seems to be in accordance also with the higher suicide rates experienced by high-income welfare countries like Finland. According to this hypothesis, people who feel discontented may feel unhappier in positive, happy places, and these contrasts may elevate suicide risk. Paradoxically, the same argument might therefore explain both the Finnish higher levels of general satisfaction but also the higher levels of suicide. For those who are unhappy, social comparison my lead to more unhappiness. This may mean that increasing life satisfaction by increasing well-being and reducing inequality could paradoxically produce more suicides as a side effect.

FINNS AND MENTAL HEALTH

In terms of mental health, Finland has an estimated rate of 15-20% of diagnosable mental health disorders (Pirkola et al, 2005). Depressive disorders are rated to be 6.5%, and are more common in the northern part of the country. The prevalence of seasonal mood disorders is 2,6% (ibid.), although there are more recent estimations of 10%. *Relative to suicide, cyclic time patterns have been observed, showing a marked fluctuation in their number, with two peaks: one in May and another one in October.* These coincide with the largest increase and drop in temperature and length of daylight.

One probable explanation of possibly many for this phenomenon might be that the temperature variations trigger changes in neurotransmitter regulations (ECNP, 2014), as well as other modifications, such as the metabolic activity in brown adipose tissue. These changes might be more problematic in people suffering from depression (Holipainen et al., 2013).

Another possibility might be related to changes in psychomotor retardation and anhedonia (lack of pleasure), two characteristics of depression, which manifest in extreme exhaustion and lack of taking any action due to a drop in certain neurotransmitters, such as norepinephrine, a stimulant commonly referred to as stress hormone, but also in dopamine, responsible for motivation. According to Sapolsky (Stanford, 2009), the probability of suicide increases when psychomotor retardation alleviates.

Due to the climate in Finland, long dark winter months are followed by an overabundance of sunlight during spring and summer. Research has shown that among the benefits of light is the enhancement of the dopamine function, alongside serotonin (Cawley et al., 2013). Similarly, bright light therapy has been shown to improve psychomotor retardation (Camardese et al., 2015). When the exhaustion is so severe that the simplest tasks are largely impossible to accomplish, the person is usually incapable of committing suicide. When, however, the extreme tiredness improves, the risk for actually doing suicide elevates. Spring and early summer is also the period of blooming and the positive experience of a new beginning, therefore it might pose a higher contrast to those more vulnerable, as stated above.

Alongside depression, substance abuse is another major burden of the Finnish public health. Alcohol abuse and dependency is the most common mental health disorder among men. There is also a strong link between alcohol consumption and suicide, with at least a quarter of the suicide cases committed under the influence of alcohol, and the rate is even higher in young adults: half in case of men and a third for women (Impinen et al, 2008).

SISU AND SUICIDE

The causes of suicide are complex, encompassing psychological and sociocultural as well as economic factors. Age, gender, social support, employment status, harsh climate, etc., all have a role in suicide risk (Patana, 2014). The Finnish culture and values revolve around introversion, low emotional expressivity, low body language, modesty, honesty, quietness, individualism, and honor. (Helkama, 2010). Finns are stoic, introverted, reserved and resilient. Perhaps one of the most telling and representative expressions of *Finnish cultural identity is "**sisu**", a concept meaning resilience, strength of will, stoic determination in face of adversity, a sort of grim courage and resoluteness, often against the odds.*

It also speaks about Finnish pessimism as well as their consistent tenacity and deterministic persistence when facing challenges. This is the nation that during the winter of 1939, their glorious *"winter war"*(talvisota), was able to withstand the Russian army of one million soldiers for long months with an army of 175.000.

This characteristic attitude seems to be as paradoxical as Finland's people being highly efficient but more suicidal than average. Honkasalo (2014) called this the *"cultural ethos of "*coping no matter what*" or solitary self-control"*, which seems to put a great load of pressure especially on Finnish men. They are four times more likely to commit suicide than women and are more violent in doing so. Lethal violence and homicide are also higher among Finnish men, more than twice compared to other Nordic countries (Honkasalo& Tuominen, 2014).

Analyzing suicide notes of Finnish men, Honkasalo (2014) concluded that *one major reason behind suicide is experienced worthlessness and social failure, mostly of middle-aged, unmarried men, with low socioeconomic and educational background.All these factors are interpreted as lack of personal value and ability, which comes from comparison with the idea of the "good Finnish man", deeply rooted in the ethos of solitary self-control,* the harsh norm of mastering one's own life but always being able to do it alone. The resulting shame for norm-breakers are much represented in the music culture, for instance. In the land of heavy metal music, Finnish metal music lyrics abound with self-destructive drinking, which is used to overcome feelings of shame (Oksanen, 2017). *Finnish men would rather die than expose their shame.*

As a final note, the Finnish paradox of happiness and suicide, with a specific type of dark humor, is very well represented in ArtoPaasilinna's novel *"Charming mass suicide"* (Hurmaavajoukkoitsemurha,1990). The novel tells the story of two Finnish men wanting to commit suicide at Midsummer, but since they picked the same hut for it, they end up saving each other through each other's presence and company. Realizing others might need similar help, they put a small notice in a newspaper, asking potential suicide-ready people to contact them. And so, begins a weird suicide-club which travels by bus through much of Europe, to find the right place to die together, but not really managing to do it. The novel opens with the following, rather gloomy representation of Finnishness:

"The most formidable enemies of the Finnish people are melancholy, sadness and apathy. An unfathomable weariness hovers over this miserable people and submits them under its yoke pushing their souls towards bleakness and seriousness. The weight of pessimism is such that many see in death the only remedy to their anguish. Spleen[1] is an opponent more relentless than the USSR."

FINLAND'S SUICIDE PREVENTION

Finland has two suicide prevention centers in two of its major cities: Helsinki and Kuopio, operated by the Finnish Association for Mental Health (FAMH). The center offers support for those who attempted suicide or self-harm, as well as for people affected by suicide. Training in recognizing suicidal signs as well as in dealing with such situations are also available. All services are free of charge and require no referrals.

Since the number of attempted suicides is believed to be ten times higher than completed suicides, and previous attempted suicide rises the risk of further attempts by 60-100 % (Suomenmielenterveysseura, 2019), Finland tries to approach this challenge with its well-known determination. They have developed a suicide prevention model called LINITY intervention model (Lyhytinterventioitsemurhaayrittäneille- Short time intervention for people who have attempted suicide), which has been proven to reduce further suicide attempts (Suomenmielenterveysseura, 2017).

CONCLUSION

The article tried to give some insight into the Finnish paradox of happiness-suicide. Happiness in Finnish terms is closer to a quiet contentment with own life circumstances and seeks, quite philosophically, life's small everyday joys. Finns' love and care of nature is well-known, with their cities even build around forests instead of building forests in the city. The cultural lack of the typical Western competitiveness is very well highlighted in an interview with a representative of the Finnish Ministry of Education who was confronted with the question regarding the latest curriculum change in 2016 about what happens if Finland drops in the PISA results due to the bold changes in the curriculum, to which she answered: *"So what?"* The main issue was to provide children with an up-to-date and meaningful education more than external results (need to find the source, I don't remember now, but source will come soon).

Suicide is a complex phenomenon, which in Finland's case seems to be closely connected to mental health, alcohol abuse, but also climate and especially cultural fac-

tors like the concept of ***"sisu".*** There is always room for development, and this is especially true in case of suicide prevention where the stakes are about life itself. However, Finland seem to be addressing the topic with its renowned quiet effectiveness.

[1] in Finnish: "musta mieli", "dark mood"

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OVERVIEW OF THE CURRENT KNOWLEDGE ON NONSUICIDAL SELF-INJURY

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TRECERE ÎN REVISTĂ A CUNOȘTIȚELOR ACTUALE DESPRE AUTO-VĂTĂMAREA CARE NU DUCE LA SUICID (AVNDS)

Rezumat: *Autovătămarea care nu duce la suicid a fost văzută ca entitate diagnostică independentă pentru prima oară în DSM-5 (Dicționar și Manual Statistic al Tulburărilor Mintale, Ediția a 5-a). Prin acest articol autorii urmăresc să aducă la zi cunoștințele despre această entitate, enumerând termenii și definițiile folosite în literatura de specialitate, epidemiologia, corelațiile psiho-sociale, funcțiile potențiale, factori de risc pe viitor, prevenția și tratamentul AVNDS. Termenii cei mai comuni folosiți sunt AVNDS și auto-vătămarea deliberată (AVD). Prevalența cea mai mare a acestui fenomen se găsește în adolescență (aprox. 20%), având drept co-morbidități unele tulburări psihice și comportament suicidal (aprox. 50% în populația normală și 70% în populația clinică). Ca funcții ale AVNDS putem include reglementarea afectului, auto-pedepsirea, anti-suicidul și anti-disociația. Psihoterapia se impune ca prim tratament pentru AVNDS, dar din cauza numărului mare de tulburări psihiatrice drept co-morbidități, recunoașterea și tratamentul acestora, poate conduce și la prevenția AVNDS.*
Cuvinte cheie*: adolescență, autovătămare care nu duce la suicid, AVNDS, AVD, epidemiologie*

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Abstract: *Non-suicidal self-injury (NSSI) became aproposed independent diagnostic category for the first time in the Diagnostic and Statistical Manual of Mental Disorders 5th edition. The objective of this review is to provide an update on current knowledge on NSSI. This paper overviewsterms and definitions of self-injury used in the literature, epidemiology, psychosocial correlates, possible functions, furthermore risk factors, prevention and treatment of NSSI. The two most common nomenclatures used in the literature for the phenomenon is NSSI and deliberate self-harm (DSH). The highest point prevalence of NSSI was found in adolescence (approximately 20%), and it is often comorbid with psychiatric disorders and with suicidal behavior (approximately 50% in normal and 70% in clinical population). The functions of NSSI contains affect regulation, self-punishment, anti-suicide and anti-dissociation. The first choice to treat NSSI is psychotherapy, but due to its high comorbidity with psychiatric disorders, the recognition and treatment of these disorders can lead to NSSI prevention as well.* ***Keywords****: adolescence, non-suicidal self-injury, NSSI, DSH, epidemiology.*

INTRODUCTION

Non-suicidal self-injury (NSSI) has become an important issue in psychiatry in the 21st century, while it seems to have a growing incidence and a strong correlation with suicidal behavior (Plener-Brown 2017: 19). In the first part of the current paper, we aim to overview both the history of NSSI in terms of definition and its place in the classification systems, and the current issues regarding epidemiology,risk factors, comorbidities, andpossible intra- and interpersonal functions associated with NSSI.

This overview is based on our research group's former Hungarian-language paper (Horváth 2015: 17), updated with current knowledge from the literature. In the last part of the paper, we summarize current knowledge and issues related to prevention and treatment of NSSI.

NOMENCLATURE OF SELF-INJURY

In the first half of the 20th century the psychoanalytic approach called the phenomenon self-mutilation (Menninger 1935: 4). They defined self-mutilation as a kind of self-healing, whereby the suicidality is limited to a part of the body, so the person can avoid suicide (Menninger 1935: 4). The first idea to categorize self-harming behaviorscheme from Pattison and Kahan (1983). They separated the self-mutilation behaviors into high orlow lethality and direct-indirect dimensionsand introduced the term deliberate self-harm (DSH) syndrome,referring only to low lethality, repeated and direct forms (Pattison-Kahan 1983: 140).

Simeon and Favazza (2001) used the term self-injurious behaviors (SIB) at first in the beginning of the 21st centuryand defined the phenomenon as deliberate and immediate direct damage to the body without the intention to die as a result of the behavior (Simeon-Favazza 2001). A few years later Favazza started to call the phenomenon NSSI (Favazza 2011). Klonsky (2007) and Andover (2012) define NSSI - similar to Favazza–deliberate direct damage to the body tissue without suicidal intent, but they highlight that it is committed in a form that is socially not sanctioned (Klonsky 2007: 27, Andover 2012: 6).

Currently the most common nomenclature in the literature is NSSI (Klonsky 2007: 27, Madge 2008: 49). DSH used also frequently, and very often suicidal behavior included in this definition (Madge 2013: 49).

DEFINITION OF NSSI

NSSI is defined as an intentional, self-inflicted damage to the body tissue, without suicidal intent (Klonsky 2007: 27). The self-injurious techniques could be cutting, burning, biting or scratching on the skin (Benjet 2017: 215), however drug overdose and jumping out of height (Valencia-Agudo 2018: 65) as possible suicide attempt methods, and any socially accepted forms (e.g. tattoo, piercing, nail chewing) were excluded from the definition (Plener-Brown 2017: 19), as well as repetitive, stereotypical forms among people with developmental disorders.

NSSI has becomea proposed independent diagnostic category for the first time in the Diagnostic and Statistical Manual of Mental Disorders 5th edition (DSM-5) and takes place in the *"Other conditions that may be a focus of clinical attention"* chapter (American Psychiatric Association, 2013). The diagnosis according to DSM-5 is shown in ***Table 1.***

The DSM-5 diagnostic criteria of NSSI
The patient should have to harm her/himself during the last year minimum 5 days, and the physical damage was moderate (thereby exclude suicidality).
The aim of self-injury was to get rid of a negative feeling, and/or to resolve an interpersonal difficulty, and/or to induce a positive feeling.
The person often planned and/or thought about self-harm, and/or preoccupation seen before the damage.
The behavior is not socially sanctioned and is not picking a scab or nail biting.
The behavior causes clinically significant distress or limits the person's functioning in daily life.
The behavior does not a symptom of any other psychiatric disorder (e.g. psychotic episode).

The most common method of NSSI is self-cutting (most often on upper extremities, second often on lower extremities, then on the torso, head and neck) (Klonsky 2007: 27, Brown: 2018: 48). Other methods (e.g. skin burning, skin biting, skin scratching and head punching) are used less often (Brown 2018: 48), but important to mention that, there are differences between countries, supposedly due to cultural differences (Min-Pei 2017: 255, Jie 2017: 226).

EPIDEMIOLOGY OF NSSI

The onset of NSSI is typically in adolescence (Whitlock 2006: 117, Csorba 2009: 18, Matsuyama 2016: 6, Valencia-Agudo 2018: 65). The lifetime prevalence of NSSI is 17.2% in adolescents, 13.4% in young adults and 5.5% in adults (Jacobson-Gould 2007: 11, Swanell 2014: 44). Despite that, in the Western European countries and in the United States the highest prevalence of NSSI is in the late adolescence (Whitlock 2006: 117, Rueter 2015: 15, Swanell 2014: 44), however in China the highest prevalence of NSSI is in the early adolescence (Law-Shek 2016: 29).

There are conflicting results about the gender differences of NSSI in the literature (Horváth 2015: 17). Based on the Pannonia-survey, Csorba et al (2009) found a higher prevalence of NSSI in females (43%) compared to males (21%) in Hungarian adolescent clinical sample (Csorba 2009: 18). Bakken and Gunter (2012) made a study with high school students from Delaware, United States (N=2 548, 50% male, 50% female, M and SD unknown), in which they found that, from the adolescents who had a history of NSSI, 17% were female, and only 9% were male (Bakken-Gunter 2012: 33). An EU sponsored international collaborate study, the Saving and Empowering Young Lives in Europe (SEYLE), in which our research group took part as well, from 11 European countries altogether 12 068 high school adolescents were enrolled, and from Hungary 2009 students (Brunner-Kaess 2014: 55, Wasserman 2010: 13). The SEYLE study reported 29.9% prevalence rate of self-injury for girls and 24.6% for boys (Brunner-Kaess 2014: 55).

Another international collaborate study, the Child and Adolescent Self-Harm in Europe (CASE), found that the average lifetime prevalence of self-injury was 13.5% in females and 4.3% in males (Madge 2008: 49).Other international researchers found that there are no significant gender differences in NSSI among adolescents (Whitlock 2006: 17, Nock 2009: 18).

Brensinand Schoenleber (2015) found in their systematic review on gender differences of NSSI, that women were more likely to use cutting compared to men, but there were no gender differences in other methods (Brensin-Schoenleber 2015: 38). They also suggested that the higher number of women was due to the fact, that women are more likely to seekfor psychiatric help than men (Brensin-Schoenleber 2015: 38).

THE RELATIONSHIP BETWEEN NSSI AND PSYCHIATRIC DISORDERS

Research shows that more than 85% of adolescents, who have the history of NSSI, have concurrent psychiatric disorders (Nock 2006: 144). Klerk et al (2011) found that the presence of a psychiatric diagnose significantly increases the risk of self-injury(Klerk 2011: 133), and other researches confirmed that these diagnoses canbe both internalizing and externalizingdisorders(Nock 2006: 144, Bentley 2015: 37,Mészáros 2017: 17). Moreover, many studies described that NSSI has comorbidity with borderline personality disorder (BPD) in more than 65% of cases (Briere-Gil 1998: 68, Nock 2006: 144, Cipriano 2017: 8). For this reason, in previous editions of the DSM, the American Psychiatric Association defined NSSI as a symptomof BPD (American Psychiatric Association 2000).

Kiekens et al (2018) made a study with college students using already the DSM-5 criteria for NSSI, and found high comorbidity of NSSI with major depressive disorder (63.8%), manic episode (20.4%), general anxiety disorder (54.1%), panic disorder (22.2%) and alcohol dependence (16.1%) (Kiekens 2018: 35).

Several studies found a high prevalence of NSSI in patients with attention deficit hyperactivity disorder (ADHD) (DiScala 1998: 102, Chronis-Tuscano 2010: 67, Hurtig 2012: 66, Allely 2014: 14, Swanson 2014: 55, Balázs 2018: 18), e.g. Hurtig et al (2012) found in their cohort study that in the ADHD population significantly more patients (69%) attempted NSSI than the non-ADHD population (32%) (Hurtig 2012: 66).

Cucchi et al (2016) made a systematic review about the prevalence of NSSI in patients with eating disorders (ED) (Cucchi 2016: 46). They found that the clinical group were three times more likely to report a history of NSSI compared with the normal population (Cucchi 2016: 46).

In Hungary Csorba found in 14-18-year-old clinical population (N=105 children, 28 boys, 77 girls, M=15.97 years, SD=1.05) that 71% of adolescents had a history of NSSI (Csorba 2009: 18). The most common internalizing disorders were major depressive episode (42%), anxiety disorders (26.6%) and dysthymia (19%), and from the externalizing disorders conduct disorders had the strongest relationship (13.3%) with NSSI (Csorba 2009: 18). Based on the SEYLE study, in adolescent community sample NSSI was most strongly associated withsuicidality, anxiety and depressive symptoms and psychoactive substance abuse (Brunner-Kaess 2014: 55).

THE RELATIONSHIP BETWEEN NSSI AND SUICIDALITY

The relationship between NSSI and suicidal behavior is approximately 70% in clinical population (Nock 2006: 144), and 50% in normal population (Muehlenkamp 2007: 11). Nock et al (2006) found that the greater the number of NSSI in the history is associated with higher risk of a suicidal attempt (Nock 2006: 144). Furthermore, the suicide attempt has higher risk, when there is a longer history of NSSI, and using several kinds of methods (Nock 2006: 144).

Kiekens et al (2018) found among college students from Catholic University of Leuven (N=4 565 people, 56.8% female and 44.2% male, M=18.3 years, SD=1.1) that with a history of NSSI 10.5% of them attempted suicide, 51.6% planned suicide and 61.8% had suicidal ideation (Kiekens 2018: 35).

Hornor (2016) collected the risk factors for suicidal behaviors in adolescents with the history of NSSI (Hornor 2016: 30) in a systematic review. Strong and moderate risk factors were the following: increased NSSI longevity and frequently, higher number of methods, increased severity of methods, BPD, hopelessness/depression, impulsivity, posttraumatic stress disorder, sexual and physical abuse (Hornor 2016: 30).

A possible explanation of the strong relationship between NSSI and suicidality is that, the two phenomena have comorbidity with the same psychiatric disorders (Hamza 2012: 32). Additionally, Hamza described that NSSI makes the person capable attempting suicide in the future (Hamza 2012: 32). There are further different theories which explain the relationship between NSSI and suicidal behavior, e.g. NSSI serves as a gateway to more extreme suicidal behavior (like marijuana to severe drug use), or there is a role of third variables, such as an underlying psychiatric disorder, higher level of stress, or serotonin system dysfunction (Hornor 2016: 30).

Some professionals even suggest, that a part of NSSI episodes is hard to separate from suicidal behaviorwhilean NSSI episode can end up with death unintentionally, or the surface signs may mask the underlying intention of the self-injurious act, furthermore intention of death is subjective and the person itself could have ambivalent intentions during the self-injuring episode (Csorba 2009: 18, Nock 2009: 18).

All these lead to a debate in psychiatry, if the current official nomenclature of self-harmplaced in DSM-5 is correct or it can be misleading to clinicians, while it emphasizes the non-suicidal aspect of this phenomenon.

FUNCTIONS AND RISK FACTORS OF NSSI

Nock (2009) made an integrated model about the functions of NSSI, which summarizes the emergence and maintenance of NSSI (Nock 2009: 18). According to his model, people have one or more distal risk factors that can lead to intra- and interpersonal vulnerabilities, which cause an ineffective coping mechanism to stressful life event (Nock 2009: 18). These risk factors could predispose a person to commit NSSI by an additional set of NSSI-specific vulnerability factors (Nock 2009: 18). All risk factors, which Nock mentioned in his model, shown in Table 2.

Table 2: The risk factors from the Integrative Theoretical Model of the Development and Maintenance of NSSI (Nock 2009: 18)

Distal risk factors	Intrapersonal vulnerability factors	Interpersonal vulnerability factors	NSSI-specific vulnerability factors
high emotional/ cognitive reactivity	high aversive emotions	poor communication skills	social learning hypothesis
child abuse/ maltreatment	high aversive cognitions	poor social problem-solving	self-punishment hypothesis
familial hostility /criticism	poor distress tolerance		pragmatic hypothesis
			pain analgesia/ opiate hypothesis
			implicit identification hypothesis

Klonsky (2007) claims in his review study, that the most common functions of self-harm is emotional control, self-punishment and anti-suicidality (Klonsky 2007: 27). These functions do not rule out each-other but knowing someone's personal reason for NSSI is very important for the individual therapy (Klonsky 2007: 27).

Plener and Brown (2017) mention several risk factors for NSSI in their study (Plener-Brown 2017: 19). The strongest individual risk factors were the following: former history

of NSSI, cluster B personality disorders and hopelessness (Plener-Brown 2017: 19). They highlight the female gender, bullying, pathological internet use, parental neglect and deprivation and child abuse as risk factors for NSSI (Plener-Brown 2017: 19).

PREVENTION AND TREATMENT OF NSSI

Primary prevention can have a very important role in wide range management strategy of NSSI, while as it is mentioned above the phenomenon is high prevalent in non-clinical adolescent populations as well. Evidence shows that exposure to peer NSSI is a strong risk factor of engaging in NSSI (Fox 2015: 42), and there are content analyses studies about huge NSSI presence in social media (Lewis 2012: 16; Moreno 2016: 58). There are afew evidence-based, effective programs at the level of primary prevention (Bem 2017; Joshi 2015: 24, Robinson 2013). These programs usually target both suicide and NSSI, population targets can be teachers (gatekeeper trainings) or students (awareness and education programs) or both (Robinson 2013:). Although NSSI is notin the main focus of Youth Aware of Mental Health (YAM)program, it is worth here to mention, thatduring the Saving and Empowering Young Lives in Europe(SEYLE) randomized study, YAM was found to be an effective universal suicide prevention program (Wasserman 2015: 385). However, further specific NSSI focused studies are needed in the effectiveness of primary prevention programs.

According to our current knowledge, the first choice to treat NSSI is psychotherapy (Ougrin 2015: 54, Plener-Brown 2017: 19). Cognitive behavioral therapy and mentalization-based therapy could be used to treat NSSI (Gonzales-Bergstorm 2013: 26, Turner 2014: 59, Plener-Brown 2017: 19). Additionally, we found that, although dialectic behavioral therapy is often associated with reduced rates and frequency of NSSI in uncontrolled trials and reduced rates of self-harm more generally (SSI and NSSI considered together), further research is needed to substantiate its advantage over active control conditions for NSSI specifically.Plener et al (2016) made a research about the German guidelines of treating NSSI (Plener 2016: 10). According to their research results, the treatment should primarily take place in an outpatient care unit, but only if the psychological, social and academic level of functioning is sufficient, the patient is able to cooperate, and the criteria are not met for inpatient treatment (Plener 2016: 10). The inpatient treatment of NSSI should take place in a Department of Child and Adolescent Psychiatry and Psychotherapy (Plener 2016: 10). The criteria for inpatient treatment are the followings: the patient is suicidal; the body harm is severe; there is no available outpatient care unit (Plener 2016: 10). In the severe forms of NSSI there is unnecessary to have surgical treatment as well (Plener 2016: 10, Plener-Brown 2017: 19). No psychopharmacological treatment is recommended in NSSI, but it might be used when the patient is agitated, and also when there is an underlying psychiatric disorder (Plener 2013: 32, Plener 2016: 10). Due to the high comorbidity of NSSI with psychiatric disorders it is important to screen psychiatric disorders and offer appropriate treatment. Some studies recommend medication such as atypical antipsychotics (aripiprazole), naltrexone and selective serotonin reuptake inhibitors with or without cognitive behavior therapy (Turner 2014: 59, Plener-Brown 2017: 19).

All of the studies emphasize that, the treatment of NSSI is very important (Turner 2014: 59, Plener 2016: 10, Plener-Brown 2017: 19), not only because the individual feels better, but also treating this phenomenon decreases the functions of NSSI (Victor 2016: 241) and all these can lead to suicide prevention as well.

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SUICIDE AND ITS SOCIO-CULTURAL PRESENTATIONS IN LITERATURE AND MUSIC

SUICIDUL ȘI REPREZENTĂRILE SALE ÎN LITERATURĂ ȘI MUZICĂ

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Rezumat: *Scopul articolului de față este de a cerceta aspectele socio-culturale și penetrația socială a caracteristicilor suicidului și a rolului modelelor simbolice, mai ales din literatură, anumite genuri de muzică și opere clasice. Dovezi pentru cauzalitatea de tip model-efect și imitație contagioasă au fost raportate în descrierile unor epidemii sau clustere suicidare din cele mai vechi timpuri până în secolul XX. În literatură și libretele de operă, ba chiar și în muzica modernă (pop sau heavy-metal), ca și în alte forme de artă sunt reflectate credințele contemporane despre relațiile interpersonale, despre conflicte și valori morale, Fenomenul cultural, nu numai că reflectă atitudinile despre suicid, ci chiar modelează opinia publică, prin aceea că influențează percepția și semnificația actului de suicid. Amintirile personale și experiențele culturale, predispozițiile și necesitățile fiecăruia, pot modela percepția noastră asupra evenimentelor ce ne înconjoară, iar de aceea fiecare din noi tinde să se identifice cu personajele din narațiune și să devină actori în piesa care ne impresionează. După părerea noastră, aceste tipuri de procese trebuie studiate în continuare.*
Cuvinte cheie: *suicid, cultură, modelare.*

Abstract: *The aim of this article is to search for the sociocultural aspects and social transmission of the characteristics concerning suicide and for the role of symbolical models and patterns in the culture especially in literature and in some music –popular music and operas. Evidence for the model-effect and contagion have been reported in accounts of epidemics or clusters of suicides from ancient times to the 20th century. Among susceptible individuals the mechanisms most often associated with them, are imitation/ identification. Literature and opera, popular music cases (even pop music, or heavy metal) like any other art form, reflect contemporary beliefs about interpersonal relationships, conflicts and moral values. The cultural phenomenon not only mirrorsthe attitudes regarding suicide, but it shapesthe public opinion, by influencing the perceptions and meanings of the suicidal act. Our personal and cultural histories, predispositions and needs influence what we perceive, and we tend to identify ourselves with the character in the plot and become actors in the play which has an effect on us. In our opinion, these types of processes have to be still studied.*
Key words: *suicide, culture, modelling*

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The aim of this article is to search for the sociocultural aspects and social transmission characteristics concerning suicide and for the role of symbolical models and patterns in the culture especially in literature and in some music – popular music and operas. The meaning of suicidal behaviour encompassing historically affective qualities is that the act symbolizes differences according to culture. In the modelling process of suicidal behaviour, the sociocultural, contextual and individual-psychological meanings of suicide are connected. Evidence for the model-effect and contagion have been reported in accounts of epidemics or clusters of suicides from ancient times to the 20th century. Among susceptible individuals the mechanisms most often associated with them, are imitation/ identification

Exploring the impact of culture, and its attitudes and values by studying the way suicide has been portrayed in a particular art form in different cultures. Literature and

opera, popular music cases like any other art form, reflect contemporary beliefs about interpersonal relationships, conflicts and values. They not only mirror attitudes regarding suicide, but they shape public opinion by influencing the suicidal meaning and they act also as agents for social cultural changes. Suicide and other acts of self-destruction are common themes in dramatic literature today, as they have been over the centuries. It is worth noting that this approach has a distinct advantage over clinical studies of fatal suicides, where the subject of the research, the suicide itself, is no longer available for us. In case of a model-suicide, the mediating process between models and imitators and the psychic mechanism in modelling can be more understandable in these works than those in everyday life or in a clinical case.

The authors think, thisstudy offers some insight into the use of suicide, for its effect on other people, the phenomenon of suicide clustering and the imitation identification mechanism characterizing suicide in world literature and opera. In order to obtain sources of data for this study, literary works and operas demonstrating the contagion of suicide and model effects were chosen from several cultures and several eras. Possible examples were selected from impressive works known world-wide from several areas, eras and cultures, from the Greeks, from the Bible throughout the Middle Ages and up to modern literary and operatic works.

In the imitation-identification process, many factors may mediate the emotional response to and cognitive appraisal of suicidal behaviour. Similarities and differences of the suicidal models and their imitators were studied with regard to sociodemographic variables (age, sex), methods and psychological variables (motives and consequences of suicide, emotional closeness to the model, attractivity-dependency). Social learning theory is used in analysis of the data from vicarious experiences which may have a role in the depiction of suicides (Bandura, 1977) especially as they illustrate the processes of modelling and imitation in these literary works.

To understand the model effects from the point of their meaning, the subjective qualities of the suicidal act in the given context were investigated (Boldt, 1988) using the Baechler categories (Baechler, 1985, Smith, 1985). Baechler has described an elaborate typology of suicide on the basis of meanings (not motives) attached to them. According to this approach there are eleven types of suicide classified into four main groups. (Escapist suicide – to escape from an intolerable situation; aggressive suicide – to revenge, to punish or to force somebody by the act; oblative suicide – to sacrifice him/herself; and ludic suicides – a high risk behaviour, to challenge fate or God). To view suicidal behaviour as a purposeful, meaningful act designed to solve an existential problem of living gives us a very useful framework in understanding the suicidal person's personality, his private logic as well as the impact of the act and the mechanisms of modelling and social transmission.

In addition, the dynamic concepts of identification and projective identification are used to understand suicidal contagion. The concept of projective identification is useful in understanding the occurrence of modelling even when there are no attractive models, sociodemographic or other similarities. In such cases the follower who is characterized by a weak identity can project his best qualities on to the internalized representation of the model and thus identify himself with the other. This happens when the borders of the self are weak beforehand, as are found in borderline, narcissistic or psychotic people (Taiminen, 1992). Also, the interaction between the concepts can be illustrated in the analysis of the literary works.

RESULTS AND DISCUSSION

Authors mean, using the framework described above allows us to draw some general conclusions. Social learning theory is especially useful in understanding episodes of suicide clustering, suicide epidemics and in the occurrence of altruistic suicides. The latter ones are essentially facts of suicide that are determined and prescribed by a certain culture. Examples are found in the works of the following authors: Fukadzava (1982), Santa (1985) (in Japanese and Hungarian villages, the oldest people regularly committed suicide to relieve their poor families); Dostoyevsky (Foy et al, 1979) (the young girls` epidemics in *"Brothers Karamazov"*); Mussorgsky, Berlioz (suicide epidemics among the heretics and among the Trojan women; Harewood, 1976); Stevenson (1974) (suicides of gamblers in the suicide club). Thomas Mann (1955) (the great friend's suicides), in some Shakespearean dramas (1981) (Julius Caesar, Antonius and Cleopatra), and in the Japanese short stories of Mishima and Mori /see Table.1./

In our opinion, these descriptions, sociodemographic similarities and traditional methods of suicide are found, along with attractive personalities, providing models and charismatic examples personifying the notion. There are also similarities in the anticipated consequence and meanings concerning the successive suicides. Social learning theory also applies for many examples of Greek and Indian

historic suicides. The clustering indicates that people are of similar sexes and ages, and that the motivations for the acts which are carried out in similar ways, imply similar meanings and consequences. (Consider Erigone's example and the Athenian women following her; the suicides of the sirens; the story of Ariadne-Phaedra-and Polycaste, the women of Messina from the Greek literature (Graves, 1960, Faber, 1970) as well as Krishna`s and king Pastu`s wives in the Mahabharata) (see Table.2).

TABLE 1.

- FUKADZAVA-*"Pilgrimsong"*-the elderly above age 70 in theJapanese villages committed suicide as a rule in the same ritual, traditional way (by going to the mountain)to unburden their starving families. Rites, ceremoniesand the *"Narayama songs"* are the cultural mediators in the suicidal modelling process.
- SANTA-*"Too many of us"*-a ritual withdrawal (to a cave) and a ritual suicide of the elderly, Hungarian village to unburden the poor families. Folk tales, songs, ceremonies are the sociocultural mediators
- MUSSORGSKY- *"Khovanshchina"*- in Russia the old believers' self-immolation. The method, the motifs the anticipated consequences are the same; Dossifey(the chief priest, leader of the schismatics, Old Believers) - is a prominent model
- BERLIOZ- *"Les Troyens"*- suicide epidemic of the Trojan women -following princess Cassandra - after the victory of the Greeks to avoid dishonour
- DOSTOYEVSKY-*"The brothers Karamazov"*- a suicide epidemic of young girls in a village in Russia was stopped when theauthorities intervened by dragging the naked corpse through the streets
- SHAKESPEARE-*"Julius Caesar"*- Cassius, Titinius, Brutus committed suicide by the same method (stabbing) to avoid dishonour on the battlefield in Phillippi Portia, Brutus` wife, followed the example of her husband. *"Antonius and Cleopatra"* - Antonius, Eros, Cleopatra and her slave girls, Iris and Charmion killed themselves following Caesar`s victory Cimarosa also adapted this theme in opera
- STEVENSON- *"The suicide club"* - suicides of members ofthe club after gambling
- MANN,TH - *"The changed heads"* - two friend's suicides (they cut their heads). They love the same woman. The meaningsof victim-suicide are common, the scene is Goddess
- Kali's church.
- MISHIMA- *"Patriotism"*-Lieutenant Takeyama to avoid dishonour disembowelled himself with his sword, his wife witnessed his ceremonial act and then killed herself with a dagger. The author, Mishima also committed seppuku (hara-kiri) in 1970.
- MORI-*"Decadence of the Abe house"*-vassals after Duke`s deathcommitted suicide, traditionally, by the same method

TABLE 2.

- **GREEK MYTHS**
- *"Antigone"* and *"Oedipus Rex"*. Suicide of Iocasta, Antigone, Haimon, Euridice by hanging and stabbing;(suicidal meanings-escape, ablative). In the literature the deaths were described by Sophocles,Euripides, Aeschylus (Faber, 1970, Anouilh, 1949, Brecht, 1969). In opera - (Mendelsohn, Orff, Honegger, Leoncavallo, Mussorgsky, Stravinsky)
- Chrysippus` and his stepmother`s, Hippodamia's, suicide Appollodorus, (Graves, 1960)
- (Common suicide meanings are shame and escape) *Ariadne - Phaedra - Polycaste*. Suicides of sisters by hanging after loss of love (the meanings of suicides areescape and revenge) Plutarch's, Appollodorus, (Graves, 1960; Faber, 1970)
- *Erigone and the Athenian women* hanged themselves (revenge, aggressive suicidal meanings. Homer, (Graves,1960) *Sirens* committed suicide after the competition with Orpheus and after the meeting with Odysseus. Homer, (meanings - self-punishment, escape)
- *Women of Messina* committed suicide traditionally after husband`s death and suicide. Pausanias, (Graves,1960)
- **MAHABHARATA**
- King Pastu`s wives and the women following Krishna killed themselves, on act that was prescribed by theculture
- **KALEVALA**
- Kullervo and his sister kill themselves at theSame place, characterized by the same meaning - (escape, shame and self-punishment because of incestuous love)
- In many works, -on the other hand - that provide detailed descriptions of suicides, the modelling upon each other seem to be connected more by tight psychological emotional links, or by the process

of (projective) identification and by complicated subjective meanings than by the obvious sociocultural similarities. (See for example the story of Iocasta-Antigone-Haimon-Eurydice in the well-known Oedipus- Kreon dramas, and its literary and musical adaptations. The mother-daughter-fiancé-and his mother committed suicide, by different methods, having connected by very tight emotional links; the Chrysippus-Hippodamia story (Table 2) or suicides of Romeo and Juliet etc. illustrate the same). The psychological phenomena occur with special emphasis in both Russian and Scandinavian representations of suicide, namely those by Dostoyevsky, Tolstoy, Ibsen, Strindberg; and in the American novels written by Heller, Miller or Plath (Table 3).

- In Dostoevsky's novel *"Crime and punishment"* (1966, p.518) Svidrigaylov sexually abuses a child who kills herself. Just prior to his own suicide, he dreams repeatedly of this 14-year-old girl who has drowned herself. In *"The possessed"*(1936, p.716) before his suicide, Stavrogin also is haunted powerfully by dreams of the little girl-suicide shaking her fist at him: *"I saw Matryosha with feverish eyes. I see her that way every day…"*. Rosmer's words in Ibsen's triangle drama *"Rosmersholm"* (1977, p.232-3) about the suicidal wife, Beata are: *"We talk about her every day… she has been still among us"*. Later the friend, Rebecca West, says before her suicidal jump: *"go after Beata, Rosmer"*. Eventually we can see in Rosmer's invited death the identification-motive and the sacrificial and self-punitive meanings of suicide.
- Tolstoj (1964, p811) writes about Anna Karenina: *"suddenly the knocked down man occurred to her mind that day when she met Vronsky at first and had already known what to do, she wanted to fall the first car down…"* and *" I punish him, I will be delivered from everything…"*(the revenge-meaning and the connection of love and death motives in her suicide appear also in the analysis of Slochower,1975).

TABLE 3.

- DOSTOYEVSKY- *"The possessed"*
- Matryosha and Stavrogin - Stavrogin raped the young girl, who committed suicide, Stavrogin dreamt day by day about her, immediately before his own suicide (suicide meanings - self-punishment, escape).
- *"Crime and punishment"* - after the little girl's suicide ravished by Svidrigajlov, the suicidal girl's face returns in Svidrigajlov's dreams day after day. The common meanings of self-punishment and escape at the individual level can be same along with the mechanism of projective identification.
- TOLSTOY - *"Anna Karenina"*- in the heroine's ' fantasy before her suicide - jump in front of the train - the man's memory appears (suicide? accident?) what she saw when she met Vronsky at the first time. Beside the meanings of revenge and escape the joining of experiences of love and death helps the appearance of the model.
- IBSEN - *"Rosmersholm"* - Johannes' wife's and later Johannes' suicides by the same method, jump from high to the brawling. There are direct references in the text to the imitation of the model (The common meanings of action - sacrificial, self-punishment).
- *"Hedda Gabler"* -Ejlert Lövborg's and later Hedda's suicides came the same way with Hedda's pistol, who inherited the gun from her father, who was an army officer. She shot herself in an elegant way against Ejlert Lövborg's shot in the stomach
- STRINDBERG - *"Miss Julia"* - Jean's, Julia's father's and Julia's suicides. Aside from the difference of methodsand motivations, there are similar meanings partly –aggression, escape. Inducement to commit suicide in theinterpersonal mechanism of projective identification canbe taken in the act in the series of suicides.
- HELLER - *"Something happened"* - the father's and Virginia's suicides.
- A MILLER - *"After the fall"* - Maggie's and Quentin's intermingling suicidal behaviours, attempts. Beside the common suicidal meanings of aggression and escape identification, projective identification is the mediating mechanism.
- O'NEILL - *"My love, Electra"* - Christiane's, Orin's and Lavinia's identical, projective identical (*"inducing"* to commit suicide) model-following suicides with the meanings of revenge and aggressive suicide.
- ANOUILH - *"Ardele"* - love suicidal pact, paired suicides with the common suicidal meaning of escape from unbearable situation.

It is either the description of fantasies associated with the model (as in the works by Tolstoy *"Anna Karenina"* and Plath *"The Bell Jar"*), or the recurrent presuicidal dreams which bear a great emotional intensity and refer to the

model, (as in the novels by Dostoyevsky *"The Possessed"* (Stavrogin), *"Crime and Punishment"*(Svidrigaylov)) that act as transmitters. For the models and their imitators in these descriptions, the rules of social learning seem to be valid to a lesser extent. The relationships and the modelling processes are characterized and determined mainly by projective identifications, partly by its intrapsychic form; and partly by hidden subjective meanings (Taiminen, 1992)

Direct descriptions of suicidal imitations also appear in Mayakovski's poem (1968) commenting after Yesenin's suicide: *"All the imitators were raving. Heaps of them point knives at themselves…"*. He writes about the subsequent intellectual suicide epidemics, and finds the same suicidal method, motifs and sociodemographic variables among the imitators (see the essay of Trotsky in 1930 about *"The suicide of Mayakovski - To the memory of Yesenin"*.

SUICIDAL PACTS

A suicide pact is an agreement between two or more people to kill themselves. These individuals form interdependent *"encapsulated units"* - when threatened with dissolution, the *"unit"* commits suicide*". There are usually dominant and submissive members in clinical descriptions, consisting of antisocial and borderline personality types. Marzuk (1999) describes homicide-suicides on the other pole of the double suicide spectrum (spousal, familicide, extra-familial),in which usually much more psycho-pathological/violent and less agreement/ identification issues are involved. The phenomenon of the suicide pact, which operates in a somewhat different way, can also be found in opera and literature. Examples are seen in Table 4, and include "*Cosi Fan Tutte*" by Mozart, a suicide attempt-pact; Bontempts short story "*A summer tragedy*"; Chikamatsu` play "*The love suicide*"; Kawatata`s "*Sleeping Beauty*" (see Weir, 1980); Bulgarian folk songs (Shipkovensky, 1975) and the drama of Anouilh "*Ardele*" (1949).*

Many love-suicide pacts were found, while in everyday life suicide pacts typically were composed of married couples, aged 50-60, who are socially isolated, unemployed, medically ill.

TABLE 4.

- MOZART- *"Cosi fan tutte"*- in the opera a suicidal pact is formed by Ferrando and Guglielmo. (A suicide attemptis made (same method-poison,and same motifs to seduce each other`s fiancés, gaming-ludic suicides)
- BONTEMPTS-*"A summer tragedy"* - A suicide pact of an old couple is presented in a short story (with the same method, same motifs, - life no longer holds meaning for them, they are ill, lonely, their children have died. Escape and oblative suicidal meanings)
- CHIKAMATSU-*"The love suicides at Sonezaki"*- A Japanese play includes a love-suicide pact
- KAWATATA- *"Sleeping Beauty"* a Japanese novel expresses the writer`s wish to commit suicide with a little girl and thus escape old-age ugliness, (suicidal meanings aggressive, escape)
- BULGARIAN FOLK SONGS (Schipkovensky) - Love-suicide pacts - the inseparability is emphasized
- ANOUILH-*"Ardeleou la Marguerite"* - Love suicide-pact
- (suicidal meaning - escape from a desperate situation)

The suicidal pact, a manifestation of collective suicide (dyad, familial or societal) has often been differentiated from model suicides which employ imitative /identification mechanisms. However, our literary research points not only to the validity of the *"common stressor"* theory, but also to the common meanings, motivations, methods and the mutual mesh and identification in real suicide pacts that are described. In our opinion they represent strong arguments against the separation of the dominant partner role usually found in suicidal pact from the problem circles of modelling (Weir, 1980, Rosen, 1981). On the other hand, the murder-suicide appears to be a somewhat different entity.

Table 5 presents additionally operas that contain suicides in which the imitation - modelling processes play a role (Feggetter, 1980, Walley, 1971). It may be noted that suicide is a remarkably frequent operatic cause of death, which, through its romantic and heroic presentation, heightens markedly its model-effects (e.g. a cluster-suicide in the Mussorgsky's *"Khovanshchina"*; and in the Berlioz`s *"Woman of Troy"* initiated by Cassandra; or an identification with a suicidal model in the Puccini`s *"Miss Butterfly"*).

Viewing suicide from the perspective of its sociocultural history allows a more comprehensive understanding of this phenomenon (Tousignant and Mishara, 1981). Suicide is seen the *"great refusal"* to say yes to an existence that is a living death for the soul and spirit. It serves as a disturber of the world`s *"false sleep"*, an aim of the great artists in their depiction of characters who take their own life (Slochower, 1975).

TABLE 5.

- **SUICIDE IN OPERA**
- Harewood (1976) lists 306 operas in which there are 77 completed suicides and 12 attempted suicides Walley and Kalish (1971) in the 104 very frequently performed operas suicide occurred in 26 percent
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- **SUICIDE MODELING IN OPERA**
- PUCCINI - *"Miss Butterfly"* - Cho-Cho-San's father's and Cho-Cho-San's suicides are committed with the same dagger, the same motivation. (Before her suicide miss Butterfly was reading her father's lines loudly written to his dagger: *"Die with honesty if you could not livewith that."*
- MUSSORGSKY - *"Khovanshchina"*–Dosifey's, Marfa's, Andrej's and the Greek orthodox' voluntary stakes after each other. Common meanings are escape and common death undertaken with dignity.
- BERLIOZ - *"Women of Troy"* – Cassandra - The women of Troyfollow her suicidal behaviour with similar method andmeaning after the Greeks' victory.
- MOZART - *"All of them are doing this way"* - Ferrando's and Guglielmo's suicidal attempts with the same method andmeaning, where the declared aim, on the basis of a bet is seduction of each other's girlfriend by means of manipulative suicide. (The game as suicidal meaning.)
- GOUNOD - *"Romeo and Juliet"* - two suicides following closelyone another with the meaning of mourning and escape (see also Blacher's, Sutermeister's opera settings about thesame theme.)
- DELIUS - *"Romeo's and Juliet's village"* - Sali's and Vreli's suicides with the same method and motivation
- CIMAROSA - *"Antonius and Cleopatra"* - Antonius', Cleopatra's, Iras', Charmian's, Eros' suicides after one another with an attractive model. Their servants follow their examples, becoming one with them in death.
- NIELSEN - *"Saul and David"* - Saul and his servant (with common meanings of escape and preservation of honesty, Saul is the prominent model; the context and the method are common.
- MENDELSSOHN; HONEGGER; ORFF; - *"Antigone"*Jocasta, Antigone, Haimon, Euridice (see Table 1.)

Analysis of the phenomena and mechanisms of modelling in relation to suicide in the world literature and operas allow us some conclusions about suicide. The mechanism of identification appears to be the most important aspect of suicide contagion and clustering. Generally, the rules of social learning theory were found to be valid. The concepts and the typology of cultural meanings of Baechler (1977) are most useful in understanding of suicidal process.

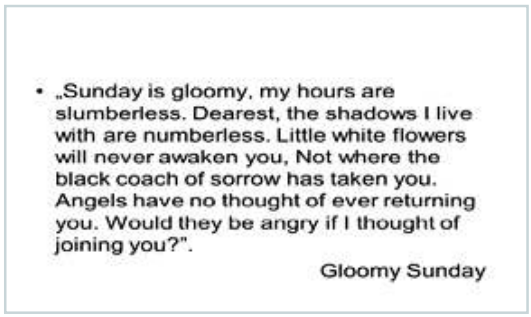
The mechanism of identification in the suicidal drama could be correctly interpreted by studying the context of common cultural meanings and particular societal attitudes. The psychodynamic concept of projective identification was useful in our literary analysis to understand how and under what conditions the suicidal models influenced the individuals` decision to commit suicide. When similarities of people in the process of modelling were not present, the motivation and the subjective meaning of the act seemed to be similar.

Presentations of suicide and modelling usually emphasize on of two elements, either the cultural traditions and altruistic motivations, or the contextual and /or individual, psychological aspects. But in the process, they generally appear as an integrated whole, and may range from the real individual person to a symbolic one drawn from an idea or tradition.

Active reading or listening to the work makes it clear that the response is far more than a simple reaction to a stimulus, but it is more of an interaction. Our personal and cultural histories, predispositions and needs influence what we perceive, and we tend to identify ourselves with and become actors in the play which has an effect on us. These processes have to be still studied.

*SUPPLEMENT - (POPULAR, HEAVY METAL MUSIC) - GLOOMY SUNDAY: DID THE "HUNGARIAN SUICIDE SONG" REALLY CREATE A SUICIDE EPIDEMIC?

- STEVEN STACK, PH.D.; WAYNE STATE UNIVERSITY, DETROIT, MICHIGAN; OMEGA, VOL. 56(4) 349-358, 2007-2008



MUSIC, (SELF) DESTRUCTION - HEAVY METAL

MEGADEATH	POISON
ANNIHILATOR	METALLICA
NUCLEAR ASSAULT	SLAYER
BLUE MURDER	SUICIDAL TENDENCIES

TEXTS:

*"FOR EARTH TO HEAL THEN WE MUST DIE, NO ONE DESERVES IT MORE"*MOTORHEAD'S - *"MARCH OR DIE"*
"THERE IS NOTHING MORE FOR ME, NEED THE END TO SET ME FREE"
METALLICA - *"FADE TO BLACK"*
"SUICIDE IS THE ONLY WAY OUT….SUICIDE IS SLOW WITH LIQUOR."
OSBORNE - *"SUICIDE SOLUTION"*
"I HATE MYSELF AND WANT TO DIE"
NIRVANA /COBAIN/ - *"IN UTERO"*

COMMENTS - INTERVIEWS ABOUT THE MUSIC:

"A song may push them over the edge…"
"I have seen it happen to a friend"
"especially if it's a song by a band or singer they admire…"

SUES

McCollum vs Osborne *"Suicide solution"*…
Waller vs CBS /Osborne/ *"Suicide solution"*
Vance vs Judas Priest /CBS/ *"Beyond the realms of death"*

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SUICIDAL BEHAVIOUR AND PANIC DISORDER

■ Delia Marina Podea, M.D., Ph.D., Arad

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Rezumat: *Tulburarea de panică (TP), este una dintre cele mai frecvente tulburări anxioase întâlnite în practica psihiatrică și generală. TP prezintă un interes major pentru cercetători datorită ratei crescute de apariție în populația generală, a impactului asupra calității vieții, a costurilor sociale, evoluției cronice și a tentativelor de sinucidere. Riscul tentativelor suicidare este mai mare decât în populația generală (7% versus 1%) fiind similar cu cel întâlnit în tulburarea depresivă majoră necomplicată (7,9%). În studiul nostru riscul suicidar a fost de 3%. Tratamentul farmacologic și psihoterapeutic fiind relativ bine cunoscut, este importantă identificarea grupelor de risc în populația generală. Se impune elaborarea unor programe educaționale în vederea reducerii tentativelor suicidare, a automedicației, a consumului de alcool, îmbunătățindu-se astfel evoluția. Anxietatea este unul dintre cele mai frecvent întâlnite simptome în practica medicală, manifestată prin tulburare de panică, care a devenit un interes major în rândul oamenilor de știință din cauza ratei crescute de apariție în populație, a impactului asupra calității vieții, și a tentativelor de sinucidere. Un factor foarte important este identificarea populației cu risc înalt, cursul și prognosticul care variază în rândul pacienților, factorii de risc asociați cu debutul sau recăderea, rolul lor în cursul bolii sau influența asupra gravității acesteia. Programele de educație pentru populația generală sunt necesare, deoarece este bine cunoscut faptul că pacienții cu tulburare de panică tind să utilizeze auto-medicație și alcool în încercarea de a-și reduce simptomele fără ajutor medical, provocând tentative suicidare. În ceea ce privește tratamentul, există probleme legate de terapie, durata tratamentului, modul în care menținem remiterea și care sunt cele mai bune metode de prevenire.*

Cuvinte cheie: *anxietate, tulburare de panică, comportament suicidar.*

Abstract: *Panic disorder(PD), a particular manifestation of anxiety, is one of the most frequently encountered disorders both in psychiatric and general practice. PD has raised a great interest among scientists due to the increased rate of occurrence in the population, the impact on quality of life, social costs, chronic outcome, suicide attempts .The risk of suicide attempts is greater than in general population (7% to 1%), being similar to that of uncomplicated major depression (7,9%). Our study revealed a risk of suicide of 3%. Pharmacological and psychotherapeutic treatment being relatively well known, is particularly important the identification of a high-risk population,of risk factors associated with the onset or relapse, and their influence on the severity of the disorder.Educational programs for the general population are needed to reduce suicide attempts, self-medication, alcohol -consumption in order to improve PD's outcome.*
Keywords: anxiety, panic disorder, suicidal attempts.

Anxiety is one of the most frequently encountered symptoms both in psychiatric and in general practice, panic disorder being one particular manifestation of anxiety. Until not so long ago, panic disorder has been a neglected condition, but during recent decades it became a topic of great interest among scientists because of the following conditions:

a) one in every 75 individuals in the world suffer from panic disorder during some time in his life;
b) the disorder has a significant impact on the sufferer's quality of life, interfering with his social, marital and occupational functioning;
c) the condition may become chronic;
d) the disease has a considerable social cost.

In this context, the panic disorder represents a major concern of psychiatrist and psychologists around the world.

The ICD10 (1) diagnostic criteria of the panic disorder are following:

A. Recurrent panic attacks, that are not consistently associated with a specific situation or object, and often occurring spontaneously (i.e. the episodes are unpredictable). The panic attacks are not associated with marked exertion or with exposure to dangerous or life-threatening situations.

B. A panic attack is characterized by all of the following:
(a) it is a discrete episode of intense fear or discomfort;
(b) it starts abruptly;
(c) it reaches a crescendo within a few minutes and lasts at least some minutes;
(d) at least four symptoms must be present from the list below, one of which must be from items 1 to 14:
Autonomic arousal symptoms
(1) Palpitations or pounding heart, or accelerated heart rate.
(2) Sweating.
(3) Trembling or shaking.
(4) Dry mouth (not due to medication or dehydration).
Symptoms concerning chest and abdomen
(5) Difficulty breathing.
(6) Feeling of choking.
(7) Chest pain or discomfort.
(8) Nausea or abdominal distress (e.g. churning in stomach).
Symptoms concerning brain and mind
(9) Feeling dizzy, unsteady, faint or light-headed.
(10) Feelings that objects are unreal (derealization), or that one's self is distant or *„not really here"* (depersonalization).
(11) Fear of losing control, going crazy, or passing out.
(12) Fear of dying.
General symptoms
(13) Hot flushes or cold chills.
(14) Numbness or tingling sensations.

C. Most commonly used exclusion criteria: not due to a physical disorder, organic mental disorder, or other mental disorders such as schizophrenia and related disorders, affective disorders, or somatoform disorders.(1)

In panic disorder the risk of suicide attempts is greater than in general population (7% to 1%)being similar to that of uncomplicated major depression (7,9%). Other studies however indicate a 20% risk in panic disorder suicide (2,3,4,5).

The rate of suicide is significantly increased in the case of association of panic disorder with major depression, alcohol and/or drug abuse and personality disorders (borderline, antisocial, histrionic, avoidance and passive-aggressive). (2)

The best predictors of suicidal ideation are the following items:

- a perception of life as chaotic and/or empty,
- affective instability,
- frequency of panic attacks,
- female sex
- self destructive behaviour (other than suicide attempts).(6)

This study sought to determine the prevalence of suicidal ideation and suicide attempts among patients with panic disorder hospitalized in the Psychiatry Department of Arad between 2009-2012.

The diagnostic of panic attacks with or without agoraphobia were based on the DSM-IV(7) and ICD10 criteria(1) with the help of which the co-morbid states have been evaluated too.

Our research is based on the study of 65 subjects (52 females and 13 men); the mean age was 33.5 years. For realizing the objective of the epidemiological study, a 16-item standard protocol was developed. The protocol assessed such variables as age, sex, marital status, length of illness and socio - economic status.

For realizing the objective of the epidemiological study, a 16-item standard protocol was developed.

The protocol assessed such variables as age, sex, marital status, length of illness and socio-economic status. Alcohol and drug histories, medical emergency room presentations, self-destructive behaviour (other than suicide attempts), affective instability perceptions of life as chaotic and/or empty and suicide attempts were rated as either present or absent.

The severity of death fears degree of suicidal ideation and severity of any suicide attempts was also rated.

Finally, self-reported frequency of panic attacks per months was included.

Certain items (thoughts of death, severity of suicidal ideation, history of suicide attempt, and severity of suicide attempt) were reviewed by a second rater for reliability estimations, in order to examine the hypotheses.

The severity of the suicide risk was estimated according to:

A) presence of thoughts of death: Infrequently, less than once a month, 2-3 times a week, almost daily;

B) Severity of suicidal ideation: never, infrequently/no risk, frequently/no risk, frequently/at some risk, frequently/severe risk;

C) History of suicide attempt: yes, no;

D) Severity of suicide attempt: very insignificant, very significant.

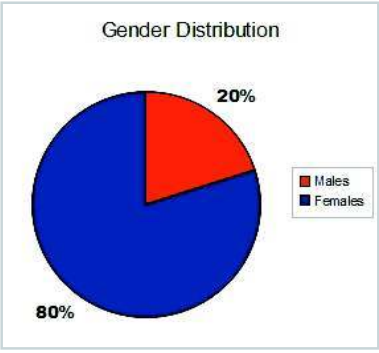

Figure 1:
Our study revealed the predominance of females (53) compared to males (12) – 80% vs. 20%

Age	Males	Females
15-24	7	13
25-34	1	7
35-44	-	28
45-54	5	4

Figure 2: *The mean age of the patients with panic disorder was 33.5.*

Panic attack (N=65)	Mean values for the Hamilton anxiety scale
Panic attack with agoraphobia (N=36)	13.14 ± 4.89
Panic attack without agoraphobia (N=29)	8.69 ± 4.64
Panic attack with agoraphobia and secondary depression (N=21)	14.11 ± 5.88
Panic attack without agoraphobia but with secondary depression (N=9)	9.28 ± 4.07
Panic attack with agoraphobia and personality disorder (N=16)	14.19 ± 4.10
Panic attack without agoraphobia but with personality disorder (N=5)	9.48 ± 4.81
Panic attack with agoraphobia, secondary depression and personality disorder (N=9)	14.39 ± 5.98
Panic attack without agoraphobia, secondary depression and personality disorder (N=2)	9.67 ± 4.98

Figure 3

The severity of anxiety depending on the associated co-morbidities and personality disorders:

Our study revealed a risk of suicide of 3.0% (two patients).

The frequency of suicide and of suicide attempts in panic disorder are due to: increased use of psychoactive medications, emergency room visits for emotional problems and a decrease in overall quality of life.

Since 1980, when the disorder was first described as a separate, self-standing entity, a lot of knowledge and clinical expertise have been accumulated and, more important, treatment schedules specific to the disorder have been developed, allowing patients to benefit from adequate therapy.(8,9)

Cognitive-behavior therapy (10,11,12) and medication (tricyclics, SSRIs, MAOIs and benzodiazepines), separately and in different combinations, have unequivocally proven their efficacy in panic disorder.

The most widely used behavioral technique is exposure, its efficacy having been demonstrated in the reduction of both anticipatory anxiety and of agoraphobia. Cognitive therapy, developed more recently, blocks panic attacks. Complex cognitive-behavioral methods seem to be the most efficacious.

None of the drug groups used has been proven tobe better than the rest, since all have both advantage and disadvantage:

-Tricyclics, for instance, can be prescribed in a single dose to be taken in the evening before going tobed, but improvements can only appear 6 to 12 weeks later, and in most cases side effects are difficult to tolerate.

-MAOIs also have several potential side effects and are accompanied by severe dietary restrictions.

SSRIs develop fewer side effects and are safer than tricyclics, owing to their lower toxicity giving rise to a reduced mortality rate in overdose; as is the case of tricyclics, however, clinical improvement only becomes apparent after 6 to 12 weeks of treatment.

Benzodiazepines act faster (one to two weeks); they have a significant effect on anticipatory anxiety, they are more easily tolerated by patients, but due to their short duration of action, the administration of several daily doses is required, and they produce dependence and withdrawal syndrome.

Comorbidity of panic disorder with depressive disorder, posttraumatic stress disorder, bipolar affective disorder, other types of anxiety, anorexia or bulimia nervosa, personality disorder and alcohol or drug abuse should be considered, as they require adequate concomitant treatment.

Panic disorder is curable, and in most cases, therapy leads to a spectacular improvement of the symptoms and to the individual's social and professional rehabilitation, followed by reintegration into the family and society.

Whenthe disorder becomes chronic, social and marital dysfunction may occur as well. The impairment of quality of life may be prevented or significantly diminished by early diagnosis and implementation of correct treatment.

In spite of the fact that interest awakened by panic disorder is still growing and with all the optimism triggered by the successes obtained in its study, the disease has not been fully understood so far.

As we would expect in a relatively young area of research, some questions still remain unanswered, while each discovery gives rise to new questions which create new perspectives for future research.

THE CONCLUSIONS OF OUR STUDY ARE:

1. The identification of a high-risk population – although the age of onset of the disorder is well known, the literature contains little information about predisposing factors. Another interesting subject to explore is that of isolated panic attacks.
2. The course and prognosis of the disorder – panic disorder has a fluctuation evolution, varying across patients and over time within the same individual; risk factors associated with onset or relapse, their role in the course of the disease or their influence on its severity have not yet been clarified
3. Education programs for the general population – it is well known that patients with panic disorder tend to use self-medication and alcohol in an attempt to reduce their symptoms without medical help.
4. Standardization of diagnostic and research methods
5. Treatment – there are still unresolved issues: what are the optimum criteria for choosing therapy, what is the ideal duration of treatment, how do we maintain remission, and what are the best methods of prevention.

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IS IT DEPRESSION TOO? SPECIFIC FORMS OF ADOLESCENCE DEPRESSION

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E VORBA TOT DE DEPRESIE? FORME SPECIFIC DE DEPRESIE A ADOLESCENTULUI

Rezumat: *Specialiștii se întrebau încă de la începutul anilor 1970, dacă există o depresie a copilăriei asemănătoarea cu cea a adultului. În mod unanim cercetările au conchis că simptomele și formele de depresie există în toate fazele de dezvoltare ale copilului. Cu cât mai (mic) tânăr e copilul la începutul depresiei, cu atât mai mare sunt diferențele față de simptomatologia adultului. Simptomatologia adolescentului cu depresie e foarte asemănătoare cu acea a adultului, până la identitate. Fenomenele recente prezente în adolescență, precum folosirea de droguri, alcool, desenarea de graffitti și fuga de la lucru sau de la școală, influențează de asemenea apariția depresiei.*
Cuvinte cheie: *depresia în copilărie, simptomele depresiei adolescentului, comportament auto-mutilant.*

Abstract: *Specialists tried to find out whether a depression analog with the adulthood illnessexists in the childhood. The first follow-up examinations started at the end of the 1970s. Unanimously, it turned out from these examinations that the symptoms and the form of depression match the child's proper age and phase of development status. The younger the child is when the depression starts, the greater the difference will be between his symptoms and the ones of an adult. The symptoms of teenage-depression are in a great deal like the one of adult's, and they can be as well identical. The latest occurrences among adolescents such as drugs, alcohol, graffiti and skiving (avoiding work or school by staying away or by leaving without permission) also influence the occurrence of depression.*
Keywords: *childhood depression, symptoms of adolescence depression, self-injurious behavior.*

It was for a long time a vexed question, whether exists already in the childhood a depression analog with the adulthood illness. The existence of childhood depressive illness, which is analogous to the one of adults, has been debated for a long time. However, several authors from the 1850s on – like Griesinger in 1845 or Schülle in 1878 – have tried to draw a comparison between the different forms of childhood melancholy and adulthood depression, still hardly any researches were done in this field until 1978. The reason for this was, on one hand, that between 1930 and 1960 psychoanalysis was the dominant school. According to this theory depression can occur only when the su-

perego has already developed. As a conclusion its appearance during the childhood is out of the question.

On the other hand, before 1970 it was of no importance to diagnose depression among children, as giving medicine to them because of psychiatric indication was not accepted at that time. Also, the therapy-methods applicable for children were restricted.

The first follow-up examinations started at the end of the 1970s. The knowledge and experience gained from them made it possible to give a more precise diagnosis and enlarge the opportunities of different therapy-methods.

It turned out unanimously from these examinations that the symptoms and the form of depression more or less match the child's proper age and phase of development status. The younger the child is when the depression starts, the greater the difference will be between his symptoms and the ones of an adult [1.].

Several authors managed to find close connections, continuity between some kinds of childhood depressions and the adult one [2.]. Also, from the prophylaxis point of view of the adult depression it is important to realize and treat in time the occurring depressions at different phases of the childhood.

TAB. I-II: The age-specific symptoms of childhood depression [3]According to prior statements the symptoms of teenage-depression are in great deal similar to the one of adult's, they can be identical as well. The latest occurrences among adolescents such as drugs, alcohol, graffiti and skiving also influence the occurrence of depression [4.].

The fact that alcohol releases depression is known for a long time however mainly adults took this occasion. As the trial of alcohol is put at an even younger age, and also the habit of adolescents' drinking alcohol is more frequent, it is no wonder that alcohol occurs as a solution to bring the symptoms of depression to an end.

Case: A seventeen-year-old young man was sent to our consultation for heavily drinking. Lately he has become sullen and silent. He shuts himself in his room, does nothing sensible. He was unable to fit himself to his new class and he does not learn. He was expelled from school because of repeated alcohol consumption and damaging.

According to the Beck-scale the undoubtedly depressed young man under the influence of drink did not feel his loneliness, depression and inhibition so oppressive and hopeless. Although he was able to contact his contemporaries only in this state, he felt guilty because of drinking. The regular taking of antidepressants and with the help of psychotherapy his need for alcohol ceased to exist.

Many young people who suffer from the symptoms of depression can obtain drugs from his friends and contemporaries sooner than find a psychiatrist who could help him overcome his depression. Because of the temporary and occasional effects of the drug and, as they see their friends' intervening as a kind of help, moreover drug consumption is a team activity, these young people very rarely or never meet an expert.

Case: 16-year-old girl patient – among her relatives there occurred depressive illness – told that at the time of her parents' divorce for about nine months she had been moody, depressed and continually tired. Her performance at school grew worse from excellent to satisfactory. Her relationship with her friends at first became troublesome as it they could hardly tolerate her being unsociable and introversive. Later, when an experienced one of them realized that she might be depressed, they persuaded her to try a joint and later another drug. The parents who were mainly dealing with themselves noticed only then that their daughter's mood is occasionally better. (The negative change formulated only later in them.) But this time they could find the connection between the sudden change of mood, and the disappearance of money, and so it turned out that their daughter uses drugs. After that she managed to get to a psychiatrist.

The feeling of inability and helplessness causes strain which leads to the self-injurious behavior of people suffering from depressive illnesses. This skiving can also be a possible way of problem-solving specific of adolescents.

Case: 15-year-old girl got to the psychiatrist because of *„misbehaving"*. The parent's complaint: the child became more and more secretive (she does not discuss matters with them as she used to), her performance at school grew worse and recently she has cut her forearm. The result of the examination is that it was a depressive episode. By taking antidepressants and with the help of psychotherapy her condition became settled.

The change of the adolescents' life generates not only the occurrence of new symptoms, but also queries the evaluation of certain prior criteria as unanimous symptoms. If an adult or a child did solely solitary activity or drew back from his family and contemporaries, we rendered depression probable. Today with the development of technology the occurrence of *„being lonely"* is more common: pc-gamers or coach potatoes. Their privacy, loneliness can be a symptom but not without doubt. We take it a symptom only when their habit of using the computer or watching the video changes suddenly and the person became lonely

According to the above-mentioned facts, it seems obvious that the relatively strict diagnostic arrangement are not static, either. They can also dynamically change with the circumstances and the way of life. As a result, we should change our completion and our point of view system based on the analysis of these symptoms.

THE AGE-SPECIFIC OF CHILDHOOD DEPRESSION:

Table I.

Age	Way of expressing depression	Other symptoms of depressive syndrome	Other psychic disorders
Baby	Crying, non-verbal symptoms	Drawing back, apathy, insufficient weightgain,developing lag, impairment of sleep long-lasting irritability, loss of courage, increased affection	Intercurrent disorders
Toddler	Crying, non-verbal symptoms		Disorder in making social contacts, aggressivity
Nursery-school child	non-verbal symptoms	Change in the sleeping, appetite,sense of shame, psychomotor	Lack of privileged attachment person
Pupil	Verbalization	Behavioral disorders: Irritability, restlessness, burst of fury, or becoming bully and peevish Shutting oneself up: over-compensation Disorder in self-evaluation, self-accusation Disorder in mood: depression, apathy Bod: stomach-ache, headache, fatigability Worsening performance at school, Disorder of attention Social adapting worsens	Oppression, Regressive symptoms, aggressivity, Psychotic symptoms

Tabel II.

Adolescent	Verbalization	Emotional symptoms: depression,dreariness, narrowing of interest Cognitive symptoms: difficulty in concentration,memory disorder Distortion in mentality: Negative self-evaluation, Negative appraisement of the environment Negative future Motivational symptoms: Weariness, anergy Death-wish Somatic symptoms: Disorder in appetite and weight	Oppression, regressive symptoms, aggressivity, psychotic symptoms

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PARTICULARITĂȚILE SUICIDULUI LA ADOLESCENȚI

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Rezumat: *Acest articol contribuie la înțelegerea amplă a fenomenului suicidului la adolescenți. Are ca scop clarificarea conceptelor legate de acest fenomen și scoate în evidență elementele caracteristice suicidului, categoriile de suicid și manifestările caracteristice adolescenților suicidari.*
Cuvinte-cheie: *suicid, adolescent, tentativă de suicid, amenințare.*

Abstract: *The peculiarities of suicide in adolescents*
This article contributes to the understanding of the phenomenon of suicide in adolescents. It aims to clarify some concepts related to this phenomenon and highlights the elements characteristic of suicide, suicide categories and manifestations characteristic of suicidal adolescents.
Keywords: *suicide, adolescent, suicide attempt, threat.*

Suicidul reprezintă a doua cauză a morții în rândul adolescenților la nivel mondial. În Republica Moldova a devenit o problemă arzătoare, care necesită o intervenție promptă, întrucât ne confruntăm cu un val migrațional de amploare, acesta generând incertitudine, neîncredere în ziua de mâine și stres emoțional profund.

În timp, sinuciderea a fost definită de mai mulți autori. Dintre definițiile cele mai celebre, o citățm pe cea a sociologului francez Emile Durkheim [3]: *"termenul de suicid este aplicat oricărui caz în care moartea rezultă direct sau indirect dintr-un act pozitiv sau negativ, făcut de victima însăși, care știe că respectivul act îi va produce moartea".*

În definiția adoptată de Organizația Mondială a Sănătății, se precizează: *"Suicidul este actul prin care un individ caută să se autodistrugă fizic, cu intenția mai mult sau mai puțin autentică de a-și pierde viața, fiind conștient, mai mult sau mai puțin, de motivele sale."*

Concepția despre moarte evoluează treptat, în câteva etape.La vârsta fragedă a copilăriei, noțiunea morții este subiectul unei neînțelegeri totale. Moartea este pur si simplu negată. Copilul mic nu poate concepe deloc că viața lui sau a altora ar putea înceta vreodată și în vreun fel. Devenind mai capabil de a asimila noțiuni concrete din practica vieții, observarea mediului și a lucrurilor înconjurătoare, el asimilează noțiunea morții cu lipsa cuiva pe care îl știa, cu absența sau cu plecarea acestuia. Chiar dacă încolțesc în mintea lui unele înțelegeri mai apropiate de fenomenul morții, copilul continuă să o privească ca pe ceva reversibil. Din acest motiv, teama de moarte la copii este mai mult o reacție afectivă și nu una rațională. Ei nu au reprezentarea intelectuală a semnificației morții.

Către vârsta de 9 ani, procesul biologic este mai bine înțeles prin analogie cu lucrurile și fenomenele din jur. Cu toate acestea, copiii la această vârstă, nu au imaginea clară a fenomenului și referindu-se la ei înșiși, ei se cred nemuritori. În reprezentarea lor, noțiunea morții este clădită pe fapte sociale concrete: doliul, îngroparea, ceremonialul, pompele funebre, etc. Datorită predominanței procesului afectiv la copil, moartea este astfel identificată cu ritualul ori cu ceremonialul pe care l-a văzut desfășurându-se odată în asemenea ocazii. Noțiunea de ireversibilitate a fenomenului morții poate fi admisă, cu toate că de data aceasta, sub o formă confuză.

În pubertate și adolescență, apare o nouă formă a înțelegerii noțiunii de moarte. Ea este asociată cu noțiunea de repulsie, durere, pedeapsă, absență, neant. Acest fel de înțelegere a morții survine la majoritateaadolescenților. Totodată, la unii din ei, noțiunea morții nu înspăimântă deloc, nu este dureroasă, ba chiar este de dorit, mai ales în faza de prepubertate. De aici, rezultă frecvența tentativelor sinucigașe și cazurile de sinucidere propriu-zisă. Unii copii se obișnuiesc des cu ideea morții prinsă din joacă și o păstrează în subconștient, iar în stări conflictuale puternice recurg ca la o soluție bine cunoscută de rezolvare a problemei lor presante.

Elementele caracteristice suicidului sunt:

- acțiunea voită a subiectului;
- starea sau nivelul de conștientizare a scopului;
- orientarea acțiunii de distrugere către sine în vederea suprimării vieții, care poate fi diferențiată de alte situații, cum ar fi accidentul sau o crimă mascată;

Pe calea suicidului sunt mai mulți *"drumeți"* cu diferite feluri de experiențe. Unii amenință că se vor sinucide, deși amenințarea nu se va concretiza faptic niciodată, alții încearcă să-și suprime viața, dar nu reușesc și, în sfârșit, alții reușesc în comiterea actului suicidar. În acest context pot fi diferențiate următoarele categorii de suicid la adolescent:

Suicidul - amenințare - caracterizează adolescenții, cărora ideea suicidală le este străină. Scopul lor nu este moartea, dar amenințările lor sunt folosite ca mijloc de şantaj, de atingere a unor scopuri sau beneficii. Atunci când scopurile nu sunt atinse, aceștia potpune în aplicare amenințările. Astfel de persoane au redutabile tentative de suicid în trecut;

Suicidul - tentativă – caracterizează adolescenții care sunt ambigui în intenția lor suicidală, spre deosebire de cei care amenință şi care înclină în mod cert balanța pentru viață;

Veleitatea suicidală - definită drept o dorință tranzitorie de autosuprimare, cu proiecția teoretică a actului, dar cu rară punere în practică. Impulsul autolitic este determinat de o stare psiho-afectivă de moment, temporară;

Echivalențele suicidare - caracterizează acele moduri de comportament care implică un risc conștientizat de subiect (conducerea imprudentă a autovehiculului, refuzul alimentar sau terapeutic).

Suicidul reușit.

Aproximativ 2/3 din cei care se sinucid sunt cunoscuți ca având cel puțin o tentativă suicidală anterioară. Sinucigașii în faza actului suicidar reușit reprezintă o categorie ce cuprinde și acele persoane care încercând să se sinucidă, au fost salvate la timp (dar e inutil, deoarece ei vor încerca până când vor reuși);

Suicidologia evidențiază în evoluția suicidului trei faze distincte și obligatorii:

Ideația suicidală- este faza de incubație, faza mintală de cercetare a motivației, în cursul căreia subiectul își pune problema morții și a necesității de a muri. Această fază este declanșată de una sau mai multe cauze: de ordin patologic, dificultăți de adaptare socială, slăbirea sau accentuarea coeziunii grupului social, etc. Cauzele acestea determină pe plan psihic formarea unei atitudini motivaționale corespunzătoare pregătirii actului suicidar.

Faza de preparative suicidale- este o fază de trecere de la imaginile abstracte, conflictuale la etapa pregătirilor succesive concrete prin căutarea formelor și metodelor de conduită autodistructivă. Această fază este influențată de anumite circumstanțe, care depind de individ sau de întreaga societate:

- *psihopatologice* (etilism cronic, narcomanie, psihopatii, stări reactive);
- *somatogene* (malformații congenitale, infirmități, boli somatice grave, incurabile);
- *sociogene* (prozelitismul, conflictele social-juridice, sociopatiile);

În cursul acestei faze asistăm la o creştere progresivă a unei stări de presiune intra-psihică, care *„explodează»* sub forma unei reacții psihogene, moment în care individul adoptă *„decizia"* înfăptuirii suicidului. Altfel spus, este momentul *„exploziei autodistructive"*.[5]

Traumatizarea activă- este faza de punere în practică a modalităților autodistructive preconcepute, urmate sau nu de reușită, adică de moarte. În aceasta etapă a conduitei suicidale, sunt importante metodele folosite și efectul lor. Efectele pot fi psihopatologice (suicidul realizat, tentativa de suicid, șantajul suicidal) și sociale (suicidul egoist, altruist, fatalist, anomic). [4]

Diverse curente teoretice încearcă explicarea fenomenelor psihopatologice sau psihologice ce conduc persoana spre acțiunea fatală sau nonfatală de autovătămare deliberată.

Modelul medial oferă o explicație lineară, tip cauză-efect, între diferitele tulburări psihopatologice, gradul de severitate al acestora și apariția comportamentului suicidar;

Modelul psihologic pune accent pe relațiile precoce (atașamentul față de mama și întreaga familie) și pe mecanismele relaționale patologice ce nu permit satisfacerea trebuințelor psihologice de bază și care se traduc prin întârzieri în maturizarea psiho-afectivă a individului și prin disfuncții în manifestarea impulsurilor și instinctelor;

Modelul bio-psiho-social accentuează predispozițiile genetice, factoriide vulnerabilitate psihologică și socială. [2]

Modelul traiectoriei comportamentului suicidarla vârsta adolescenței include următorii factori de risc: biologici, psihologici, cognitivi, ambientali.

Factorii de risc biologici evidențiază criza hormonală declanșată la începutul pubertății, care cresc rata suicidului prin mărirea potențialului de agresivitate. Hormonii androgeni produc nu numai virilizarea băiatului dar, aduc după sine și amprenta stilului *„bărbătesc"* în comportamentul tânărului. Exploziile hormonale cauzate de distorsiunile

producției de hormoni pot să coincidă cu evenimente de viață negative. Această suprapunere deseori generează comportamente agresive și auto-agresive.

Factorii de risc psihologici pun accent peformarea identității personale și înțelegerea sensului propriei identități. Adolescenții care au dificultăți în a-și stabili identitatea, nu dezvoltă aptitudini de a lupta cu stresul specific al acestei perioade.

Deseori natura impulsivă și agresivă a tinerilor îi orientează spre acte autodistructive cu mult înainte de comiterea suicidului, comportamente îndreptate împotriva societății care măresc cota de stres, generând conflicte în serie cu autoritățile legale, dar și cu cei mai apropiați oameni. Un factor de risc psihologic este și orientarea homosexuală atât la băieți, cât și la fete. Factorii de stres psihosociali asociați cu stabilirea identității *„gay”*, precum și stilul de viață aparte, constituie factor de risc pentru acest grup special.

Factorii de risc cognitivi se referă la progresul cognitiv prin dezvoltarea abilității de a se angaja în gândirea abstractă și ipotetică. Gândirea ipotetică conduce imaginația adolescentului spre procesul de idealizare a lumii dar, de multe ori, adolescentul nu are dezvoltată abilitatea de a testa realitatea potrivit principiului realității (testul *„aici și acum”*). Astfel se produc multe decepții. Pe de altă parte, adolescența reprezintă o reînnoire a perioadei de egocentrism, tinerii pretinzând că ei sunt singurii care înțeleg cu adevărat prezentul. Acest egocentrism crește sentimentul conștiinței de sine, totodată și iluzia *„invulnerabilității”*, astfel angajându-se de multe ori în activități și comportamente foarte riscante. Acest stil de comportament denotă lipsa perspectivei clare asupra viitorului șia planului de viață la majoritatea adolescenților suicidali. Adolescentul începe să se simtă constrâns să aleagă calea suicidului datorită apariției unei gândiri negative, iar abilitățile sale de rezolvare de probleme devin inoperante. Gândirea celor cu ideație suicidală este plină de interpretări şi de distorsiuni formale sau de conţinut, cum ar fi: supra-generalizarea, rigiditatea cognitivă, abstractizările selective, stima de sine scăzută.

Factorii de risc ambientali subliniază conflictele familiale, la care au fost martori adolescenții cu ideație suicidală. Disfuncția familială poate culmina cu o separare parentală sau cu acte medico-legale în familie (homicid). Pe de altă parte, familiile celor care încearcă să comită suicid au o incidență crescută a problemelor medicale și psihiatrice: a alcoolismului, abuzului de droguri, a violului, incestului, abandonului, etc. Totodată,adolescențiiabuzați sexual prezintă o incidența crescută a depresiei, a farmaco-dependenței sau a tulburărilor de conduită, toate acestea, fiind asociate cu potențialul suicidar.

Manifestările caracteristice adolescenților cu intenție suicidală sunt:

- Ascetismul sau retragerea, interiorizarea, neglijarea corporală, cu o pronunțată nuanță primitivă, lipsa de igienă, portul unor haine uzate, ponosite, ca *„auto-pedeapsă”*;
- Ascetismul și intelectualizarea, stări bizare în atitudinea adolescenților, care apar, de regulă, ca o consecinţă a frustrărilor afective anterioare, generând o continuă stare ostilă, rar exprimată prin atitudini. Adolescenții simt că sunt la o răscruce, de unde pleacă numai două căi: imaturitatea Eului sau introvertirea;
- Sindromul de abandon, manifestat prin degradare, care începe prin căutarea partenerilor multipli şi mai ales a senzațiilor tari, sfârșind prin consecințele psihice care decurg din acestea, declasarea socială și sinuciderea;
- Dizarmoniile fizice și psihice, exprimate printr-o pubertate precoce, care se manifestă sub forma unor impulsuri diverse: manie, fugă, acte de delicvență, refulate în final în suicid și pubertatea ce se manifestă prin infantilism și dependența de mediul familial;

Dizarmoniile psihologice, caracterizate printr-o pubertate normală și psihic infantil. Consecința firească a acestui fapt este lipsa integrării perioadei de pubertate într-o personalitate care este nepregătită să o primească.

Aceste fenomene relevă complexitatea actului suicidar din perioada cea mai delicată, cea mai fragilă a vieții omului, adolescența.

O atenție deosebită îl merită sindromul pre-suicidal și semnele de atenționare a unui eventual suicid. Apariția unor comportamente dramatice conturează gravitatea modificărilor din viața adolescenților. Printre acestea se numără: automutilările, pregătirile finale de moarte însoțite de daruri făcute prietenilor, performanțele școlare deficitare. Acest tip de comunicarea intenției suicidare este considerată unul dintre semnele cele mai des întâlnite, de anunțare a unui viitor comportament letal, având o logică proprie. Totuși, schimbările individuale și familiale care apar după o tentativă de suicid, sunt de natură complexă și joacă un rol fundamental în evoluția ulterioară. Dar deseori și din nefericire, relația cu familia rămâne o problemă adesea nerezolvată, familia încercând să anuleze complet evenimentul și să-i nege valoarea de semnal, pe când, pentru modificarea dinamicii familiale și a posibilităților de schimbare, ar fi necesară capacitatea de a recunoaște

gravitatea actului, opusă banalizării, precum și abilități de acceptare și recunoaștere a suferinței psihice. Această dublă recunoaștere îl privește atât pe adolescentul însuși, cât și pe părinții acestuia. [1]

Dacă pentru un adult natura evenimentelor precipitante ar părea nesemnificativă, pentru adolescent chiar și conflictele minore pot să ia amploare și să constituie unpunct crucial pentru destinul lui, întrucât decesele prin suicid ale adolescenților au succedat în timp conflictele interpersonale, fie cu părinții, fie cu iubitul sau iubita, fie cu autoritățile juridice. Pe de altă parte, **publicitatea** făcută în jurul sinuciderii unor persoane cunoscute sau apariția suicidului în grupul de colegi sau prieteni au un efect de modelare, deoarece stilul imitativ joacă un rol semnificativ în viața tinerilor, imaginația acestora fiind captată de evenimentele tragice sau eroice.[2]

Recunoașterea adolescenților cu risc suicidar este dificilă, deoarece aceștia deseori își exprimă într-un mod nesigur și neclar intențiile lor, dar pot fi luați în considerație anumiți indicatori:

Tentativa anterioară de suicid: deseori, se crede, că dacă adolescentul a trecut printr-o tentativă de suicid, nu va mai încerca încă o dată, datorită experienței dureroase a recuperării. Dar de fapt, o tentativă de suicid prezintă un risc crescut de a o repeta;

Amenințarea cu sinuciderea: mesajele de genul *"nu vreau să mai trăiesc pe lumea asta"*, sau *"ar fi mult mai ușor pentru toți, să mor"* trebuie luate în serios și analizate motivele acestor afirmații. Ar trebui să ne analizăm modul de comunicare cu adolescentul și să-i oferimsuportul atât de necesar. În asemenea situație nu este recomandată amenințarea acestuia cu pedeapsa pentru acele mesaje;

*Depresia***:** este dificil de recunoscut simptomele unei depresii la adolescent datorită faptului că este considerată o problemă a adulților. Indicatorii unei stări depresive ca: tulburări ale comportamentului alimentar, mai frecvent lipsa poftei de mâncare, tulburări de somn(dificultăți de adormire, insomnii, somn excesiv fără regularitate), scăderea capacității de concentrare, scăderea performanțelor școlare, starea de apatie și lipsa de energie, dezinteresul pentru activitățile plăcute anterior, autoblamarea excesivă, tristețea, oboseala accentuată, probleme comportamentale la școală, pe o perioadă de minim două săptămâni trebuie să ne determine să ceremajutorul unor specialiști;

Discuția despre moarte sau preocuparea de moarte: orice interes neobișnuit legat de moarte, prin discuții, desene, poezie, muzică, postere trebuie să constituie un motiv de îngrijorare și un pretext de a discuta cu adolescentul despre aceste subiecte și motivele pentru care este preocupat de aceste teme. O temă frecventă în preocupările adolescenților, care au avut ulterior o tentativă de suicid este problema terorismului, războiului sau a misiunilor suicidare;

Izolarea de prieteni și familie: izolarea este un semn al unei stări de nefericire sau de durere a adolescentului. Mulți din cei care se gândesc la suicid nu comunică cu prietenii sau familia pentru a nu-i supăra sau întrista. Este recomandabil ca adolescentul să fie învățat să solicite ajutor atunci când simte că nu poate vorbi cu persoanele apropiate. Oferirea informațiilor despre serviciile de consiliere este foarte utilă în acest caz. Posibili indicatori a unor probleme ar fi: comportament de izolare excesivă și neadecvată stilului adolescentului, renunțarea și evitarea participării la activitățile sociale cu prietenii și familia, dificultăți de a părăsi casa, etc;

Tulburări comportamentale: starea de nemulțumire a adolescenților se manifestă prin anumite comportamente cum ar fi: fuga de acasă, chinuirea animalelor, agresivitatea fizică și verbală (lovirea repetată a fraților sau prietenilor, acte de distrugere a unor bunuri la școală sau din alte locuri publice). Pedepsirea acestor adolescenți datorită comportamentelor pe care le manifestă, duce la accentuarea sentimentului de nefericire și la implicarea lui tot mai mult în planul de sinucidere;

Abuzul de substanțe: din nefericire, de multe ori, adolescenții consumă alcool sau droguri înainte de actul de suicid. De aceea este foarte important ca în prevenția consumului de substanțe să se accentueze și acest aspect. Consumul de substanțe este un semnal de alarmă că ceva nu este în regulă cu adolescentul;

Impresia suicidului în masă: adolescentul poate înțelege acest fenomen ca o manifestare a unor convingeri filosofice sau religioase, de aceea unele mesaje transmise de mass-media sunt destul de periculoase;

Toți acești indicatori nu trebuie confundați cu *miturile* asociate suicidului la adolescenți, cum ar fi:

Adolescența este o perioadă fericită din viață, lipsită de griji *și în care există doar probleme minuscule de adaptare.* Este greșit să credem că vârsta adolescenței protejează tinerii de traume. Există o multitudine de probleme cu care se confruntăși pentru care nu sunt încă pregătiți să facă față, cum ar fi de exemplu: moartea unor persoane semnificative, abuzurile emoționale, fizice sau sexuale, violența

adulților, rigiditatea standardelor impuse de adult, consumul de substanțe. De aceea, mai optim este să-i învățăm pe adolescenți să facă față adaptativ situațiilor de criză;

Adolescenții care vorbesc despre sinucidere nu recurg niciodată la acest gest. Sunt dovezi care arată că majoritatea adolescenților care s-au sinucis, au vorbit despre moarte și au făcut afirmații despre dorința lor de a-și pune capăt vieții. Deci, orice mesaj asociat cu suicidul trebuie să constituie un motiv de atenționare;

Cei care au tentative de suicid nu vor decât să atragă atenția. Orice tentativă de suicid este un semn alarmant al unei probleme și tratarea acesteia cu superficialitate este o gravă eroare care poate convinge adolescentul că nu este înțeles şi acceptat și că suicidul este singura modalitate de a scăpa de disperarea și lipsa de speranță resimțită.

Este suficient ca adolescenții să vadă partea bună a vieții şi se vor simți mai bine**.** Pentru adolescentul cu intenție de suicid, această afirmație poate agrava situația şi duce la accentuarea convingerii că ceea ce simte şi crede el, este inadecvat, fiind o formă de invalidare. A-i spune unui adolescent că *"mâine lucrurile vor arăta altfel"* nu face decât să-i adâncească sentimentul de izolare şi însingurare, deoarece el nu se poate gândi la viitor, ci doar la prezent;

Adolescenții nu știu cum să se sinucidă și nici nu au puterea necesară să o facă. O idee eronată este a considera tentativa de suicid *„un accident"* fără intenția de curmare a zilelor. Adolescenții ştiu foarte bine cum pot să-şi ia viaţa, unii dintre ei au planuri foarte elaborate cu privire la suicid. De aceea este recomandabil investigarea cu atenție a oricărui *"accident"* prin care tânărul își pune viața în pericol;

Adolescenții care se sinucid au tulburări psihice. Este dovedit că procentul celor care se sinucid și care au o tulburare psihică este mult mai mic decât s-ar crede. Cauzele suicidului sunt complexe și diferite de percepția obișnuită a oamenilor. Se întâmplă des ca părinții adolescentului care a avut o tentativă de suicid, să nu recunoască acest lucru, datorită convingerilor eronate despre suicid și din teama stigmei sociale pe care o implică suicidul.

În cazul adolescenților care recurg la suicid, părinții sunt singurii responsabili. Majoritatea părinților se blamează pentru tentativa de suicid a copilului lor și cred că numai ei poartă vina pentru această situație, mai ales că societatea are tendința deînvinovățire a părinților. De cele mai multe ori însă, adolescentul încearcă să-i protejeze și să-i excludă din problemele sale, astfel părinții fiind ultimii care identifică semnele unui viitor act suicidar.

Când adolescentul cu depresie începe să se simtă mai bine înseamnă că perioada de criză a trecut. Contrar părerilor comune, riscul suicidar la o persoană cu depresie este mult mai mare în perioada în care este perceput de ceilalți că este mai bine. Tocmai în această perioadă, adolescentul dispune de energia necesară planificării unui act suicidal. Găsirea acestei soluții extreme îl face să se simtă mai bine și mai liniștit. De aceea trebuie să fim atenți la semnele care pot fi un indiciu fals de recuperare.

Intervențiile primare, care pot ajuta adolescentul suicidar sunt variate.

Primordial este ruperea izolării pe care tânărul o trăiește și abordarea directă a subiectului suicidului. Acest lucru ajută adolescentul să dizolve ideea sinuciderii, să-și exprime suferința și să vorbească despre lucruri care îl preocupă, îndemnându-l să exprime tot ce simte și trăiește în raport cu acest gând. Este foarte importantă disponibilitatea de a-l asculta fără critică, evitând bruscarea, culpabilizarea și morala. Este recomandabilă recunoașterea legitimității problemelor sale și evitarea minimalizării dificultăților tânărului (ceea ce pentru noi poate părea o problemă minoră, pentru el reprezintă o problemă majoră).

O altă măsură de intervenție constă în evaluarea rapidă a posibilității unei urgențe suicidale, verificând dacă există idei suicidale continue, dacă dispune de mijloace prin care să-și poată lua viața, dacă a ales locul și momentul pentru a o face. Tânărul trebuie ajutat să se liniștească, să accepte să-și amâne gestul și să fie de acord să primească ajutor profesional. Nu lăsăm adolescentul singur, înainte să ne asigurăm că urgența a fost calmată și în cazul în care observăm că riscul crește, mergem de urgență cu el la un spital.

Totodată îl ajutăm să-și evalueze situația, ceea ce îi va permite să găsească soluții noi, explorând împreună o gamă de alternative posibile și orientându-l spre acțiuni concrete.

Ulterior, contribuim la creșterea stimei de sine, încurajându-l în progresele pe care le face în comportamentele independente, evitând să facem lucrurile în locul lui, favorizând autonomia sa și respectând limitele și capacitățile adolescentului. Încercăm să-l motivăm să-și reia activitățile care îi plac sau care îi plăceau, în măsura în care este capabil și în ritmul său.

Este inadmisibilă sfidarea, provocarea în legătură cu sinuciderea și oferirea *"rețetelor de fericire"* personale.

Toate intervențiile menționate, presupun suportul familiei adolescentului suicidal, implicarea acesteia ca factor favorizant al ameliorării comunicării părinți – adolescenți, al adoptării de strategii mai eficiente în rezolvarea probleme-

lor, al resituării locului adolescentului în interiorul familiei, astfel contribuind la re-conexiunea socială a acestuia.

În *concluzie*, din cele relatate anterior, putem afirma că suicidul la adolescenți este un subiect delicat și totodată dureros, care necesită strategii naționale de prevenire, întrucât ratele de suicid sunt în continuă creștere. Scopul acestor strategii nu ar trebui să se focuseze doar pe stoparea acestui fenomen, ci și pe cultivarea dragostei pentru viață și viitor, la tinerii adolescenți.

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ISTORIA ACTIVITĂȚII BÁLINT LA TG. MUREȘ

■ Dr. Farkas Evelyn, UMFST Tg. Mureș

INTRODUCERE

Am luat cunoștință inițial de metoda Bálint, metodă de perfecționare a medicilor de familie, încă la mijlocul anilor 80 ai secolului XX. Printr-o conjunctură favorabilă am participat în anul 1991 la o Conferință Internațională Bálint la Budapesta, iar în anul 1994 la un grup Bálint tot la Budapesta unde i-am cunoscut pe dr. Harmathy Éva și pe dr. Schnell Endre. În anii 1993 și 1994 am luat parte la câteva grupuri Bálint la Fundația Oasis din Tg. Mureș si la un grup Bálint ținut de Asociația Bálint din România la UMF Tg Mureșîn limba maghiară,în cadrul Disciplinei de Sănătate PublicăȘi Management Sanitar. În anul 1996 am devenit membră a Asociației Bálint din România.

IPOTEZA DE CERCETARE

Ținând seama de experiența altor țări în acest domeniu, împreună cu studențiîn medicină de la UMF Tg. Mureș, unii dintre ei deveniți ulterior membrii Asociației Bálint din România, am încercat, începând din anul 1996, să aplicăm metoda Bálint la universitatea noastră, pentru prima dată la o universitate de medicină din România. În acest sens am beneficiat de sprijinul deplin al conducerii de atunci a universității.

METODA DE LUCRU

Între anii 1996 - 2009 am organizat împreună cu studenții mediciniști grupuri Bálint mici bilunar, iar după o pauză de 3 ani am reușit să introduc metoda Bálint la un curs privind relația medic – pacient, la materia Asistența primară a serviciilor de sănătate, din 2012 pânăîn prezent. În anul 2018 am introdus, împreună cu colegii, mei Munzlinger Ildikó și Munzlinger Attila, la propunerea lor un grup Bálint mic la Sesiunea științifică a studenților mediciniști maghiari, organizat la Tg.Mureș (TDK).

REZULTATE ȘI CONCLUZII

Prin activitatea noastră de 21 de ani am reușit să ne realizăm visele. Grupurile Bálint mici au funcționat la UMF Tg. Mureș în perioada 1996-2009. Unii dintre participanți și organizatori au obținut și succese individuale, obținând premii la concursul organizat pentru studenți la Ascona de către Federația Internațională Bálint, pentru prezentare

de caz prin corespondență (Hegyi Csilla, Wolfhart Karola). În toți acești ani am beneficiat de ajutorul material și moral al Asociației Bálint din România, a Fundației Oasis din Tg.Mureș și al Societății Muzeului Ardelean (EME). Unii dintre studenți au aderat la Asociația Bálint din țara noastră, precum și la Organizația Internațională Bálint Junior, cu ocazia unei conferințe a acesteia, ținută la Budapesta în anul 1998. În anul 2009 activitatea grupurilor mici Bálint a fost suspendată timp de 3 ani datorită unor probleme personale proprii și ale celorlalți organizatori. Începând cu anul 2012 am putut să ridicăm activitatea grupului Bálint de la UMF Tg.Mureș la un alt nivel, reușind să întroduc un curs-grup Bálint mare în curricula universitară la materia Asistența Primară a Stării de Sănătate, la început la ambele secții, apoi, din anul 2013, numai la secția maghiară. La început aceste grupuri se desfășurau cu colaborarea dr. Vajda - Hegyi Csilla și a doamnei psiholog Görög Ilona, care și-au asumat rolul de leaderi de grup, ulterior dr. Bálint Ágnes, medic de familie, doctorandă și cu pregătire în psihologia grupurilor, și-a asumat rolul de coleader (2016), eu având rolul de a conduce grupurile mari studențești (anul VI medicină generală), până în prezent. Avem în urmă 21 ani de activitate Bálint, încununată de succese și bucurii. Doar câteodată am avut insuccese și a trebuit să facem sacrificii. Doresc ca această activitate să fie continuată de colegii tineri care să preia ștafeta de la noi, foștii începători, deschizători de drumuri.

REVISITING BALINT: BALINT GROUPS IN THE INTEGRAL MAP

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This paper is based on a lecture presented at the 25thAnniversary National Balint Conference of the Romanian Balint Association, MiercureaCiuc, Romania,September 27th-30th 2018

Part one: the integral map of Wilber and Balint's approach within it.
Part two: Balint groups – the importance of emotions, relationships and integration

Rezumat: *Articolul se referă la modul în care s-a dezvoltat Abordarea Balintiană de la începuturile ei din anii 60 ai secolului trecut până în timpurile noastre, iar în el se scoate în evidență munca lui Balint, a câtorva contemporani și a școlilor acestora în cadrul Planului Integral a lui KenWilber. Tema esențială supusă discuției este principiul unificator al conducerii Grupului Balint pentru diferitele școli de terapie și practică. Contribuțiile lui Balint la înțelegerea deplină a vieții minților noastre, bazată pe relațiile dintre noi, pe capacitatea de transformare a grupului și rezultatul acestui proces integrativ sunt trecute în revistă, cu detalii în articol. De asemenea se stipulează că Abordarea Balintiană poate juca un rol determinant în dezvoltarea modernă a neuro-științelor, iar în acest scop sunt aduse câteva dovezi. Așa cum un analist poate să se poticnească în timpul unei analize din cauză că "limbajul adult este inutil sau confuz... tocmai pentru că nu există o convenție generală asupra înțelesului cuvintelor"[2], determinând ca acea zonă a minții pe care Balint a denumit-o greșeala de bază să intre în scenă, liderul Balint se poate poticni de procese similare în cadrul grupului. Asta ar putea sugera că pacientul s-a comportat asemănător în cabinetul medical cu ceea ce este replicat în grup, printr-un proces paralel. Dacă liderul de grup reușește să înțeleagă corect această atmosferă, el sau ea poate beneficia de ilustra propunere a lui Balint de a lucra cu pacientul în regres – ce trebuie de făcut și ce nu trebuie făcut - ca să genereze și să mențină în grup o atmosferă ce adaugă elemente semnificative pentru o mai bună înțelegere și pentru a iniția schimbarea pozitivă. Contribuțiile lui Balint sunt interpretate*

și lămurite din punctul de vedere al neuro-științelor moderne, care aduc dovezi actuale pentru teoria lui elaborată de el în trecut. În cele din urmă, sunt ilustrate avantajele metodei ca o practică de grup dint-un punct de vede totalmente informat.
Cuvinte cheie: *grupuri Balint, greșeala de bază, psihologie integrativă, regresie, neuro-știință.*

Abstract: *The article focuses on the development of the Balint Approach since its birth in the 60s of the last century till modern times, and outlines Balint, some of his contemporariesand their schools within Ken Wilber's Integral Map.The essential theme proposed for discussion is the unifying principle of Balint group supervision for diverse schools of therapy and practice. Balint's contributions for the deep understandingof our mental lives, based on our relations to each other, the transforming capacity of the group and the ensuing from this process of integration are reviewed in depth. It is argued that the Balint approach can play an important role and evidence is provided building on the modern development of neurosciences.Just like the analyst may stuck upon moments in analysis when "the adult language is useless or misleading… because words have not always an agreed conventional meaning" [2], prompting that the area of the mind which Balint coined basic faultis entered, the Balint leader might stumble upon similar process in the group.This may suggest that the referent's patient/client has probably behaved likely in the practicewhich is now replicated in the group through the parallel process. And if the leader gets a good grasp of this atmosphere, she/he could benefit from Balint's brilliant proposal how to work with the regressed patient – what shall she/he do or not do in order to provide and hold an atmosphere in the group where meaningful events for understanding and change happen.Balint's contributions are interpreted and elucidated from the point of view of modern neuroscience which gives evidence to the theory elaborated by Balint. And finally, the advantages of the method/approach as group supervision are illustrated from an integrally informed point of view.*
Keywords: *Balint groups, basic fault, integral psychology, regression, neuroscience.*

PART ONE: **THE INTEGRAL MAP OF WILBER AND BALINT'S APPROACH WITHIN IT**

The two main authors that will be continually mentioned throughout the paper are Michael Balint and Ken Wilber. And although this text is not intended as a review of all their work, some of their most popular writings are listed below and are used as a reference to the proposed discussion.

Michael Balint

- *Individual Differencesof Behaviour in Early Infancy.* Dissertation for Master of Science in Psychology. London (1945)
- *Primary Love and Psycho-Analytic Technique* (1956)
- *The Doctor, His Patient and the Illness.* London: Churchill Livingstone (1957)
- *Thrills and Regressions* (1959)
- *Basic Fault* (1967)
- *The Clinical Diary of Sándor Ferenczi.* First cloth edition (1988)

Ken Wilber

- *The Spectrum ofConsciousness* (1977)
- *No Boundary* (1979)
- *The Atman Project* (1980)
- *Up from Eden* (1981)
- *Sex, Ecology, Spirituality* (1995)
- *A Brief History of Everything* (1996)
- *Integral Psychology: Consciousness, Spirit, Psychology, Therapy (2000)*

Wilber – The Integral Approach, AQAL and its Applications

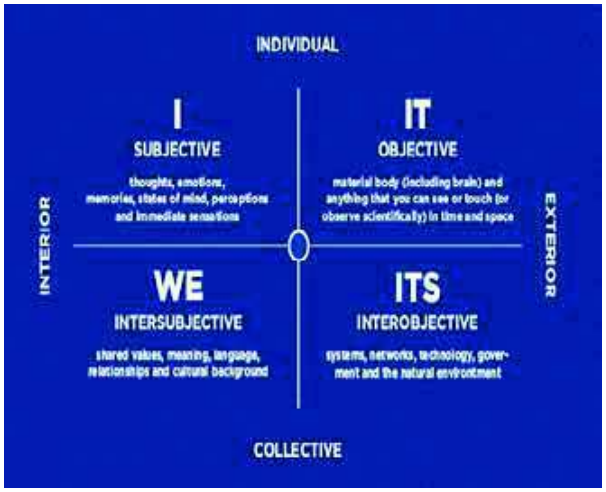
Integral Psychology isone of the most advanced trends of psychology based on the Integral Theoryof Ken Wilber and presents one of the first truly integrative models of consciousness, psychology, and therapy.The beginning is set in the early 70's, with the publication of *The Spectrum of Consciousness*[14]- an attempt to synthesize Eastern religious traditions with Western structural stage theory**.** Not by chance some of the most advanced scientist, philosophers and thinkers today name Wilber asthe*"Einstein of Consciousness"* [13].

Before going to a more thorough review of Wilber's integral map, let's throw a look at the development of Western psychology in the 20th century. Bence Ganti, Wilber's student and associate, draws a map of the Four paradigm shifts in Western psychology during the 20th century[5]. He builds upon Wilber's theory and the natural way of appearance and development of the different psychological theories and schools along the evolutionary path.The shifts are illustrated through the changed viewpoints for the human psyche and the therapeutic methods as a result of the cultural development. The main psychological / psychiatric schools typical for the relevant period are listed.

Four Paradigm Shifts in Western Psychology in the 20th Century

- **1900 – 1960 (Modernism):** FROM ILL TO NORMAL (Psychoanalysis; Behavioral Sciences, Cognitive Therapy)
- **1960** – Humanistic Psychology **(Post-Modernism):** FROM NORMAL TO SELFACTUALIZATION(Carl Rogers, Abraham Maslow)
- **70s & 80s** – Trans-personal Psychology **(Post-Post-Modernism):** FROM NORMAL ***TO SPIRITUAL SELFACTUALIZATION***(Stanislaw Groff, Charles Tart, Roger Walsh)
- **80-s & 90s** – Integral Psychology – FULLSPECTRUM MODEL OF HUMAN CONSCIOUSNESS(Ken Wilber – The Ladder of Psychological Development)

Fig.1. *Four paradigm shifts in Western psychology in the 20th century*



The AQAL Map and Explanation of the Quadrants

Upper Left (UL); ***subjective****:* individual, self, consciousness, experience – **I**
Lower Left (LL); ***inter-subjective:*** culture, worldviews, meaning, collective – **WE**
Upper Right (UR); ***objective:*** object, organism, behavior, thing – **IT**
Lower Right (LR); ***inter-objective:*** systems, (social) structures, networks, environment - **ITS**

According to Wilber,*"…an integral approach is based on one basic idea: "…no human mind can be 100% wrong… nobody is smart enough to be wrong all the time. And that means, when it comes to deciding which approaches, methodologies, epistemologies, or ways or knowing are "correct," the answer can only be, "All of them."*Wilber points out that we need to reach a global psychology where each one would be *integrally informed*[11].

Wilber's ideas grow more and more inclusive over the years and he draws upon the writing of numerous Eastern and Western scientists, philosophers and writers, incorporating each and every sphere of the human life, knowledge and experience. Thus, he creates his integral theory naming it AQAL, meaning *"All Quadrants All Levels"*. According to Wilber, AQAL is one of the most comprehensive approachesto reality - a meta-theory, a hyper-theory, or simply *"theory of everything"*, by the name of his most popular book *A Brief History of Everything* [12] – writing trying to convey his theory in an understandable (digestible)way.

The Integral Map suggests that there are four main perspectives of explaining the world. Thus, all of the existence, all knowledge and experience are placed in a **four-quadrant grid**. The division goes along the axes of *"interior-exterior"* and *"individual-collective"*. In such a way we come up to the four quadrants:

Fig.2.*The AQAL Grid*

Whatever situation/problem/issue we take – it contains in itself all the four dimensions. On the one hand we havethe feelings about it and the way we perceive it (UL); from the second side we have the collective view of the situation and the overall cultural view of the issue (LL); from third we have what the problem is factually of physically about and what kind of immediate behavior it shows (UR); and finally – there is the big systemic view of the issue, which corresponds to the structural boundaries and systems the problem is entrenched in.

And now, if we focus of the UL quadrant, the interior subjective part – we will come across of one of the most comprehensive structural stage theories of human consciousness, developed by Wilber. As mentioned above, in his first book *"The Spectrum of Consciousness",* hesynthesizes the Eastern religious traditions with the Western structural stage theory and describes human development as following a set course of stages of development. Wilber builds upon several structural stage theories of developmental psychology (Piaget's theory of cognitive development; Erikson's stages of psychosocial development, Kohlberg's stages of moral development and Jane Loevinger's stages of ego

development). Yet he goes beyond the personal level of psyche and adds facts from the transpersonal field, thus reaching to his full-spectrum model of human consciousness. He groups these stages into three basic levels: ***pre-personal*** (subconscious motivations), ***personal*** (conscious mental processes), and ***transpersonal*** (integrative and mystical structures). Meanwhile Wilber equates the levels in psychological and cultural development with the hierarchical nature of matter itself.

A convenient and clear diagram of the stages of human development involving the psychological states (including the pathologies) and the corresponding therapeutic interventions is his holistic model of the Evolution of Consciousness [5]. *(N.B.Thestages in the diagram are denoted by alphanumeric code where W stands for Wilber and the bolded letters – for the most appropriate use of the therapeutic modality)*

Psychological states (including pathologies) and corresponding interventions

- W1 psychotic - *psychiatry (medication) – **W1**, W2, W3*
- W2 personality disorder - *psychoanalysis – W2, **W3**, W4, W5*
- W3-4 neurotic - *humanistic psychology – W5, **W6***
- W4-5 normal - *transpersonal psychology – W7 – W10*
- W6self-actualized
- W7-10 spiritual levels (enlightenment)

Fig.3. Holistic model of the evolution of consciousness (after Bence Ganti)

For example – psychoanalyses (including Balint approach) works with levels W2 - W3 -W4 -W5 but is centered on W3 (defense mechanisms, repression, psychodynamic method, early childhood memories and conflicts), while psychiatric treatment and medication are appropriate for W1 (psychosis) and W2 & W3 (major depression for example) but not so adequate for the more advanced levels.

Wilber emphasizes that the different psychological / psychotherapeutic schools and even the spiritual traditions cover just a part of this universal scheme of development. *"Boundaries are illusions, products not of reality but of the way we map and edit reality. And while it is fine to map out the territory, it is fatal to confuse the two"* [11]. The issue is not which school is better or opposing the others, but which are the aspects of the universal scheme covered by the different schools and where are they most adequate and applicable.

Balint - Social and Professional Context, Balint's Contemporaries and Balint's Contributions

And now, having outlined the universal model of the evolution of consciousness and the developmental stages, let's try to locate Balint and his approach within this universal map.

No doubt we need to focus on the 50's of 20th century and the atmosphere when Balint laid the foundation of his approach. The social and professional context of these days was marked by the aftermaths of the Second World War. And taking the professional psychological and psychiatric perspective - the urge to hold on to the human values in an atmosphere of economic, social and political crisis, and not succumb to the burden, grief, misery and destructions of the WWII.

The Predominant Paradigm in Western Psychology wasModernism**:** *from ill to healthy, i.e. normal*, according Ganti's scheme[5]. The mainstream schools already established were Psychoanalysis; Behavioral Sciences, Cognitive Therapy. The general practitioners (family doctors) in that context, especially in England at the beginning of National Health Service, where the Balints (Michael and Enid, his third wife), introduced their method, were under a lot of strain and many did not seem to get the satisfaction they should from their work. They were not at ease with the prevailing attitude of primary doctors opposed to the specialists and second hand*" against "*meaningful" medicine.

This is the context in which Balint introduced new dimension of the idea of psycho-somatic illness and stressed out the importance and the advantages of the family doctors to treat both mind and body at the same time. The endeavors of the Balints led to the Renaissance of family medicine.

The Balint Group is probably one of the earliest methods of clinical supervision. It started as a series of seminars in Londonin the 50's, provided by Michael and Enid Balint – the method name coined after its founders – aimed at helping the family doctors to reach a better understanding of what the two Balints called *"the psychological aspects"* of general practice [1]. The method consisted of case presentation by a referent (the family doctor), followed by a discussion – the emphasis put on the emotional content of the doctor-patient relationship.

Balint has given different names to the group - *Training Cum Research Group (most popular)***,** group discussion, case presentation, discussion seminar, discussion group. The key component of the exercise, in his own words, is*"free atmosphere of give and take where each participant can share his problems with the hope of receiving more clarity from the experience of the other participants"* [1]. The group needs to have a clear structure and rules of leading,

and whatever the professional background of the leader, he/she needs to have undergone training and experience in the specific Balint method. One of the widely cited **lapsus linguae** of Balint is *"To benefit from a group you need at least two years of treatment – I mean training",* which underscores the dual effect ensuing from the participation in a Balint group: the personal aspect – ***"a limited but significant change in the personality"*** of the doctor,and the professional aspect – a family doctor better equipped to understand and reflect the emotional problems of his patients [1].

It is important to outline the closest and farther professional circle around Balint in order to better understand the contributions of his method.

Wilfred Bion, an influential British analyst, one of the first to analyze patients in psychotic states using psychoanalytic technique, is important with his contributions to the developing analytic theories of splitting, projective identification and the use of counter transference. The listed terms together with his elaboration on the group dynamic, delineating the three basic assumptions states of the group (dependency, fight or flight, pairing) against the working state of the group [3], are very important in providing further explanation of the functioning of the regressed patient. The way this is reflected in the Balint group when the referent presents a case with a regressed patient throws light on the parallel process [1] in the group. When a group adopts one of the three basic assumption states instead of the working state – this interferes with the task the group is attempting to accomplish. The hypothesis here is that the group, through the parallel process, will similarly regress or rather – different group participants would mirror the different splatted parts of the patients' psyche, suggesting that the patients has been functioning from the state of the basic fault [2].

Another eminent figure of the time is **Viktor Frankl**, the Austrian neurologist and psychiatrist who survived the Holocaust. He is the founder of logotherapy, a form of existential analysis, being cited as *"The third Viennese School of Psychotherapy"*.Frankl's experience in the concentration camp contributed to the founding of logotherapy and the author's search and finding of meaning in all forms of existence, even the most brutal ones. Not by chance Frankl contributed a lot to the school of humanistic psychology. Although not directly linked to Balint's studies, the experience of Frankl relates much to Balint's personal involvement, the loss of his parents during the Nazi period, and his deep understanding of the human psyche and relationships reflected in his works.

The American psychologist, **Carl Rogers** is widely considered to be one of the founding fathers of psychotherapy research and the founderof the Client-centered approach of the school of Humanistic psychology. He is thought to be one of the most eminent thinkers in psychology and cited by different authors and schools for the forging of the three core conditions necessary and sufficient for achieving a therapeuticchange: unconditional positive regard, genuineness (authenticity) and accurate empathic understanding plus non-possessive warmth. In person (client) centered therapy the focus is on the person, not on the problem and the aim is the client to achieve greater independence. *"The curious paradox is that when I accept myself as I am, then I can change [6]"*.

Another famous figure form the Humanistic psychology school is the American psychologist **Abraham Maslow**, most popular for his *"Hierarchy of Needs Scale"*. In a review of General Psychology survey from 2002Maslow was ranked as the tenth most cited psychologist of the 20th century. He is often quoted to have said *"In any given moment we have two options: to step forward into growth or to step back into safety"*.

This elucidates the hierarchy of needs and their ranking starting from the bottom up: physiology, safety, love/belonging, esteem, and self-actualization. The hierarchy of human needs model suggests that human needs will only be fulfilled one level at a time. According to Maslow's theory, when a human being ascends the levels of the hierarchy, he/she may eventually achieve self-actualization, but self-actualization is not an automatic outcome of fulfilling the needs of the lower levels [7].

And the last two authors, the British analysts Donald Winnicott and John Bowlby, are importantnot only because they belong to the same group like Balint - *The Independentor Middle Group of British analysts* -but also because the theoretical foundationsthey put much brilliantly with the advancement in neuroscience today, throwing new light on the work of Balint with the regressed patient. Representatives of the Object Relations School, both of them are known for their involvement in early child development and psychology and emphasize that the primary motivation of the child is object-seeking rather than drive gratification.

Donald Winnicott, author of some of the most enduring theories of the child, coined terms such as the *"transitional object",*the *"holding environment"*andthe *"good enough mother",*concludes that *"The foundationsof health are laid down by the ordinary mother in her ordinary loving care of her own baby"* [15].

John Bowlby, notable for his interest in child development and his pioneering work on the Evolutionary Theory of Attachment, strongly emphasizes that *"attachmentis a deep and enduring emotional bond that connects one person to another across time and space"*[4]. The has been described as the dominant approach to understanding early social development and has given rise to numerous empirical research and studies into the formation of children's close relationships. There are four basic characteristics that basically give clear understanding of what attachment really is. They include a safe heaven, a secure base, proximity maintenance and separation distress. There four attributes are evident in the relationship between the child and his/her caregiver and present a base for a series of discoveries in the sphere of neurosciences [8].

THE ANALYTICAL BACKGROUND AND BALINT'S CONTRIBUTIONS

To delineate Balint's contribution among this colorful palette of thinkers in the sphere of analysis, psychotherapy and developmental psychology, we should remember that he was proponent of the object relation school and part of the independent tradition in British psychoanalysis. He had the habit of calling himself *"on the fringe"* of the analytical movement. Balint was very interested in the mother-infant relationship and early in his career wrote a key paper on *"Primary Object-Love"*(1937), continuing further to develop this concept until finally his seminal book, ***"The Basic Fault. Therapeutic Aspects of Regression (1967)"*** - was published, uniting his earlier works: *The Three Areas of the Mind (1957), Primary Narcissism and Primary Love (1960), The Regressed Patient and his Analyst (1960) and The Benign and Malignant Forms of Regression (1965)*[2].

Key for understanding Balints therapy with the regressed patient is his elaborationon the concepts *"areas of the mind"* and *"levels of work"*. According to him there exist three areas of the mind, listed backwards:No 3 –The Area of the Oedipus conflict; No 2 – The Area of the Basic Fault; No 1 – The Area of Creation.

In the ***Area of Creation*** there exists no external object which means that no object relationship and no transference are available. The subject is in his own and his main concern is to produce something out of himself, but the process of Creation, i.e. the turning of the pre-objects or object-embryos into proper objects is unpredictable.It is important here to make the comparison of these concepts with Bion's concepts of alfa & beta elements and alfa function. Balint himself has not written too much about the analytical foundations of the process in the Balint group except for reference to the parallel process. That's why researchers often resort to the in-depth writings of Bion to explain Balint.

In the ***Pre-Oedipal (non-verbal) level*** is impossible to use the adult language because the interpretation is not understood as such by the patient. (NB. Compare here the similarity of concepts with Ferenczi's *"Confusion of Tongues between the Child and the Adults"*). Patients on this level are often described as *"deeply disturbed"*, *"profoundly split"*, *"highly narcissistic"*, *"with immature ego"*, etc.

In the ***Oedipal level*** the adult language is an adequate and reliable way of communication and the analysts' interpretations are experienced as interpretations.

Pursuing this conclusion about the areas of the mind, Balint states that two possible levels of analytic work exist: that on the Oedipal level and that on the Pre-Oedipal level, while there is no possibility to work on the area of Creation because of the lack of external objects and resulting from this lack of transference and object relationship.

Balint continues to further elaborate these concepts and takes the view that it is not proper to name a level with what it is, i.e. Pre-Oedipal, but to try to give an adequate explanation and a respective name. In such a way he coins the concept ***Basic fault*** to replace the previous name of Pre-Oedipal and continues with thorough distinction between these two levels, as follows:

Characteristics of the Oedipal Level	Characteristics of the Level of the Basic Fault
1. Everything at the Oedipal level – whetherit relates to genital or pre-genital experiences – happen in a **triangular relationship**	1. All the events that happen on that level belong to an exclusively **two-person relationship**
2. It is **inseparable from conflict -** caused by ambivalence arising in the complexities of the relationship between the individual and his two parallel objects (conflict is subject to solving)	2. This two-person relationship is of a particular nature – entirely different from the well-known human relationship of the oedipal level. It is ***Primary object relation = Primary Love***
3. At this level **the adult language is an adequate and reliable means of communication**	3. The nature of the dynamic force operating at this level is not of a conflict, but of a **fault, a mistake, a deficit, something missing, erroneous, broken or damaged**

	4. **Adult language is** often **useless or misleading** in describing the events at this level, because words have not always an agreed conventional meaning

Fig.4. Comparison of the Characteristic of the Oedipal Level and the Level of the Basic Fault

Psychoanalysis begins at level 3 (the Oedipal level) where the patient is capable of a three-sided experience – the Oedipal problems between self, mother, and father. The area of the Basic Fault is tricky with its exclusively two-person relationship and is a great challenge to the analyst/therapist success. Therapeutic failure is attributed by Balint to the analyst's inability to *"click in"* to the mute needs of the patient who has descended to the level of the basic fault' [2].

Balint maintained that 'the basic fault can only be overcome if the patient is allowed to regress to a state of oral dependence on the analyst…and experience a new beginning" [2]. Balint described three primitive (pre-verbal) object relationships in the regressed patient and coined the respective terms for them:

Primary Love(Primary relationship) - the most primitive **harmonious interpenetrating mix-up** between the developing individual and his primary substances or his primary object

Ocnophilia – relationship between the individual and his primary objects in which the life of the *ocnophilic*individual is safe only in close proximity to objects, i.e. clinging; being separate is experienced as horrid and dangerous. It is Interesting to compare this concept to the concept of the *"attachment behaviour"*of Bowlby (1958).

Philobatism – relationship between the individual and his primary objects in which the philobatic individual experiences the objects as unreliable and hazardous and is inclined to dispense with them and seek out the friendly expanses.

Typical for all three forms of primitive relationship is that the individual demandsto be allowed to take one's objects,or environment for granted; they simply cannot have any interest of their own; their only concern must be the preservation of the harmony – whatever the cost to them.

Thinking about regression – its functions and its use - Freud is the first one to elaborate on this topic and proclaim that regression has four roles: (1) mechanism of defense, (2) factor of pathogenesis, (3) specific form of resistance and (4) important ally in therapy. All the good but it's obvious that these are studied only within the limits of ***one-person psychology***. Balint is the one to describe a fifth, very important characteristic: (5) the role of regression in the object relations. Regression has both **intrapsychic** and **interpersonal** aspects and the latter are crucial for the therapeutic effect. Regression is only ***one symptom*** of the interaction between the patient and his analyst and this interaction has at least three aspects. These aspects are determined by the way in which the regression is: (a) recognized by the object (analyst); (b) accepted by the object; (c) responded by the object.

Balint makes difference between the benign forms of regression and the malignant forms of regression of the patient,because being capable of making this differential diagnosis is crucial for the analyst's behavior, attitudeand stance in order to achieve therapeutic success.

Differential Diagnosis between Benign Regression and Malignant Regression

Benign Regression	Malignant Regression
1. Not much difficulty in establishing a mutually trusting atmosphere reminiscent of the primary relationship	1. Precariously balanced mutually trusting atmosphere; frequent symptoms of desperate clinging as safeguards against possible breakdown
2. Regression leading to a true new beginning and ending in a real new discovery	2. Malignant form of regression - several unsuccessful attempts at reaching a new beginning; unending spiral of demands and needs; development of addiction-like states
3. Regression for the sake of recognition, in particular, of the patient's internal problems	3. Regression is aimed at gratification by external action
4. Only moderately intensity of demands, expectations or "needs''	4. Suspiciously high intensity of demands, expectations, or 'needs''
5. Absence of signs of severe hysteria in the clinical picture and of genital-orgastic elements in the regressed transference	5. Signs of severe hysteria in the clinical picture and of genital-orgastic elements both in the normal and in the regressed form of transference

Fig. 5. Differential Diagnosis between Benign Regression and Malignant Regression

Taking into account the information from this differential diagnosis, the analyst should abide to the following recommendations of what is preferable to do and what to abstain doing when working with the regressed patient.

The Analyst and the Regressed Patient

What can the analyst do?	What to try to avoid
To accept acting-out in the analytic situation as a valid means of communication, without any attempt of speedily organizing it by interpretation	To avoid becoming or even appearing in the eyes of his patient as "omnipotent and omniscient"
To be present at adequate distance - neither far- away (abandonment), nor too close (suffocating) – the aim is that the patient should be able to find himself	Avoid premature interpretations of transference in attempt to pull the patient at Oedipal level - danger of ocnophilic interpretations
To offer "something" to the patient which might function as a primary object - i.e. to provide primary object that can be cathected with primary love (! Mind the difference between "giving primary love" and "offering oneself" to be cathected with …)	To accept the regression & avoid unnecessary pressure – the patient needs an unobtrusive environment/ climate in order to stop the tendency of developing relationshipsof inequality between himself and his objects
The analyst must function as a provider of time & and of milieu NB. compare this to the "good enough mother" of Winnicott	Not to aim or behave all the time as a separate, sharply contoured object - i.e. to accept the role of a true primary substance, which is there, which cannot be destroyed (like the water and the earth)

Fig. 6. The Analyst and the Regressed Patient – Recommendation for Practice

And as a conclusion, while making a summary of Balint's insights, ideas and concepts for thesetruly provoking moments of working with the regressed patients – which we will see further how they relate to the atmosphere and the process in a Balint group – we come to the understanding that providing atmosphere and relationship are crucial for the therapeutic success [2]:

(1) Providing an atmosphere in which the regressed patient can find him/herself and ***make a step towards "new beginning"***is an important part of the therapeutic task;

(2) Apart from being a ***"need-recognizing"***and perhaps even a ***"need-satisfying"*** object, the analyst must be also a ***"need-understanding"*** object, who, in addition, must be ***able to communicate his understanding to his patient;***

(3) ***Providing and holding an atmosphere*** in which ***therapeutically meaningful events*** happen is of crucial importance. It's important also that the patient is given possibility to understand his own and those of the analyst **contributions** to this atmosphere. Compare here to the concept of ***"the mutual investment fund"*** introduced by Balint for the doctor-patient relationship [1].

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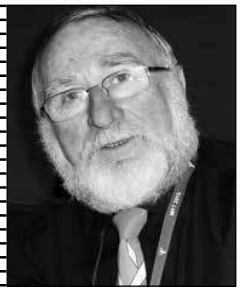
ȘTIRI DIN VIAȚA ASOCIAȚIEI

Albert Veress - Miercurea Ciuc



4-7 APRILIE 2019: A IV-A CONFERINȚĂ NAȚIONALĂ BALINT, CHIȘINĂU

Dragi colegi,

Îmi rup din puținul timp dintre două conferințe Balint, pentru ca cea de-a doua conferință unde voi participa în acest weekend la Plovdiv, să nu estompeze impresiile de la Chișinău. Voi atașa și câteva din sumedenia de fotografii, pentru cei care aveți cont Facebook unde le puteți vedea. Pentru început amintesc punctat câteva impresii:

- bine-cunoscuta ospitalitate călduroasă și implicare totală a soților Taranov-Calancea.
- un program încărcat pretențios pentru vineri și sâmbăta din care o parte a rămas doar pe hartie (nu ne-am plâns!)
- vizita la sediul Asociației Balint din Moldova în care pe lângă secretariat și sala de grup există un spațiu pentru grădiniță, unde pot petrece timpul copiii balintienilor participanți la activități
- un secretariat numeros, dotat cu cele necesare pentru preluarea banilor, eliberarea chitanțelor și bonurilor de masă de diferite culori
- efectul clădirii impozante a Spitalului Republican a fost mai mare decât incomoditatea spațiilor pentru grupuri: grupul mare s-a ținut pe podiumul amfiteatrului imens, iar grupurile mici, unele, au avut loc in săli cu scaune fixe în care ne-am așezat aproape în șir indian.

Mă opresc la aspecte pe care le consider mai importante - să ne gândim la a urma exemplul colegilor din Moldova: - tema conferinței foarte bine aleasă -Profilaxia Sindromului Burnout la personalul medical, - numărul impresionant de parteneri înșirați pe pliantele / afișele conferinței: IMSP Spitalul Clinic Republican *«Timofei Moșneaga»*; Școala de Management în Sănătate Publică a USMF *«N.Testemițanu»*; Agenția Națională pentru Sănătate Publică; Societatea Psihiatrilor, Narcologilor, Psihoterapeuților și Psihologilor Clinicieni din Moldova; Universitatea de Stat din Moldova; Asociația Balint din România, Institutul pentru Studiul și Tratamentul Traumei din România, Asociația Psihologilor din România, Asociația Social Link din Romania, Iași; Asociația Expert Psy din România, București; College of Medical Sciences SUA.- mediatizarea bine organizată.
Iată câteva linkuri:

https://usmf.md/ro/noutati/medicii-sunt-cei-mai-predispusi-sa-faca-burnout-profesional?fbclid=IwAR1ImJFNqt83Ke8hy9p0TBf628Y1FpT4hHWGKCfOezeUbtcbBIBSKVufXEk,
https://ru.publika.md/moldavskie-vrachi-vse-chashhe-stradayut-ot-sindroma-yemocionalno goygoraniya_2178385.html?fbclid=IwAR3tlDPWt6EvaD7MPZ27rnFqPTVgxk3eVvzJ_AdYVlGDSbF1qqiwlOBzdus#ixzz5kP7SWUmg
http://www.sanatateinfo.md/News/Item/8432?fbclid=IwAR17heWF9lVsH6KevdMZ1jAaiu-NcR33zlepzWF8AJUycrX837dEyd2z5Qg
https://www.facebook.com/canal3.md/videos/2349648508613922/UzpfSTEwNjcyNzI5ODg6MTAyMTUzMDkyODUyMTk4NjQ/
https://www.trm.md/ro/buna-dimineata/buna-dimineata-din-8-aprilie-2019-partea-i-a.

La întoarcere grupul nostru din microbuz a început căutarea temei pentru conferința noastră din septembrie. Iată o variantă la care am ajuns până acum: Abordarea multidisciplinară a adicțiilor/adicției în practica cotidiană/ contemporană.

Așteptăm să veniți cu idei pentru a o putea promova și pregăti.

Cu drag, Ilona Görög

13-14 APRILIE, 2019: CONFERINȚA NAȚIONALĂ A ASOCIAȚIEI BALINT DIN BULGARIA, PLOVDIV:

Dragi colegi, notez câteva impresii de la conferința Societății Balint din Bulgaria (BBS) (14-15 aprilie) la care am participat alături de Éva și Berci.

Ca și la Chișinău, au predominat prezentările. A fost doar

un grup mare Balint demonstrativ și două grupuri demonstrative cu metode inrudite: psihodrama-Balint ţinută de mine, și un grup de prelucrare a unei dileme morale, ținută de Silviya, pe care sper să o experimentăm éi la noi.

Toate lucrările ppt. au avut dublu text, bulgară și engleză. Autorilor li s-a cerut să le predea cu traducere, iar traducerea prezentării mele despre psihodrama-Balint a fost făcută de Vesselka, care ne-a tradus și în timpul grupului demonstrativ (poate v-o amintiti, a fost la conferința noastră 2018).

Berci a cerut instantaneu autorilor să ne trimită pentru Buletin lucrările din domeniul oncologiei, iar eu le-am amintit că, dorim să avem în Buletin și o secţiune cu ştiri de la parteneri.

Sâmbătă d.m. a avut loc adunarea lor generală, iar pe noi ne-a condus la un tur bine planificat doctorița minunată, chirurg-oncolog, Vanya Baleva, cu care am cutreierat în numai 2 ore si jumătate 3 din cele 7 coline pe care este așezat Plovdiv, incluzând două muzee și o pauză de cafea.

Noua președintă a BBS este Ecaterina Vitkova, psiholog, colega cu care a venit Gergana la Sohodol. Ne-au explicat, că regulamentul lor nu permite alegerea consecutivă în aceeaşi functie mai mult de 2 mandate. Gergana rămâne în birou, poate ca secretară. Funcțiile vor fi discutate/decise la prima ședintă a noului birou. Noi am cerut ca Vesselka să rămână persoana de contact. Sigur vom continua corespondența cu cei pe care le-am cunoscut mai bine! Mai mulţi membri ai BBS sunt cadre universitare: de exemplu, Silviya Aleksandrova-Yankulovska predă bioetica. In conducerea grupului se simte puternic că, mai mulți membri au formare în psihanaliză.

Grupul mare a fost condus de o colegă plecată de câțiva ani în Germania, Dr.Galia Petrova-Popova, împreună cu psihiatrul psihanalist Kimon Ganev, colider (i-ați putut citi un articol in Buletin). În faza de lucru membrii grupului au împărtășit mai întâi emoțiile proprii trezite de prezentare, mai apoi au căutat imagini metaforice pentru înțelegerea aspectelor lăuntrice ale situației.

Acum Galia lucrează la un spital de stat în Germania, unde a pornit un grup Balint. Din păcate a și plecat imediat după grup, asa că nu am avut ocazia s-o întreb care este recunoasterea acestor participări. Am întrebat-o în schimb pe Gergana, care ne-a explicat că cei care vin au diverse apartenențe profesionale, și practică grupul Balint din interes propriu. Creditele înscrise pe certificatele eliberate sunt luate în calcul doar în procesul de formare a liderilor de grup. Au 22 lideri formați de-a lungul anilor, 5 dintre ei primind diplomele în cadru festiv la această conferință.

Cina amicală la care ne-au invitat a fost într-un restaurant cu decor și muzică tradițională. Nu a fost inclusă în taxa de participare - au participat doar cei mai motivați, achitându-și consumul, inclusiv pentru noi, deși am fi dorit să contribuim.

Au fost mai multe avantaje cu călătoria într-o singură mașină, dincolo de costul mai mic: am împărtășit impresii, am clarificat unele aspecte pe care traducerea *"la ureche"* sau mai de la distanță nu ni le-a transmis exact, am discutat idei privind colaborarea cu BBS, Asociaţia din Moldova şi Soc. Maghiară Balint, întâlnirea de la sfârșitul lunii cu consiliul IBF și conferința noastră din septembrie.

Vă rog să veniți cu propuneri dacă să fie invitați şi din partea unor instituții, autorități, universitari? Să cerem traducerea în engleză a prezentării separat (două proiectoare) sau în cadrul fiecărui diapozitiv? Ce program social-cultural să realizăm? Să asigurăm creditarea prin căile deja amintite (colegiile județene ale medicilor? Asoc. Med. Familie? alte idei?). Timpul ne presează să fixăm tema, să anunțăm data timpurie de înscriere; data până la care se acceptă rezervarea, dacă dorim să avem hotelul Express pentru noi, trebuie să știm dacă vom putem ocupa toate camerele).

Cu drag,Ilona

17-19 MAI, 2019: WEEKEND NAȚIONAL BALINT DE VARĂ, BĂILE BÁLVÁNYOS.

Rolul de gazdă și organizator local i-a revenit vicepreședintei noastre, Baka Tünde, care s-a achitat cu brio de ambele sarcini. Ne-a surprins și de această dată cu inițiativele ei în efectuarea ecusoanelor, al programului întâlnirii și al cadoului oferit fiecărui participant. Bravo ei!.

31.V.-2.VI.2019: CONFERINȚA NAȚIONALĂ A ASOCIAȚIEI PSIHOSOMATICE BALINT DIN UNGARIA, BUDAPESTA:

Notez câteva idei *"la călduț"* privind participarea noastră, a unui grup de 5 colegi, la Conferința *"Roots and Routes"* a Societații Maghiare de Psihosomatică MB și la Ședința consiliului IBF.

Programul a fost destul de încărcat, pentru ca pe lângă 4 grupuri mici, grup mare și sesiune de prezentări, o după

amiază a fost dedicată vizitării locului unde a activat Michael Balint, unde a fost înființată- prima clinică de psihanaliză. Acolo au fost cuvântări și s-au așezat coroane de flori din partea IBF și organizatori.

Am fost repartizați în grupuri mici diferite - așa ca fiecare a venit cu experiența muncii cu lideri diferiți. Au fost aspecte *"creative"* în grupuri, dar liderii au solicitat în mod similar ca participanții să împărtășească mai întâi emoțiile stârnite de cazul prezentat și apoi fanteziile ce se asociază.

Personal am urmărit mai cu atenție aspecte organizaționale și de recunoaștere/acreditare:

La ședința consiuliului am aflat că Societatea Balint din Germania - este o societate exclusiv medicală, doar medicii sunt membrii plini, psihologii pot participa, dar au statut de membru extraordinar, nu au drept de vot. O colegă din Finlanda a cerut să fie primită în IBF ca membru individual pentru că acolo psihologii nu sunt acceptați în Soc. Balint. Cel mai revoltați față de aceste situații au fost cei din grupul englez, reproșând că nu se respectă spiritul balintian. În alte țări componența este mixtă, aspectul comun este că *"oferă îngrijire"*.

IBF-ul nu pare să ia poziție, nu stabilește/impune standarde minime - acceptă pe toți cei care se declară *"balintian"*. Cum a formulat pertinent Berci la grupul final - experiența definitorie este de *"unitate în diversitate"*.

Acum, dacă ați citit până aici, urmează ce este mai important - se caută oferta de găzduire a Congresului IBF 2021. Ce ziceți, ne inhamăm? Propunerea ar trebui formulată, trimisă până la mijlocul lunii iulie. Vă rog să vă exprimați cât mai rapid și să luăm o decizie împreună!

Görög Ilona

PLANURI DE VIITOR

Albert Veress - Miercurea Ciuc

27-29 SEPTEMBRIE, 2019:
A XXVI-A CONFERINȚĂ NAȚIONALĂ BALINT,
PREDEAL, HOTEL EXPRESS.

Cazare 29 euro dbl. sau sgl., 43 euro/apt./4 pers./. (+3 RON taxă stațiune/pers./zi). Taxă de participare: 40 euro pentru membrii Asociației Balint, 50 euro pentru nemembri. Cina din 27. IX. și prânzul din 28. IX. câte 35RON, Banchet pentru însoțitori: 28. IX.: 60 RON (pentru membrii ABR cu cotizația plătită la zi și participanți nemembri este inclusă în taxa de participare). Termen de înscriere și de rezervare a cazării: 20 septembrie la adresa de e-mail abr.secretariat@gmail.com sau la nr. de telefon Pap Maria Mihaela: 0727-357.631

CONFERINȚA NAȚIONALĂ BALINT DIN BULGARIA-PLOVDIV, 13-14. APRILIE 2019

WEEKEND NAȚIONAL BALINT DE VARĂ, BĂILE BALVANYOS, 17-19 MAI, 2019

CONFERINȚA NAȚIONALĂ BALINT DIN UNGARIA-BUDAPESTA, 31.V.-2.VI. 2019

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