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Fundamentals of suicidology

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PREFACE

According to WHO (2021) due to suicides in the world, about 1 million people die annually (on average, 11.4 cases per 100 thousand people), while the Russian Federation traditionally occupies one of the leading places in terms of completed suicides (17.1 per 100 thousand population according to data for 2022). Despite the scale of this problem, in many regions of the country, suicidological services began only a short time ago, and the level of awareness of psychiatrists, clinical psychologists, psychotherapists in relation to this problem is often insufficient due to the deficiency of actual literature on this profile.

The work was based on the results of the generalization of data reflecting the most generally accepted approaches in modern clinical psychiatry and suicidology, and many years of teaching at the Department of Psychiatry, Narcology and Psychotherapy of the Volgograd State Medical University were also used.

The manual reflects the theoretical foundations of suicidology, the principles of organizing suicidological service in the Russian Federation, methodological aspects of crisis therapy and prevention of suicidal behavior. These measures will allow students to acquire relevant clinical knowledge, skills applicable in the practical activity of the doctor, to form clinical thinking.

1. Suicide as a phenomenon, causes, risk factors, antisucidic factors of a personality.

Suicidology is a field of psychiatry that studies the causes of suicides and develops methods for preventing and preventing them.

As an independent scientific discipline, suicidology was formed only in the middle of the 20th century. The emergence of this concept as a scientific term we owe P.G. Rozanov, who first used this concept in his work “Of suicide” (1891).

Suicidology is a complex multidisciplinary science. Based on a number of related sectors of scientific knowledge: psychology, psychiatry, pedagogy, social, jurisprudence - it comprehensively studies suicidal behavior. To distinguish suicidology into a separate scientific discipline allows its own object and subject of research, as well as the theoretical, terminological and methodological apparatus.

Basic concepts in suicidology

Suicide is a purposeful deprivation of self -life. The term “suicide” was first used in the book Brown's “Relygio Medici”, written in 1635 and, which saw the light in 1642 (quotes: Alvarez A., 1971). However, individual authors believe that (Daube D., 1972; Hyde D., Blokh C, 1998), this term appeared already in the 12th century.

Suicidal behavior is a more voluminous concept. Actually, any internal and external forms of mental acts are called suicidal behavior, directed by ideas about depriving themselves of life. It should be noted that the term “behavior” combines a variety of internal (including verbal) and the external form of mental acts, which, according to modern psychological views, are in relations between genetic kinship.

Internal forms of suicidal behavior include suicidal thoughts, ideas, experiences, as well as suicidal trends that are divided into plans and intentions. The listed series of concepts, on the one hand, reflects the differences in the structure, in the subjective design of suicidal phenomena, and on the other hand, represents the scale of their depth or readiness for the transition to external forms of suicidal behavior.

It is practically advisable to use three steps of this scale, and to highlight in front of them, a special one, a reinjected “background” in the form of anti-vital experiences. Thoughts about the absence of the value of life that are expressed in the formulations of the type: “do not live”, “you will not live, but you exist”, etc., where there are still no way of life, there is a denial of life, will be hidden.

The first step is passive suicidal thoughts. They are ideas, fantasies on the topic of their death, but not on depriving themselves of life. An example of this is expressing: “It would be good to die”, “fall asleep and not wake up”; “If something happened to me and I would die ...”, etc.

The second step is suicidal planning. This is an active form of manifestation of suicidality, that is, the tendency to compare, the depth of which increases parallel to the development of the plan for its implementation. Methods of suicide, time and place of action are thought over.

The third step is suicidal intentions. They suggest adding to the idea of a solution and a volitional component that encourages a direct transition to external behavior.

The period from the occurrence of suicidal thoughts to attempts by their implementation is called **presuicide**. Its duration can be calculated by minutes (“acute presucyde”) or months (“chronic presuycide”). With prolonged presuicide, the process of developing internal forms of suicidal behavior clearly follows the stages described above. However, this sequence is not always found. In acute presuids, suicidal thoughts and intentions can be observed immediately - without previous steps.

External forms of suicidal behavior include suicidal attempts and completed suicides. The “completed suicide” is understood to mean death from damage caused to itself.

The term “**suicidal attempt**” refers to an attempt to injury or suicide, which did not lead to death.

Demonstrative-blackmail suicidal behavior involves not depriving oneself of life, but by the subject of this intention to demonstrate to attract the attention of others.

Parasuicide behavior is characterized by a self -mutilation, which is usually done in order to reduce the experienced emotional stress or the discharge of aggressive affect.

True suicidal acts are characterized by the consistent implementation of the deliberate plan of suicide.

Causes of suicide

The World Health Organization lists about 800 causes of suicide. Among them:

41% are unknown;

19% - fear of punishment;

18% - mental illness;

18% - household dysfunction;

6% - interpersonal relationships;

3% - money losses;

1.5% - fatigue from life;

1.2% - physical diseases.

Risk factors

Suicidal behavior has many reasons. It is associated with a whole complex of factors interacting with each other and creating a real danger to humans. It includes:

• mental factors, such as deep depression, schizophrenia, drinking alcohol and drugs and anxiety disorders;

• biological factors or genetic features (the presence of suicides in a family history);

• life events (loss of a loved one, loss of work);

• psychological factors, such as interpersonal conflict, cruel treatment or history of physical and sexual violence in childhood, as well as a sense of helplessness;

• Social and environmental factors, including the availability of suicide means (firearms, poisonous gases, drugs, herbicides and pesticides), social isolation and economic difficulties.

Antisucidal factors of personality

Antisucidal factors of a personality are formed positive life attitudes, a life position, a set of personal factors and the psychological characteristics of a person, as well as mental experiences that impede the implementation of suicidal intentions.

These include:

- a strong sense of duty, determination;

- concentration of attention on the state of one's own health, fear of causing physical harm to yourself;

- taking into account public opinion and avoiding the condemnation of others, ideas about suicide shallow and rejection (condemnation) of suicidal behavior;

- the presence of life, creative, family and other plans, ideas;

- the presence of spiritual, moral and aesthetic criteria in thinking;

- plan of near future and life prospects;

-attachment to relatives, close people, the degree of significance of relations with them;

- level of religiosity and fear of sin of suicide;

The formation of antisucidal factors:

• constantly communicate with the child, do not leave him alone with his thoughts;

• strengthen confidence in their abilities and capabilities;

• inspire optimism and hope;

• show compassion, surround themselve with warmth and understanding;

• exercise control over the behavior of the child, analyze his relationship with peers.

The more antisucidal, life-affirming factors have a person, in particular a teenager, the stronger his “psychological protection” and internal self-confidence, the stronger his antisucidal barrier.

2. CONCEPTUAL MODELS OF SUICIDES.

There is no single theory of suicide. The question still remains open, which is primary: biological programming for self-destruction, mental disorders, personality deformations, or a behavioral (psychological) strategy acquired from family members aimed at finding a way out of a crisis situation only in a suicidal way.

Experts from different fields of knowledge interpret the nature of autoaggressive behavior in different ways.

The medical model of suicide.

Suicide is a sign or consequence of an illness. The disease is the result of the interaction of certain causes (genetic, biological, etc.) of a person and the environment (physical, psychological and social conditions). Therefore, when developing preventive programs, it is necessary to take into account the specific etiology of the disease, the psychological characteristics of the human condition and environmental conditions.

Proponents of the medical model consider psychological and behavioral disorders to be the most common etiological factor of suicide. Successful prevention programs require timely diagnosis and appropriate treatment of mental disorders.

The psychopathological concept of suicide.

French psychiatrist Philippe Pinel wrote about the link between suicide and mental disorders. In the "Medical and Philosophical Description of Mental Illness," he described "melancholy with a suicidal tendency."

The psychopathological concept of suicide was substantiated by Pinel's pupil, the French psychiatrist of the XVIII century Jean-Etienne-Dominique Esquirol. The result of his forty years of psychiatric activity is reflected in the textbook "On mental illness." Esquirol strongly associated suicide with mental

pathology. He considered suicide as a product of a painfully altered psyche, qualifying suicidal symptoms as a symptom of mental illness. "Suicide shows all the signs of the mental illness of which it is a symptom," he wrote.

de Tour identified four forms of suicide: manic, automatic or impulsive, suicide in melancholics and obsessive-compulsive.

The famous psychiatrist Sergei Sergeevich Korsakov (1854-1900) did not so clearly associate mental illness with suicide. He did not rule out the possibility of interpreting suicide as unrelated to a person's mental state. His reasoning has not lost its relevance today. He wrote: "Suicide is a phenomenon that often occurs in life and belongs to the number of acts that do not go beyond the scope of activities that a completely normal person can commit. Indeed, when a person decides to commit suicide out of a sense of duty or based on the requirements of reason, it can be in his right mind. But statistics show that most suicides come from psychopathic families and often present acute signs of mental instability.

According to the concept of the founder of suicidology in the USSR A. G. Ambrumova (1971), each case of suicide is the result of the interaction of situational, personal and psychopathological factors. She considered suicide as a consequence of the socio-psychological maladaptation of the individual to the conditions of the conflict she was experiencing.

In modern American psychiatric guidelines, mental health is also considered a very significant factor in committing suicide. In the United States, 95% of people trying to commit suicide have been diagnosed with mental and behavioral disorders. Depressive disorders account for 80% of this number, schizophrenia – 10%, dementia or delirium - 5%.

The biological concept of suicidal behavior.

Consideration of suicidal behavior as a clinical phenomenon indicated the presence of some specific pathological changes in the body of a suicidal person. Since the beginning of the 19th century, when suicidal behavior was considered within the framework of the medical model, until today, the search for the biological basis of suicide has been underway.

Since the second half of the 20th century, biological predictors of suicidal behavior have been actively studied. Biochemical correlates, physiological, neurophysiological and other parameters of the body's vital activity that can potentiate suicidal behavior are being studied. To date, no unambiguous biological predictor of suicidal behavior has been found, although proponents of the neurochemical and genetic hypotheses of suicide have identified a number of factors that allow us to identify some biological patterns of suicidal behavior formation, which in the future can be used to create differentiated therapeutic programs.

Anatomical and anthropological direction

Anatomical and anthropological studies of suicidal behavior began to be actively conducted in the 19th century. The British doctor F. Winslow summarized his research and the data of Esquirol, Falre and other scientists in the book "Anatomy of Suicide". In some observations, he also revealed a "disorganization" of the heart.

In the future, the researchers limited their search to the area of the brain in which they tried to find a kind of "suicide center". The result of the research was the conclusion not only about the absence of specific anatomical and anthropological markers of suicidal behavior, but also about the absence of a direct relationship between suicidal behavior, anatomical and physiological data and the presence of mental illness).

The neurochemical hypothesis

One of the most developed biochemical hypotheses of suicide is serotonin. In a study of depressed patients who committed suicide, serotonin deficiency (decreased metabolism of 5-HIAA) was found in the cerebrospinal fluid. Moreover, a lower level of the serotonin metabolite was detected in those suicides who attempted suicide in a more severe and violent way (for example, a shotgun blast, a fall from a height).

People who have attempted suicide and have a serotonin deficiency are 10 times more likely to retry suicide than patients with higher serotonin levels. The

relationship of aggressiveness, suicide and serotonin with the level of amine metabolites in the cerebrospinal fluid was revealed. It has been proven that a low level of serotonin activity is observed in people with suicidal tendencies without clinical symptoms of depression.

In the study of monoamine oxidase in plasma platelets in healthy volunteers, it was found that in those with the lowest levels of this enzyme, the number of suicides in the family history was eight times higher than in those volunteers whose plasma platelet levels were high.

The genetic hypothesis

The suicide rate among relatives of suicides is significantly higher than in the general population. American suicidologists have found that in 6% of suicides, one parent committed suicide, which is 88 times higher than in the general population. It turned out that if one of the monozygotic twins committed suicide, the second had a dramatically increased suicide risk. Danish researchers have shown greater consistency in relation to the suicide factor in identical twins than in fraternal twins (R. Komer, 2002). However, it should be noted that the same genetic data is interpreted by psychodynamically and clinically–psychologically oriented researchers as confirmation of the fact of the influence of suicide of a loved one on the modeling of behavioral strategies in difficult life circumstances.

Suicide was a family tradition of the Nobel Prize-winning American writer Ernest Hemingway (1899-1961). In 1928, the writer's father, Dr. Clarence Hemingway, haunted by financial failures and exhausted by illness, shot himself with a rifle. Sister Ursula and brother Lister also committed suicide. The writer's granddaughter Margot, who successfully worked as a model, but then became addicted to alcohol, poisoned herself with sleeping pills.

Hemingway suffered from alcohol addiction and depression. A few months before his suicide, he was treated in the hospital, where he tried to get rid of delusions of persecution and hallucinations. Electroconvulsive therapy (ECT) treatment his condition worsened, his memory deteriorated sharply, and Hemingway could no longer write. After two unsuccessful attempts at recovery, in

the early morning of July 2, 1961, he brought his favorite double-barreled Boss shotgun to his forehead and simultaneously pulled both triggers.

E. Durkheim's sociological theory

From a sociological point of view, suicide belongs to the field of social pathology and is considered one of the models of deviant behavior.

E. Durkheim drew attention to the relationship between the processes occurring in the social environment and suicidal activity in his sociological study "Suicide", which has become a classic. Although this work was published back in 1897, it remained relevant and the most cited for more than a hundred years.

As a sociologist, Emile Durkheim (1858-1917) distanced himself from the psychological and psychopathological explanations of suicide, then considered the main cause, and statistically investigated the relationship between the frequency of suicide and various social characteristics amenable to processing (gender, age, social class, religion, marital status, etc.). He used the collected statistical data as a basis for his theory of social solidarity. According to this theory, the high suicide rate in society indicates a weakening sense of belonging.

Based on the analysis of statistical data, E. Durkheim called anomie the main cause of suicidal behavior (Greek. A-nomi - lawlessness, norm). In a state of anomie, the bonds that unite people weaken, which makes people less resistant to life changes and challenges, which leads to an increased suicide rate. "Every society, according to E. Durkheim, at a certain historical moment has a certain tendency to suicide.

" E. Durkheim identified three social types of suicide:

1) Selfish suicide

Suicidal behavior in this case is explained by the fact that the ties that unite a person with society, family, and friends weaken or break, which leads to extreme individualism. To the extent that human activity is collective by nature and mental processes are socially determined, such a rupture of social ties is tragic for the individual. A person loses his meaning of life and an object for the application of his energy. Life is devalued. This type of suicide is characteristic of creative people, whose personality is characterized by heightened individualism.

2) Altruistic suicide.

This time, suicidal behavior, on the contrary, is characterized by a poorly developed personality. The importance of a society or a group of people is so important that a person misses his identity and implicitly follows the requirements of the majority. Durkheim calls altruistic suicide a sign of "lower-order societies." He introduces into this concept the ritual of suicide of elderly and infirm people in primitive societies, mass suicides in totalitarian religious sects, voluntary and hand-burning of women after the death of their husbands (sati).

3) Anemic suicide.

In this variant, the prerequisite for suicidal behavior is the loss of ideals that have been paramount for many years, spiritual values, a state of immorality and loss of faith, a massive change in the accepted social hierarchy, an existential vacuum. Such suicides become not uncommon during the period of revolutionary processes in society.

E. Durkheim attributed suicide to one of the types of deviant behavior and considered it a category of social pathology (such as drug addiction, alcoholism, crime and prostitution). Modern sociologists also agree with his opinion.

The psychocultural theory of M. Farber

M. Farber has developed a law that can be described as follows: the frequency of suicides in a population is directly proportional to the number of individuals who are more vulnerable than others and the scale of deprivation inherent in this population. He also expressed this pattern with the formula:

$S=f(V,D)$,

where S is the probability of suicide;

f – function;

V – increased vulnerability;

D – the scale of social deprivation.

From the above formula, it becomes clear that the maximum probability of committing suicide in a population is a period of social upheaval, in which the level of neuroticism (and hence vulnerability) of society suddenly increases.

Cases of conscious suicide are also possible at such moments when a person with a fairly stable and strong psyche unexpectedly finds himself in an extremely difficult social situation (D). Describing a similar situation, M. Farber, as an example, talks about the events in the eastern sector of Berlin, divided by a wall, in which the number of suicides increased 25 times overnight (August 13, 1961).

The above law synthesizes the judgments of E. Durkheim, which speak of a close relationship between the number of suicides and socio-demographic characteristics (D) and the ideas of psychoanalysts who searched for the root cause of suicide in the personal characteristics of an individual (V).

Sociocultural theory by Karen Horney

K. Horney described the basic principles of sociocultural theory, which explains suicidal behavior as a result of the influence of sociocultural factors and personal characteristics of a person on each other. Her work reliably describes that modern culture contributes to the emergence of an increased level of anxiety in people, which becomes the cause that stimulates suicidal risk or its equivalents in the form of various addictions. Horney identified four main methods of avoiding anxiety in modern Western culture:

1) Rationalization of anxiety. The most effective method of justifying your evasion of responsibility. Anxiety transforms into rational fear.

2) Denial of anxiety, that is, its elimination from consciousness.

This method causes somatovegetative manifestations in humans. The mechanism of conscious overcoming of anxiety due to its ignoring is also described.

3) An attempt to drown out anxiety by using different types of addictions (alcohol, drugs, etc.).

4) Avoiding thoughts, feelings, urges or situations that cause anxiety.

K. Horney considered the cause of suicide to be "basic anxiety", which is created during childhood and manifests itself due to the discrepancy between a person's ideas about his personality and an "idealized image" or a standard accepted in society. In the event that the feeling of non-compliance with sociocultural standards increases, a person commits "execution suicide".

Norman Faberow's Theory

Norman Faberow is considered the founder of modern suicidology. The monograph "Cry for Help", written by him together with E. Schneidman, is dedicated to people who have fallen into despair and are alone. He identified loneliness as the most important event that stimulates suicidal behavior. Studying loneliness in the aspect of psychology, he identified some of the prerequisites for this phenomenon:

1) Insufficient socialization of a person (the more obvious the discrepancies between human values and social values become, the higher the danger of a person becoming an outcast).

2) Getting into an environment with reduced communication skills or in difficult personal and social situations (emigration, refugee status, abrupt socio-cultural and economic changes in the country of residence, etc.).

3) Loss of loved ones, work, social status.

The special worldview and attitude of talented people, which determine the presence of characteristic values and desires that differ from similar aspirations in society, resulting in misunderstanding and rejection.

Working with personal patterns of suicidal behavior in psychiatric hospital patients, N. Feiberow divided them into 4 groups:

• Patients who commit suicide in order to find a better life.

• Patients who have committed suicide due to psychosis.

• Patients whose suicide is an act of revenge against a lover.

• Elderly patients, the helpless, who see suicide as an end to suffering.

The theory of Edwin Schneidman

E. Schneidman identified the following character traits of suicides:

- severe mental pain;

a sense of alienation from society;

- a feeling of complete hopelessness and helplessness;

- the idea that there is no way out of this state except death.

Using his personal clinical experience, he created a typology of suicidal individuals:

1) Death seekers: persons who intentionally commit suicidal acts, after which it is impossible to stay alive, since there is no way to get saved;

2) Initiators of death: patients with a fatal diagnosis who commit suicide to stop their medical care (disconnecting a needle or cannula), which leads to a fatal outcome;

3) Players with death: people deliberately seeking unreasonable risk, committing events in which the probability of survival is minimal. A typical example is the Russian roulette players, where the chances of dying are 5 out of 6;

4) Those who approve of death: a category of persons who have a serious and open desire to end their lives, but do nothing to fulfill such an installation. An example is lonely and abandoned old people, as well as young people with an increased level of anxiety.

In addition, E. Schneidman described ten features of suicide that must be kept in mind for successful psychotherapy:

- The common goal for suicide is to try to find a solution to the problem.

- The general purpose of suicide is to stop consciousness.

- A common incentive for suicide is mental pain, which is impossible to cope with.

- Frustrated psychological needs are a common stressor in suicide.

- A common suicidal emotion is helplessness – hopelessness.

- A common internal attitude towards suicide is ambivalence.

- The general state of mind in suicide is a narrowing of the cognitive sphere.

- A common action in suicide is flight.

- A common communicative action in suicide is a warning about one's intentions.

- The general pattern is the correspondence of suicidal behavior to the general style of behavior during life.

The concept of A. G. Ambrumova

In the concept of A. G. Ambrumova (1971), suicide is presented as a consequence of the socio-psychological maladaptation of a personality in the process of conflict experienced by it. Objective changes in a person during maladjustment are changes in his behavior (up to his pathological transformation) and deterioration of social functioning. Subjectively, maladjustment manifests itself in various psycho-emotional shifts: from negative emotions (anxiety, mental pain, resentment, indignation, etc.) to clinically pronounced psychopathological syndromes. In other words, manifestations of socio-psychological maladjustment exist on two levels: pathological and non-pathological.

Each suicide is a consequence of the interaction of situational, personal and psychopathological factors. Also, suicidogenicity does not lie in the event itself, but is characterized by the psychological (personal) characteristics of a person, his personal experience gained throughout his life, and the instability of interpersonal relationships.

In the context of this concept, suicidal behavior is considered as one of the types of general behavioral reactions of a person in extreme conditions over the entire range of diagnostic variations – from mental norm to pronounced pathology.

A. G. Ambrumova presented suicidents with the following diagnostic categories:

- Mentally ill.

- Patients with borderline mental disorders.

- Mentally healthy.

The numerical ratio of these diagnostic categories is: 1.5 (mentally ill): 5 (borderline disorders):1 (without mental disorders).

In her work, A. G. Ambrumova and her students put forward the thesis that there is no direct dependence of suicidal behavior on the nature and severity of painful experiences, and making a suicidal decision becomes possible only after personal processing of a suicidal conflict.

Even people who have committed suicide in a psychotic state, the "pseudo-real" conflict passes through the prism of basic personal attitudes.

A. G. Ambrumova and V. A. Tikhonenko (1980) described possible prerequisites for suicidal behavior:

1) Protest: a response to the negative actions of objects that caused a traumatic situation (revenge is one of the protest motives);

2) Appeal: the opportunity to receive help from the outside; the purpose of this action is to attract attention to oneself and the desire to receive compassion from others, thereby changing the traumatic situation;

3) Avoidance: avoiding punishment or suffering (getting rid of the severity of a mental or somatic condition);

4) Self-punishment: an attempt to atone for "one's own guilt" in committing suicide;

5) Rejection of life: the purpose and reason of suicidal behavior converge (the purpose is suicide, the reason is the rejection of existence).

The fundamental factor in the above categories, which potentiates suicidal manifestations, is suicidal conflict.

I. P. Pavlov's concept

Pavlov studied the goal reflex not only in the physiological aspect, but also as a psychological phenomenon. Pavlov argued that as a person lives his life, he always has a goal for which a person is ready to use all his energy. He also emphasized that often a huge amount of energy is used to achieve unjustified goals and vice versa. The primary thing for a person is not the fact of achieving his goal, but the process performed for this purpose. However, for the full, effective

manifestation of the goal reflex, some tension is necessary. The Anglo-Saxons answer the question: "What is the main condition for achieving the goal?" as follows: "The existence of obstacles."

I. P. Pavlov described the lack of a goal as a determining factor in committing suicide in a large number of people. "Don't we often read in the notes left by suicides that they end their lives because they have no purpose?.. The tragedy of suicide lies in the fact that he most often has a fleeting, and only much less often prolonged, delay, inhibition... I. P. Pavlov expressed this point of view in 1916 at the 3rd Congress on Experimental Pedagogy in Petrograd.

"If each of us cherishes this reflex in ourselves as the most precious part of our being, if parents and all teachers of all ranks make it their main task to strengthen the development of this reflex in the tutored mass, if our society and statehood open up wide opportunities for the practice of this reflex, then we will become who we should and can be". The absence of a previous goal should be immediately replaced by another one, because a person has endless opportunities and ways to choose personal goals. At a time when the patient's reflex of purpose is fading, it is necessary to set new directions for his development and existence, give examples of selfless struggle with the disease, instill faith and hope for healing.

The concept of Antoon A. Leenaars (1988)

- The suicidal person is in a state of unbearable mental pain.
- The suicidal person feels hopeless and helpless before the existing problem.
- The suicidal person has difficulty interacting in society, which leads to frustration of his need to communicate with people.
- The suicidal person even engages in impulses of anger (including homicidal ones) towards another person.
- The suicidal person is not able to adapt to the difficulties that arise.
- Direct communication is difficult for the suicidal person, which is associated with unconscious elements of the psyche.

- A suicidal person identifies with another person who does not respond to their emotional need, which leads to psychological pain.
- The suicidal person has a chronic history of loss and failure.
- The suicidal person demonstrates low abilities to develop constructive and mature tendencies of his personality.
- The suicidal person discovers the inconsistency of thinking, its narrow focus and the impossibility of forming a different attitude to suicide.

Concept by Aaron Beck (Leenaars, 1990)

- Suicide is mediated by depression. The critical link between them is a sense of hopelessness.
- Hopelessness, defined in terms of negative expectations, is a significant factor in suicide. The suicidal person considers suicide to be the only correct solution to his / her difficult situation.
- The suicidal person sees the future negatively and often improbably. He / she foresees great suffering, frustration, and deprivation.
- The suicidal person evaluates himself negatively and unrealistically (as incurable, helpless). Self-criticism, guilt and regret are all associated with low self-esteem.
- The suicidal person sees himself as deprived of something. Thoughts about loneliness, uselessness and material insecurity are formed.
- Such thoughts can be criticized by society, but he/she sees them as the only true ones.
- Suicidal thoughts are mostly generated automatically, without their will, and often show cognitive distortions (not related to schizophrenia): nothing, never, always, excessive generalization or minimization, misunderstandings, selective abstraction, negative biases.
- The suicidal person's affective reaction is proportional to their assessment of the situation , regardless of , the actual intensity of the event.

- Regardless of the nature of the affect (anxiety, sadness , etc.) , distortion of the situation is associated with cognition.

1. Suicide is a form of behavior that people learn through negative experiences in life. Childhood experiences or society form a person with suicidal tendencies and precipitate a suicidal act.
2. For suicide the experience of punishment by the child in the process of his upbringing is critical. First of all , the suicidal person learns to suppress heteroaggression and turn it on himself.
3. Suicide can be predicted based on the basic laws of learning. Suicide is a well- formed behavior that is supported by the environment.
4. Suicidal thoughts are a stimulus followed by a response in the form of suicide. Cognition (as an example - self-praise) can act as an amplifier or fixer of this act.
5. The suicidal person's expectations play a critical role at the time of suicide. He / she is waiting for confirmation (rewards for the act).
6. Depression, especially its cognitive component, is very much related to suicide and is very important for explaining suicidal behavior (for example, depression can be caused by learning and / or reward).
7. Suicide can be a manipulative act. It is supported and fixed by others.
8. The suicidal person is not socialized. He / she is not socialized enough in traditional culture. The suicidal person failed to learn traditional cultural norms regarding life and death.
9. Suicide can be reinforced (fixed) by many environmental factors (subcultural norms), the influence of TV, sexual preferences of a certain line of behavior, suicides of people who are important in the life of the suicidal person (modeling), family and other environmental and cultural models.

R. Maris ' theory of adaptation

The main postulates - of R. Maris ' coping theory are presented in the following articles:

1. Suicide is the result of dissatisfaction with the human condition and chronic depression with despair and inability to manage the human condition (its cruelty, limitation, rudeness, unpredictability, loneliness).
2. People who are suicidal have access to (and know) ways to kill themselves.
3. Suicidal hopelessness refers to recurrent depression, repeated life failures, long-term negative relationships, and social isolation.
4. Suicidal people usually try to adapt or isolate themselves in a destructive way (alcoholism, drug addiction, sexual excesses, suicide attempts).
5. Suicidal people have an ambivalent attitude towards death. Although they usually want to die, their behavior doesn't have to be intentional.
6. A suicidal person is largely rational in order to avoid something (pain, unhappiness, despair, etc.). Suicide – is either an act of aggression towards others, or (less often) a willingness to sacrifice oneself in order to change the situation or increase the value of one's life.
7. Suicides are characterized by the inability to solve certain problems that arise at certain stages of their life.
8. Suicides were traumatized at an early age or came from families with multiple problems, especially those with fathers.
9. The suicides had serious problems at work or physical illnesses.
10. People who commit suicide are not deeply religious people.

3. SUICIDAL REACTIONS.

Maladjustment reactions

Suicidal maladaptation reactions are associated with the influence of objectively and subjectively significant environmental factors, that cause frustration of life needs and generate a state of psychological crisis. Maladaptation is quantitative in nature and consists of limitations in a person's ability to manage social functions, behavioral changes in the micro-social environment, and negatively colored psychological experiences.

It is characterized by the fixation of attention on the crisis problem, the connection of the state with the change in the situation and the preservation of working capacity. The suicidal danger of reactions is determined by a sharp decrease in constructive planning for the future and manifests itself in the form of an experience of despair.

Determining factors for the development of a particular variant of suicidal reaction were not temperament, but such factors as the degree of tolerance of frustration in general; the place that the frustrated need occupies in the value system; the state of a person's energy resources ; and the peculiarities of interpersonal relationships with other significant people in the area.

Depending on the predominance of the affective, cognitive , or behavioral component of the crisis, three maladaptive suicidal reactions are distinguished: the reaction of opposition, the pessimistic reaction, and the reaction of demobilization.

The reaction of the opposition arises as a protest against the actions of other significant figures and is characterized by a pronounced extra-punitive attitude of the individual, a high level of aggressiveness and a clearly negative assessment of others and their activities.

Self-aggressive tendencies arise at the height of the manifestation of resentment, anger, as a result of heteroaggressive statements, up to murderous. Premorbid self-esteem of patients is reduced under the influence of a suicidal attitude such as: "humiliation is worse than death." They view the current crisis

situation in general terms, stating that they do not want to live in a world where injustice reigns.

The total duration of the suicidal reaction (from the moment of exposure to psychotrauma to the disappearance of suicidal tendencies) was relatively short and averaged three weeks.

A pessimistic reaction develops in a situation of irreversible loss of a significant person or other dominant values. Its distinctive features are a negative assessment of the present, future and one's own capabilities; the disappearance of the meaning of life. The corresponding changes in the worldview, worldview, judgments and assessments, modifications of the value system are expressed, which lead to the formation of negative ideas about the situation, which is assessed as real or potentially unfavorable.

This perception causes a persistent decrease in the level of optimism and hinders productive planning of activities in the future. Secondly, self-esteem decreases, and a sense of insufficient personal capabilities increases.

Patients are prone to introspection and pessimistic conclusions when interpreting various life events. These features lead to the predominance of the cognitive component in the development of a pessimistic reaction. The above - mentioned component contains negative images of their own uselessness, hopelessness and pain in later life, a pessimistic conclusion about the impossibility of overcoming the crisis due to lack of time and opportunities.

Such ideas are not a consequence of a morbidly altered mood, but, on the contrary, precede it and are completely determined by the specifics of the cognitive sphere, the tendency to form maladaptive attitudes. These attitudes are closely related to ideas about something bigger than one's own life, about the importance of family, personal, social, prestigious and other values.

In comparison with the suicidal reactions described above, the demobilization reaction is characterized by the most dramatic changes in the communicative and motivational-volitional sphere.

There is a refusal of habitual contacts or their significant restriction, as a result of which persistent feelings of loneliness, helplessness, and hopelessness remain. There is also a partial refusal of activity, and their productivity decreases and does not satisfy the patient himself, leading to psychological discomfort, a sense of rejection and isolation.

This reaction usually occurs in young people who are characterized by mental immaturity, low resistance to frustration, and a tendency to "leave" or "avoid" difficult life circumstances. Patients are relatively easy to experience a sense of failure, " failure in life", accompanied by a decrease in motives and volitional efforts aimed at eliminating conflict. Due to the lack of an active desire to achieve the goal , any attempts to change the life situation end in failure, which leads to a narrowing of ideas about reliable means of resolving the psychological crisis and its further deepening.

Neurotic reactions

The content of suicidal experiences in patients with neurosis is characterized by a relatively small connection with the traumatic situation. Fixation on one's own state prevails, in which non pronounced somatovegetative disorders come to the fore . Other clinical manifestations are poorly formed and unstable.

Suicidal risk is low and is limited to suicidal thoughts at the peak of the experience. In suicidal people, presuicide lasts about three weeks; as a rule, suicidal tendencies persist in the post-suicidal period for 8-10 weeks, gradually transforming into suicidal-hypochondriac symptoms with a tendency to a prolonged course. Depending on the main clinical syndrome, four neurotic suicidal reactions are distinguished: hysterical, phobic, hypochondriac and asthenic.

Hysterical neurotic suicidal reaction is observed in patients who are characterized by increased autosuggestion, excessive demands on others in comparison with themselves, and an excessive need for attention.

These patients exhibit suicidal tendencies in emphatic and demonstrative ways, try to shift responsibility for their suicidal behavior to others, easily come

into conflict with them, use the severity of their condition as a way to cause feelings of guilt in significant others and improve their attitude to themselves.

The severity of suicidal feelings depends on the attitude of others; the mood changes quickly, patients quickly move from laughter to violent sobs. On the one hand, they emphasize the exclusivity, intolerance of their suffering, and on the other hand, they are passive in psychotherapy work, using it as an excuse to attract the attention of the doctor.

Phobic neurotic suicidal reactions are observed in patients who in a premorbid state are characterized by increased susceptibility, anxiety; such patients have fears from childhood: darkness, loneliness, the dead, death. Subsequently, they are accompanied by claustrophobia, fear of driving in the subway, accompanied by vegetative crises in the appropriate situation.

Such disorders develop episodically, against the background of asthenia or a traumatic situation, and are usually stopped independently. In the clinical picture of hospitalization, the main place is occupied by suicidal and suicidal experiences; the fear of insanity joins them in the midst of emotional tension.

The risk of suicide is low due to the fear of suicide and death, which is an anti-suicidal factor. Such patients often turn to the doctor with a request to once again convince them , that they are fully capable of controlling their behavior and mental activity, but for a while they calm down, and at the height of anxiety, they again have suicidal and suicidal tendencies, phobic experiences.

Hypochondriac neurotic suicidal reaction, in addition to suicidal experiences, is manifested in fears for one's health, which are supported by the existing somatogenic and asthenovegetative symptoms. Such patients in the premorbid period are characterized by anxious suspiciousness, increased concern for their health; during inpatient treatment, they show increased interest in the data of a planned somatic examination and ask to appoint consultations with various specialists, conduct an in-depth medical and psychological examination.

On the one hand, they fix the doctor's attention on various symptoms of their condition, on the other hand, they agree extremely negatively to drug therapy

because of fear of possible side effects of drugs, they are afraid to get used to them. Fear for one's own health and fear of disability in the event of an unsuccessful suicide attempt play the role of an anti-suicidal factor.

Asthenic neurotic suicidal reaction occurs in patients in crisis on the background of increased mental exhaustion and reduced performance.

Such patients in the pre-comorbid period are characterized by a low level of energy and easily succumb to difficulties, become discouraged even with small failures, quickly become discouraged when overloaded (especially emotionally and intellectually), try to avoid difficult situations, are responsible and especially conflicted.

When excited, these patients lose sleep and appetite, become irritable, incontinent, tearful, and sensitive. Occasionally, they develop vegetative disorders with elements of hypochondriac attachment.

In the hospital, such patients are unsociable, spend a lot of time in bed, complain about difficulties in concentrating on any mental work, and are pessimistic about their ability to overcome the crisis.

At the same time, they do not seek help, declare that they have accepted their fate and ask only to ease their suffering. Such indifference to one's future, including the outcome of a traumatic situation, reduces the urgency of the frustrated need and thus acts as an anti-suicidal factor.

Psychopathic reactions

The effectiveness of correcting aggressive and autoaggressive tendencies largely depends on taking personal factors into account. Psychological studies reveal certain personality traits in suicidal individuals and, in particular, features of immaturity in the emotional and cognitive spheres. The following features of suicides are distinguished: emotional dependence; schizoid; stuck affect; emotional-vegetative lability; impulsive, undifferentiated aggressiveness, provoking a large number of conflict situations; a tendency to destruction and self-destruction; a special attitude to death.

The results of experimental psychological studies show that suicides differ in character traits that are absent in patients with neuroses, and this allows us to talk about "suicidal development", which manifests itself at the level of character accentuation that does not reach the degree of psychopathy, indicates a correlation of character accentuation with the type of suicidal reaction (situational, demonstrative, affective).

Among suicides, hysterical and excitable psychopaths predominate (39% and 30%, respectively), followed by asthenic and affective psychopaths. Excitable psychopaths are most likely to have repeated suicide attempts. The type of suicidal behavior is not strictly associated with radical psychopathy.

Thus, in hysterical psychopathy, not only attempts of demonstrative blackmail are observed, but also true ones (such as conversion, protest, avoidance); in excitable psychopathy - not only protest suicides are observed, but also evasion of military service. The widest range of causes and features of suicidal behavior is observed in asthenic and psychiatric patients. The risk of suicide is higher in the following cases:

- in "marginal" and mosaic forms of psychopathy, in which there are no rigid, clinically filled pathological response patterns;

- at the stage of forming a psychopathic structure;

- with a long -term personal study of a conflict situation without a specific way of responding to a particular form of psychopathy, that is , with a delayed psychopathic reaction.

Lazarashvili describes the following forms of suicidal reactions in psychopathic individuals of the excitable circle.

Melancholic-depressive reaction is observed in situations of loss of loved ones, breakup of particularly significant relationships, and decline in professional prestige. Expressed melancholic attachment is experienced as an extremely painful bodily sensation in the heart, head, accompanied by thoughts of undeserved resentment, injustice of suffering, depressive reassessment of the past in the presence of a slight psychomotor delay.

An anxiety-depressive reaction is formed in a situation of the threat of the collapse of the welfare state, an incurable disease, legal liability, and the loss of significant people. Anxiety prevails over the tendency to melancholy, anxiety, excitement, a feeling of an unbearable situation. This condition is based on a sthenic component that transforms into suicidal behavior as an outburst of protest, appeal , or avoidance.

A dysphoric reaction occurs when they are confronted with an obstacle that has arisen in front of their purely selfish goal, the requirements for normalizing their behavior. A suicide attempt is usually preceded by an interpersonal conflict in a professional or personal-family context. The reaction is characterized by outbursts of anger, swearing, threats against the background of an angry and gloomy mood.

A suicide attempt is usually made when heteroaggression is impossible to detect, and aggressive behavior is sometimes preceded by self-harm. Suicide is always acute, attempts are made by the first object that comes to hand, , self-harm and poisoning with household chemicals prevail.

A suicide attempt, although accompanied by the idea of death, is more likely a release of attachment and in its personal meaning is a reaction of protest, revenge.

Pseudoraptoid reaction is observed in conditions of long -term processing of traumatic experiences associated with the violation of personal and social relationships. Against the background of mental stress , there are ideas about the future of a threatening nature, anxiety, anxiety, sleep disorders and pronounced asthenia.

In presuicide , there is a struggle of motives, followed by a sudden suicide of the "suicide abduction" type. A suicidal decision is made in the case of additional and often seemingly insignificant psychotraumatic effects. Suicide is serious and life-threatening. Postsuicide is most often suicidal , with severe asthenia.

The dynamics of the post-suicidal state in excitable individuals can be suicidally fixed or manipulative. In the first case , with an unresolved conflict situation , decompensation deepens more and more and chronic maladaptation occurs. Repeated suicide attempts occur in conditions of mild trauma, are real and have very serious medical consequences.

With a manipulative type of post-suicide and a change in the psychotraumatic situation in a favorable direction for the patient , inadequate adaptation with pseudocompensatory formations and periodic seizures is noted.

Suicide attempts in excitable individuals relieve affective tension, narrowing the field of consciousness, have an impulsive mechanism, and create the impression that the situation is inadequate. Each subsequent repetition of an autoaggressive act that sensitizes a person creates a readiness for repeated suicide attempts, allowing them to take increasingly risky actions, often with a high probability of death. Regardless of the nature of the next post-suicidal event, egocentric attitudes and hysterical forms of reaction gradually increase in the individual .

Hysterical personalities show a wide range of different disorders. It is characterized by many hours of dramatic presentation of an unusual image of the disease, interspersed with stories about meetings with famous people and other fantasies, which makes it difficult to diagnose.

In the department , patients become "the most difficult, the most difficult , or the most patient", seek to be the center of attention, intrigue, and conflict, insist on prescribing fancy medications, and threaten staff with complaints and suicide. Experiencing anger and provoking hostile feelings towards themselves in others, patients unwittingly aggravate the severity of their somatic condition.

There is a sensitive type of hysterical personalities who are characterized by psychophysical infantileness, youth and fragility combined with feigned naivety and frankness. Behind their ostentatious impracticality lies a worldly acumen and resourcefulness.

Demonstrating their weakness, these people make others dependent on their desires and whims. In situations of prolonged mental stress , they develop conversion, somatized and asthenoipochondriac reactions, eating disorders.

4. DETERMINATION OF SUICIDAL RISK OF DEPRESSION (BECK SCALE).

Suicidal risk – is the degree of probability of suicidal impulses, formation of suicidal behavior , and implementation of suicidal actions.

The severity of suicidal risk can be determined by comparing suicidal and anti-suicidal personality factors, as well as the degree of influence of situational and environmental factors on the individual. There are the following options for suicide risk:

- acute: a high probability of suicidal acts should be considered as an emergency;

- chronic: long -term existence of therapy -resistant suicidal experiences that do not stop after a suicide attempt.

The Beck scale was proposed by A. T. Beck in 1961 1961 and developed on the basis of the author's clinical observations, which allowed us to identify a limited set of the most significant and significant symptoms of depression and complaints most often presented by patients. After comparing this list of parameters with clinical descriptions of depression contained in the relevant literature, a questionnaire was developed that included 21 categories of symptoms and disorders. Each category consists of 4-5 statements that correspond to specific manifestations/symptoms of depression. These statements were ranked as the specific contribution of a symptom to the overall severity of depression.

The questionnaire is issued to the patient and filled out by them.

Scores for each category are calculated as follows: each point on the scale is rated from 0 to 3 , depending on the increasing severity of the symptom. The total score ranges from 0 to 62 and decreases as your condition improves.

Table 1

Beck Scale Question Form

	0. I 'm not sad.	

	1. I feel sad (sad, sad). 2. I'm constantly sad and can't get my mind off it. 3. I feel so sad that I can't bear it	
	0. I 'm not particularly gloomy about the future. 1. I 'm gloomy about the future. 2. I feel that I have nothing to look forward to in the future. 3. I feel that nothing good is waiting for me in the future , and that nothing can be changed	
	0. I don't feel like a failure. 1. I feel like I have more failures than others. other people. 2. Sometimes when I look back on my life, it seems to me a chain of failures; 3. I feel like an absolute loser (as a spouse, as a parent...)	
D	1. I don't feel particularly dissatisfied; 2. I don 't enjoy anything as much as I used to; 3. Nothing else gives me satisfaction; 4. I 'm not happy with everything	
	0. I don't feel particularly guilty. 1. Most of the time I feel like a bad or unworthy person. 2. I feel a certain amount of guilt. 3. I feel that I am a very bad, unworthy	

	person	
F	0. I 'm not disappointed in myself. 1. I 'm disappointed in myself. 2. I 'm disgusted with myself.	
	0. It doesn't occur to me to harm myself. 1. I feel that it would be better for me to die; 2. I have a specific plan to commit suicides; 3. I would kill myself if I succeeded	
	0. I haven't lost interest in people. 1. I'm less interested in people than I used to be. 2. I almost completely lost interest in people and became indifferent to them. 3. I 've completely lost interest in people and don't think about them	
I.	0. I make decisions as easily as you do. earlier; 1. I try to delay making decisions. 2. I find it extremely difficult - to decide anything. 3. I lost my ability to make any decisions	
	0. I don't feel like I look any worse than I used to. 1. I 'm worried that I look older and unattractive.	

	2. I feel like my appearance is getting worse, which makes me increasingly unattractive; 3. I feel like I look ugly or repulsive	
K. 	0. I can work as easily as before. 1. I have to make some effort to do something; 2. I find it very difficult to force myself to take on a new role. anything; 3. I can't do anything at all	
	0. I don't get any more tired than usual. 1. I get tired faster than before. 2. I get tired of everything. 3. I'm too tired to do anything	
M. XIII.	0. My appetite is no worse than yesterday. 1. My appetite is not as good as it used to be. 2. Myung's appetite has become much worse. 3. I have no appetite at all	

Table 2

Interpretation of the results obtained

Degree of depression severity	

5. SUICIDES IN PATIENTS WITH SCHIZOPHRENIA.

Suicidal behavior in patients with schizophrenia

Suicidal behavior in schizophrenia is most often caused by psychogenic reactions in response to adverse environmental influences and is observed with a slow and low-progressive course of the process, as well as in remissions with a paroxysmal course. It is characterized by the relative safety of the patient, criticality, "reactivity" to the situation. The reasons for the loss of a significant person and the awareness of their inadequacy in various fields of activity prevail. The risk of suicide is higher in asthenic and psychopathic types of remission.

More rarely , suicidal behavior is observed, which is caused by psychotic disorders in the simple form of schizophrenia with personality changes, metaphysical intoxication syndrome, autistic-pessimistic worldview, dissent, and dysthymic disorders. Suicidal conflicts develop in an abstract and virtual sphere, dominated by depressing colorful ideas about the meaninglessness of life and the futility of life. These patients are characterized by suicidal mania with a chronically high risk of suicide.

The third psychotic variant of suicidal behavior occurs in the acute development of paranoid-affective and paranoid-hallucinatory crises. Pathological motivation of suicidal behavior is associated with delusions of insolvency, self-accusation, condemnation, harassment and physical impact; hypochondriac and dysmorphophobic ideas; delusions of jealousy, verbal hallucinations, including those of an imperative nature; various depersonalization and senestopathic disorders; pathological changes in self-esteem; primary loss of meaning in life.

The following motives of suicidal behavior in patients with schizophrenia were revealed:

- indefinite threat (experiences ranging from qualitatively intense to indefinite fear, such as an impending catastrophe);

- life-threatening (experiencing a specific fear for life); u - threat of personal devastation and degradation (experience of increasing mental disorganization);

- changing the worldview (experiencing the loss of the ability to react emotionally to the environment);

- change in self -awareness (experiencing your own change);

- unfair treatment (experience of undeserved accusation, conviction),

- harassment (experience of unfair "harassment" by others);

- somatic illness, physical suffering (experiencing the presence of a life-threatening disease, deformity);

- loss of a loved one (experiencing the loss of a loved one);

- a change in the usual stereotype of life, loneliness (experiences associated with social isolation, unfavorable lifestyle changes),

- sufferings and misfortunes of others (experiences of self-condemnation, self-accusation),

- failure (experiencing your own inferiority);

- loss of prestige (experiencing low self-esteem on the part of "*others");

- primary loss of the meaning of life (experiencing the aimlessness and meaninglessness of one's own existence).

Types of suicidal behavior in patients with schizophrenia

The autistic-rationalistic type occurs when the patient's autism increases in combination with personality changes, usually in the form of a special autistic-pessimistic worldview (usually within the framework of a simple form of schizophrenia). Isolation syndrome is characterized by withdrawal from the real world and reorientation of the patient's personal position at the social level. These changes determine the appearance of an autistic-pessimistic worldview and suicidal behavior. Suicidal conflicts arise against the background of a peculiar worldview and are devoid of any real basis. Suicidal motives take on an unreal, abstract character. The social environment is perceived as an obstacle to "meaningful" forms of activity and behavior.

The content of the conflict is first of all the loss of the meaning of life, connected not with depression, but with the constantly changing position of the individual. These personal attitudes are practically not subject to spontaneous fluctuations and do not decrease under the influence of antidepressants. Suicidality

in patients of this group is extremely persistent and is associated with the threat of death.

The psychotic form of suicidal behavior with the arbitrary realization of suicidal intentions is associated with an affective-paranoid attitude to the environment and to one's own personality. The clinical picture contains a variety of productive psychopathological syndromes (paranoid, depressive-paranoid, acute delusional, oneiroid , etc.), including conflict -causing moments. Suicidal motives are formed against the background of conflict situations determined by the content of psychosis. The most common cause of suicide in paranoid states are experiences caused by the content of psychosis: the threat of death, unfair treatment, suffering and misery of others, harassment. For patients , these situations are real and involve deep life experiences.

Suicidal attempts with this type of motivation are made against the background of acute affective tension, the peak of the affect of fear, anxiety, despair, resentment and hopelessness. In a paranoid life-threatening situation , the generalized motive for suicidal behavior is the patient 's own conclusion , that "it is better to commit suicide than in constant agony, fear, and anticipation of the coming painful death at the hands of enemies or shame." The threatening situation is a real experience in the delusional structure of psychosis, which explains the high risk of suicide in these cases. The duration of the suicidal period in this group of patients is determined by the duration of the psychotic state.

The psychotic type of suicidal behavior with the involuntary realization of suicidal intentions is formed in conditions of psychotic alienation from mental and motor-volitional processes, which are determined by the presence of imperative verbal hallucinations that carry the command to commit suicide, mental mental and kinesthetic automatisms, "symbolic suicide signals".

Psychopathological disorders have a smaller spectrum compared to the previous group. Most often , in the pre-suicidal period and at the time of suicide attempts , hallucinatory-paranoid syndromes with imperative verbal hallucinations or kinesthetic mental automatisms with suicidal content are

observed. This is followed by atypical affective-paranoid and depressive disorders, accompanied by phenomena of verbal pseudohallucinosis with suicidal imperatives. There are also acute hallucinatory-delusional states, reduced oneiroid states , and acute Kandinsky syndromes.

The development of hallucinatory-predominant Kandinsky syndrome begins with verbal illusions, elementary hallucinations. In the future , there are "voices" that comment on the thoughts and actions of patients. The suicidal theme of the content of hallucinations arises after the patient's own suicidal thoughts , which are conflict situations associated with psychosis.

The imperative nature of hallucinations resolves later and reflects the level of suicidal readiness of the patient. In some cases , suicidal imperatives are "reinforced" by kinesthetic psychic automatisms. Such patients feel that an external force is acting on them, which "drives them into a loop", controls their movements when opening veins, directs them to the place where the pills are lying , etc. .

The risk of suicide is particularly high in the early stages of schizophrenia. An apparently unmotivated suicide attempt is the first manifestation of a mental illness. When the disease manifests in the mantle of depersonalization-derealization , patients develop an acute state of self-transformation with anti -life experiences, a sense of impending danger, catastrophe, and inexplicable fear. The increase in affective tension leads to a narrowing of consciousness and later to partial amnesia. Tension is relieved by suicide, the motivation of which is often not explained by patients due to amnesia.

In low-progressive, neurotic, psychopathic and paranoid variants of schizophrenia, as well as during remission , psychotraumatic factors play a leading role in the formation of suicidal behavior in patients. Clinical features of a slow -moving process with the formation of peculiar personality changes determine non -standard types of reactions, the structure of which often includes suicidal tendencies and actions. Minor psychogenic hazards in the minds of patients easily turn into unbearable, hopeless situations. Nonconformity, life disability, selectivity

of contacts, difficulty of adaptation in the team create and increase interpersonal conflicts.

Patients with asthenic type of remission are most sensitive to various psychogenic effects , while patients with psychopathic and paranoid forms of remission are characterized by greater inadequacy and paradoxical reactions. Usually , suicidal behavior can be detected during asthenic remission, in which there is a pronounced sensitivity, a sense of loss of personal, professional, and social prestige.

Psychogenic reactions that occur in patients under the influence of a constant feeling of mental discomfort, internal conflict of personality, are often implemented in suicidal actions by the type of appeal or avoidance.

Suicidal behavior during a psychopathic personality change usually occurs in conflict situations of an ordinary or working nature. It is often possible to identify the discrepancy between social claims and their real capabilities. While the real circumstances are often hypertrophied, or paradoxically interpreted. Conflicts in such situations have an external character, with objective suicidal statements and threats. , Self-directed aggression , is usually combined with aggression towards others. In most cases , they are demonstrative in nature and are carried out on the grounds of protest or conscription.

6. AGE -RELATED ASPECTS OF SUICIDOLOGY.

According to statistics , every day more than 1,000 young people try to commit suicide. This is the second most common cause of death in youth, and if you include suicide disguised as other types of violent death, then probably the first.

The greatest number of suicidal behavior attempts are made at the age of 16-24 years; due to the vulnerability of this social group. Loss of personal support and life support. Loss of unity with society. Loss of faith in a better change in the future. Fear for health and painful death. Depressed state after an abusive relationship. Post-traumatic stress disorder, due to being in a war zone. Experiencing loss. Imitative self-harm, due to the contagiousness of self-traumatic behavior.

Suicidal behavior in children and adolescents

Self -injuring behavior of children and adolescents is extremely dangerous. Subsequent suicide attempts persist in 60% of cases.

A pronounced feature of childhood is the lack of formation of the concept of death, which leads to a lack of fear of it. This concept is formed only by the age of 11-14 years. In this connection , at this age , there is a discrepancy between the goals and means of suicidal behavior: for example, if you want to die , you choose means that are not dangerous from the point of view of adults , and on the contrary – , demonstrative attempts are often "overplayed" due to underestimation of the danger of the chosen means and methods. Due to lack of formation and lack of life experience , the most insignificant conflict situation can be considered as hopeless, and therefore it can be extremely suicidal. In addition , a burdened family history makes a big contribution. Suicidogenic components of family education include: overprotection, authoritarianism of parents with rigid attitudes, coupled with a low level of culture and education. Conflicts in the

family are more often based on the young person's rejection of the parents ' value system.

Loss of relationships with parents is one of the most powerful stimulators of suicide syndrome in adolescents. The more often a teenager thinks about ending his life , the less he trusts his parents. While good trusting relationships between children and their parents reduce the risk of suicide by up to 1%, constant quarrels, on the contrary, lead to an increase in this risk by up to 18%. Most psychotraumiruyushche children suffer the cold indifference of their parents to their personality. The deadly cold of loneliness is felt in the responses of 17% of boys and girls who say that in difficult moments of their lives they do not want (or can not) turn to anyone for help. - Motivation and dynamics of suicidal behavior also differ in the peculiarity of the child-adolescent stage of ontogenesis . Children are characterized by mosaic and variable presuicidal status, which makes it particularly difficult to recognize the threat of suicide. Latent depression is also very dangerous at this age . Depression in children and adolescents is difficult to diagnose, as it is often masked by hyperactivity and aggression. The most suicidal group of children, consisting of teenagers who are distinguished by highly moral principles with an idealization of feelings of love and sexual relations.

The main motives of suicidal behavior in children:

32% - resentment.

30% - protest.

38% – loneliness, shame, dissatisfaction with themselves.

Types of suicidal situational reactions in adolescence

The deprivation response (most often in the younger and middle teens). Characteristic: loss of interests, decreased emotional background, reticence, unsociability , and negative experiences. A history – of harsh authoritarian parenting.

Explosive reaction (most often middle adolescence). For her , the most pronounced are: affective tension, aggressiveness, an inflated level of claims to

others, and aspirations (often unfounded) for leadership. In the anamnesis – upbringing in a family where these behavioral patterns are traditional for adults. Those who commit suicide aim to take revenge on the abuser, to prove their case. As a rule, suicidal actions are committed at the peak of affect; in post -suicide, criticism of suicidal behavior is not formed immediately, and an oppositional attitude towards others remains.

Self-withdrawal reaction (most often middle and older adolescents with immaturity traits). Characteristic: emotional instability, suggestibility and lack of independence. These are pedagogically neglected teenagers with low intelligence. The purpose of suicidal actions is to avoid difficulties.

The age -related peculiarity of self-aggressive behavior of mentally healthy adolescents is expressed in the specifics of suicidal actions, which are expressed in the following.

Self-harm. A combination of both auto- and heteroaggression is characteristic. In the anamnesis - upbringing in dysfunctional, antisocial families; most often an epileptoid type of accentuation; puberty crisis is decompensated; school adaptation is disrupted. Emotional state during self-harm – anger and resentment. For such teenagers , it is typical to unite with peers who find themselves in a similar life situation.

Demonstrative blackmail suicides with an aggressive component. The families of these teenagers are conflicted, but not antisocial. Most common in these adolescents are: hysterical and excitable types of accentuation; less pronounced pubertal decompensation; in the peer group , they experience discomfort as a result of overestimated claims. In primary classes , adaptation is normal, but with the appearance of difficulties , it is disrupted. By committing suicide , a teenager seeks to assert his rightness and take revenge on the abuser. With this type of behavior , implementation occurs immediately, which in most cases leads to a" replay " that ends fatally. If the situation is not resolved in this way, then a repeat is possible.

Demonstrative blackmail suicides with manipulative motivation. Families of such teenagers are disharmonious, with inadequate upbringing, in which there are many contradictions. These teenagers are characterized by hysterical accentuation, in puberty – demonstrativeness, capriciousness, skillful manipulation. Up 5–to the 5th-6th , good adaptation is shown, but with the appearance of difficulties in the school curriculum and due to high self-esteem and the level of pretensions , maladaptation is possible. This leads to the fact that in a group of peers they first occupy a leadership position, and then there is a drop in authority. Presuicide in these adolescents is more prolonged, since the most rational search for painless ways to end life occurs. At the same time, others are informed about their intentions in advance. When the situation is resolved in a suicidal way , it is fixed.

Suicides motivated by self-withdrawal. At first glance , the families of these teenagers are prosperous, but unstable; conflicts are more often implicit . Therefore , such adolescents are characterized by: high anxiety, unstable self-esteem, feelings of guilt; emotionally labile, unstable, sensitive accentuation, mental infantilism; as well as lack of independence, conformity, passivity, low stress tolerance. The puberty crisis ends with neurasthenia. Failure at school results in fear and guilt. In the eyes of their peers , they do not have a high status, so they cannot resist pressure - , which is why they often engage in antisocial activities. Presuicide in this case is prolonged, with a sense of fear, , as a rule, rather risky methods are chosen. In the nearest postsuitsde - fear of death, shame, remorse; the risk of repetition is low.

Suicidal behavior in the elderly

Problems of suicidal behavior in involution, this age is characterized by: difficulties in acquiring new ideas; weakening of control over emotional reactions; tendencies to egocentrism; unmotivated mood swings with a predominance of elements of melancholy and which reduces adaptation to changes in the external environment.

The main causes of suicidal behavior in adulthood are identified as mental trauma, as well as a decline in personal and social prestige. Suicidal factors of this age are associated with the absence of family, loved ones, a sense of loneliness; overestimation of life, the transition to retirement; misunderstandings between family and the environment. Suicidal behavior in older age is characterized by true suicides as a result of "summing up life results", they are characterized by verified planning of suicidal acts and the so -called "cold" suicide. At the same time, a person does not leave himself a chance of survival.

There is some specificity in the content of psychogenic conflicts and types of psychogenic suicidal reactions depending on the age periods:

1) At the age of 45-55–55 years (the most numerous type) , suicidal psychogenic reactions of the type of intimate and personal "catastrophes"are observed:

- cheating on one of the spouses, leaving the family;

sudden loss (more often death) of one of the spouses or significant other. 2) At the age of 55-65–65 years , there are crisis states, usually in response to an undesirable retirement , a decline in the career ladder, creative failure to realize their plans. This is characterized by arguments about lost values, lack of prospects in old age; in addition , there is a reduced mood with some hypochondriacal coloring. A significant psychotraumatic factor may be a simultaneous combination of a decrease in social status with a loss of sexual prestige;

3) At the age of 65-75–75 years , psychogenic reactions of the depressive type are observed with the experience of feelings of infringement, unfair treatment of family members. Asthenovegetative disorders with an abundance of so -called "volatile" pains and fixation on them, as well as sleep disorders, are often detected. The most suicidal moment is the transition from a depressive reaction to an oppositional one, when suicidents actively insist on intervention from others with mandatory punishment of family members for "encroaching" on the patient's material values. At the same time, the patient zealously defends his lost positions and rights.

The age -related nature of suicidal behavior requires special psychological assistance for suicidal people of different ages. So, if for groups of young suicidents and middle -aged people, axiological correction, harmonization of intellectual activity and the emotional sphere, development of emotional structure, restructuring of perception, formation of the moral and spiritual level of the individual, as well as personal growth, destruction of barriers that prevent adaptation are shown first of all, then for suicidents over 60 years of age – environmental therapy (creating a permanent communication environment for single elderly people).

7. ORGANIZATIONAL ASPECTS OF SUICIDOLOGY.

At the moment, there is an urgent need to organize a special suicidological service that meets the principles of crisis therapy, since most suicidents remain out of the field of view of psychiators. Currently , there are no more than 20 psychotherapy centers in Russia , which can also help crisis patients.

Crisis services are characterized by their attitude to patients. Most telephone services provide early prevention of suicidal behavior, working with crisis clients. There are special services whose work profile is designed to work with suicidal people. Some services set as their main goal the prevention of suicide, identify the location of the subscriber and transmit information to medical or police agencies, or send their employee to a potential suicide. Others , on the contrary, recognize the client's right to commit suicide, and some take risks using provocations: they offer the client to commit suicide and conclude a suicide contract with him so that he can feel the inevitability of a fatal outcome and change his mind.

The desire to avoid hospitalization of the patient is one of the goals of crisis therapy, as this complicates the task of adapting the subject to his life environment. Referral to the hospital is carried out only , if the patient, without a pronounced suicidal risk, is motivated to do so, otherwise, there are high risks of wasting time. A compromise option is treatment in a day or night hospital (for working patients) .

There is a practice of staying in a crisis hostel located outside the hospital . This type of cohabitation is characterized by creating a home environment, a practical lack of staff and systematic medical measures, and the most free regime. There are no more than four patients in the hostel , and the duration of stay in it is up to seven days. Home crisis hospitals are also used, when patients (usually two) are placed in someone else 's family, where they are under the dynamic supervision of a doctor and nurse for three weeks. A key role in the effectiveness of crisis dormitories and home hospitals is played by the beneficial impact of the therapeutic environment.

High suicidal risk in combination with a conflict situation is considered by many researchers as an indication for short -term inpatient treatment, which is the initial part of therapy. But conducting crisis intervention in a psychiatric hospital is difficult and ineffective. There is evidence of thematically and interpersonally oriented group therapy in the therapeutic community, which includes patients and staff of a neurological or therapeutic department. This approach has its drawbacks, since the problems of suicidal patients are far from the main tasks of the above - mentioned departments, and it is possible to eliminate difficulties by creating specialized crisis hospitals.

Indications for treatment in a crisis hospital are high suicidal risk in patients with acute affective states, including psychotic ones. Treatment is carried out for a period of 3-7 days; the number of beds in the hospital is 6-13. Patients are served by a special crisis team consisting of : 2-3 psychiatrists, a psychotherapist, a social worker , and specially trained nurses. Various types of therapy are provided daily, such as intensive individual, family, and group crisis therapy. These hospitals are characterized by a free mode of movement, stimulation of responsibility and independence of patients, treatment after discharge is carried out on an outpatient basis or in another department.

A similar department can be a specialized "post-crisis hospital", where the course of treatment lasts 3-4 weeks. The frequency of classes is close to outpatient crisis therapy and is 2 individual and 1-5 group classes per week. Such hospitals are usually located in a multi -specialty hospital; in order to speed up the start of treatment. Thus , the waiting period and complexity of registration tend to be minimized. A characteristic emphasis is placed on social assistance, semi - stationary mode, and club work.

Suicidology centers abroad work on the basis of a socio-psychological approach, the peculiarity of this model is the ability to attract trained non-professionals; after stopping the risk of suicide , the client remains left to himself. The domestic model of suicidological care compares favorably with its foreign

counterparts in that it is provided within the framework of public health on a professional basis, in compliance with the principle of continuity.

The work of the service is regulated by the Order of the Ministry of Health of the Russian Federation No. 148 of 06.05.98 "On specialized assistance to persons with crisis states and suicidal behavior". The structure of the suicidology service includes the following links.

Territorial Suicidological Service

Themain tasks of the territorial suicidological service include:

- timely recognition and management of crisis states; ;
- solving diagnostic issues and applying suicide prevention measures;
- crisis therapy and rehabilitation of patients in the post-suicidal period;
- registration and recording of suicides and attempted suicides;
- conducting psychoprophylactic work with the population;
- providing organizational, methodological and advisory assistance to medical and preventive institutions of the assigned territory for the prevention, early recognition and relief of crisis conditions.

The suicidology service should consist of four divisions:

1. a helpline located separately from the psychiatric service .
2. office of a suicidologist at a neuropsychiatric dispensary (HDP);
3. office of social and psychological assistance in the polyclinic;
4. crisis hospital in a general hospital.

The suicidological service should be fully deployed as part of the republican, regional or regional HDP, as well as on the basis of one of the dispensaries in Moscow and St. Petersburg. As a service coordinator (with the right 0,5 to hold the position of department head).

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A full-fledged suicidological service should be deployed as part of the republican, regional or regional HDP, as well as on the basis of one of the dispensaries in Moscow and St. Petersburg. Coordinator of the service (with the rights of half the position of head.) it is advisable to appoint a doctor of the suicidological office of the HDP who has experience in administrative work, whose duties include:

- organization and coordination of the activities of each department of the service;
- staffing of full -time positions and training of personnel;
- informing employees of the service of instructional and methodological materials on topical issues of suicidology ;
- control over the implementation of the mentioned materials;
- maintaining information about suicidal attempts in the service area;
- preparation of analytical annual reports on the service's activities;
- personal involvement in solving complex diagnostic and therapeutic problems;
- educating society to work on suicide prevention. Units of the suicidological service should be completed based on the following calculation:

Suicidologist – 1.0 position per 100 thousand people. us (0.5 positions per 50 thousand of us); Medical psychologist - 1.0 position per 100 thousand of us. (0.5 positions per 50 thousand of us); Social worker - 1.0 position per 100 thousand of us. (0.5 positions per 50 thousand of us); Nurse - 1.0 position per 100 thousand of us; Nurse - 1.0 position per 100 thousand of us.

Workload standards and time allocation for employees of outpatient departments of the suicidological service:

1. The standard load of a suicidologist is: at an outpatient appointment , 2.5 visits per hour; at a hospital consultation , 2 consultations per hour; at a home visit , 1 visit per 1.5 hours.

2. The standard of the psychologist's workload during the examination is: 3 hours for 1 examination, including working with the patient – 2 hours;

preparation for the examination, data analysis and drawing up a conclusion – 1 hour.

3. The social worker's workload rate is 2.5 visits per hour on an outpatient , basis, and 1 visit per 1.5 hours outside the office .

The helpline is an emergency psychotherapy unit , that provides round-the-clock resolution of various crisis states, interpersonal and social conflicts at an early stage, and psychological assistance to single people. Recommended number of Helpline staff: per 1 million inhabitants: 2 psychiatrists (psychotherapists), 2 medical psychologists, 2 nurses, 0.5 positions of a statistician.

Social and psychological Assistance Office

The Office of Social and Psychological Assistance – KSPP) is a structural subdivision of the HDP, designed to detect and provide outpatient care for people with crisis and suicidal states among the population who do not need dispensary supervision.

CPPS should be located in territorial polyclinics, medical units of large industrial enterprises and universities and specialize in receiving and providing assistance to: adults, university students, and adolescents – including those with initial forms of drug and alcohol addiction.

Adolescent CPPS should be located in separate rooms. A doctor of an adolescent CPD should have a specialization in adolescent psychiatry. A special feature of the adolescent KSPP is also the need to conduct , psychohygienic and psychoprophylactic work with parents, employees of the public education and vocational education system, employees of city and district inspections for minors; this work serves as an additional source for detecting suicidal behavior in adolescents.

If a suicidal state of a non-outpatient level is detected in a teenager , the KSPP doctor carries out hospitalization of the teenager in a psychiatric hospital or in a Crisis hospital.

Any person can contact the KSPP anonymously . Indications for further management of CPP patients and providing them with medical and socio-psychological assistance are:

- non-pathological and neurotic situational reactions;
- psychopathic reactions, situational decompensation of psychopathies;
- psychogenic and neurotic depressions in an unspoken form;
- pathological personality development;

psychogenically determined reactions of patients with mental and drug -related diseases against the background of full-fledged long -term remissions and a low-progressive course.

The KSPP does not conduct military, labor, or forensic psychiatric examinations, nor does it issue certificates and documents to institutions, with the exception of courts and investigators. Information about individuals who have applied for CPI on their own is not subject to disclosure and transfer to other medical institutions. In case of suspicion of a mental or drug -related illness in a patient who has independently applied to the KSPP, the KSPP doctor should not send a notification to the psychoneurological (narcological) dispensary, but should indicate to the patient and his accompanying persons the need to visit the appropriate dispensary. The exception is made by patients with acute psychotic disorders who pose a public danger to themselves and others, information about which is transmitted to the dispensary in accordance with the established procedure.

The frequency of repeated visits to the KSPP by patients of any diagnostic category, as well as the appointment of psychotropic drugs to them, is determined depending on the condition of the applicant, is not limited and cannot serve as a basis for transferring the patient to the supervision of the dispensary. Initial and repeated patient visits to the CPP are carried out in strict accordance with ethical principles, on a voluntary basis, excluding any element of coercion or publicity.

KSPP employs: a psychiatrist who has specialized in suicidology and psychotherapy, a medical psychologist, a social worker ,and a nurse.

The KSPP doctor must:

- conduct outpatient examinations, therapeutic and rehabilitative management of all persons who have committed suicide attempts and are in crisis states;

- issue , if necessary , temporary disability certificates and certificates of exemption from study;

if there are appropriate indications , issue referrals for hospitalization in a crisis hospital;

- when applying to the internal affairs bodies , take part as an expert in the investigation of cases involving suicides;

- systematically conduct classes with medical workers of the service area on suicide prevention measures; popularize psychohygienic knowledge and skills among the population through lectures, discussions, seminars , etc .; explain to the population the tasks and functions of the CSPP;

- keep medical records in accordance with the established rules; if suicidal manifestations are detected , mark in outpatient cards: "suicidal attempt" or " suicidal intentions " with an indication of the date;

- draw up a report on the work done, submitting it to the head of the suicidological service and also to the chief doctor of the dispensary under whose jurisdiction the KSPP is located .

The duties of a medical psychologist and social worker coincide with the duties of the corresponding specialists of the suicidology office of the dispensary set out below.

A KSPP nurse must:

- make weekly reports on all cases of suicides and attempts among the population of the service area that are not under the supervision of the dispensary, based on information obtained in the office of the suicidologist of the dispensary;

- maintain a suicidological card file based on the information received , located in the

KSPP;

- ensure that patients ' primary and repeated visits to the KSPP are made within the time limits set by the doctor

by personal contact with the patient;

- together with the doctor , participate in outpatient appointments of patients, assist the doctor in maintaining medical records and preparing annual reports.

Office of a suicidologist at a neuropsychiatric dispensary

Suicidal contingent of a neuropsychiatric dispensary. Mentally ill people are much more likely to commit suicide than healthy people. The risk of suicide in people with reactive depression is 100 times higher than in healthy people, with endogenous depression – 48 times, with schizophrenia - 32 times. Among people admitted to a psychiatric hospital for a suicide attempt, 60% commit repeated suicidal acts within six months of being discharged from the hospital. It is noted that the risk of suicidal behavior in patients with endogenous psychoses is more pronounced: in young patients with a recurrent chronic course of the disease; with a high premorbid intellectual and social level; with a high level of claims; with a panic reaction to the disease; with the perception of the future as complete hopelessness.

According to V. E. Tsuprun (1986, 1989), the risk of suicide , in women under the supervision of a neuropsychiatric pharmacy is 1.5 times higher than in men. Suicide attempts are more often made by patients aged 20-29 years, then suicidal activity gradually decreases. Among patients who have completed suicide, suicide peaks between the ages of 50 and 59 for both sexes.

Among patients with suicidal behavior , there are several times more people with delinquent behavior compared to the same indicator in the clinic. The number of attempts increases in the spring and decreases in the fall. Most suicide attempts occur between 6 p.m. and midnight. Half of the patients resort to self -intoxication (more often - women), and in most cases they use psychotropic and hypnotic drugs. Every third person opens their veins (more often - men), every tenth hangs himself.

Patients with reactive depression and psychopathy have the highest risk of suicide, while patients with affective psychosis and schizophrenia have a slightly lower risk. After 5 years from the onset of the disease in patients with schizophrenia , suicidal activity decreases due to an increase in emotional and energy deficits. The motivation of suicide attempts in reactive depressions, psychopathies, and neuroses is mainly determined by psychotraumatic situations. In affective psychoses and schizophrenia , during periods of exacerbation , affective-delusional psychopathological disorders play an important role in motivating suicidal behavior , and in remission , the role of real conflict situations increases.

Chronic maladaptation is observed in patients with paranoid schizophrenia and psychopathy of excitable and asthenic circles, in which 60% of patients report repeated suicide attempts. The clinical picture of schizophrenia in these cases is determined by paranoid symptoms with asthenopathic inclusions in remission. The pessimistic worldview formed in the process , combined with thinking disorders and paradoxical judgments , creates conditions for the emergence of persistent communication disorders, accompanied by an unbearable sense of alienation. Patients suffering from psychopathy are characterized by introversion, excessive vulnerability, anxiety, mood disorders, " incontinence " of affect. Psychopathological symptoms in these patients differ in severity and stability. Interpersonal conflicts (both real and caused by painful experiences) are characterized by a sense of hopelessness and determine the occurrence and long - term persistence of suicidal tendencies. Monitoring of suicidal patients with chronic maladaptation includes systematic observation by a suicidologist, strict medical examination rules, active medical and nursing patronage, careful assessment of suicide risk, and differentiated assessment of the risk of suicide. psychopharmacological therapy and timely hospitalization.

As a rule, patients with manic-depressive psychosis, cyclothymia and simple schizophrenia experience periodic maladaptation to maladaptive crises, during which 30% of patients repeatedly attempt suicide. The mental state is

dominated by depressive, dysthymic and asthenopathic disorders. Sensitivity, lack of mobility and sociability of patients create grounds for exaggerating the significance of real conflict situations, often with an inadequate response to them and an increase in the actual painful experiences with a sense of low value of their insolvency. Patients with frequent adaptation crises receive psychotherapy aimed at increasing self-esteem and self-acceptance, mental stability, activity, and organizing assistance from the closest social environment. It is necessary to carefully monitor visits to suicidal patients at least twice a month, as well as close contact of the suicidal person with the family and relatives of the suicidal person, patronage at home and at work, and timely hospitalization for indications.

Patients with psychopathic schizophrenia, organic lesions of the central nervous system with psychopathic symptoms, as well as excitable and hysterical psychopathies with severe behavioral disorders have periodic maladaptation with deviant behavior. Autoaggressive actions in such cases are more often protest-demonstrative in nature, repeated suicides are noted in 50% of patients. Patients are characterized by severe emotional and volitional disorders, antisocial attitudes, deviant and delinquent behavior, and intolerance to restrictions. These features contribute to the complication of conflict relations, cause behavioral excesses in patients, often with the manifestation of hetero - and autoaggression. Sonapax and neuleptil are used in the treatment of patients with periodic maladaptation in the presence of behavioral disorders; for periodic affective disorders , a combination of antidepressants, neuroleptics and lithium is used. Psychotherapy is aimed at the value reorientation of the individual, the destruction of the pattern of demonstrative suicidal behavior.

The office of a suicidologist at a neuropsychiatric dispensary (polyclinic) is a structural subdivision of this institution and is designed to serve suicidal patients and suicidal patients under the supervision of a PND. A psychiatrist ( ) with a specialization in suicidology, a medical psychologist, a social worker and a nurse work in the PND suicidology department (outpatient department) .

The contingent of patients to be monitored in the suicidology office is represented by two groups:

1) patients who have attempted suicide

2) patients with suicidal tendencies

Patients 1- of group 1 should be taken to the suicide clinic as early as possible after a suicide attempt. In cases where they are admitted to a psychiatric hospital after a suicide attempt, the suicidologist should examine them in the hospital during the first week, and then monitor their condition weekly, participating in patient management and counseling at discharge. At the same time, together with the attending physician , the clinical condition is clarified , the scope of localization of the conflict is revealed, the degree of its relevance after a suicide attempt, adequate therapy is selected , and the need for social assistance from the HDP is clarified.

At the first examination in the psychiatric department , medical contact with victims is established, which is fixed and maintained in the future during outpatient observation. This contact is based on an approach aimed at restoring a positive and constructive attitude to life, to one's personal and social status , taking into account the characteristics of the micro -social environment.

If the patient is not hospitalized after a suicide attempt, he should be invited as soon as possible to the suicide office, where he will be observed in the future for rehabilitation and prevention of repeated suicidal actions.

Individual suicide management tactics vary depending on the type of post-suicidal state, the severity of suicidal risk, the characteristics of the course of the reaction, mental status , and specific microsocial conditions. The following scheme of suicides ' appearance in the doctor's office is recommended.

For suicidal patients undergoing inpatient treatment: in the first 2 months after discharge from a psychiatric hospital - weekly visits; in the next 2 months - 1 once a month; then for six months - monthly; after this period - monitoring of participation. For non-hospitalized suicides: in the first 2 weeks after the attempt -

1 time in 3-4 days; the next month and a half - weekly; then for six months - monthly with a control package a year after the attempt.

Patients of the 2nd group - who have not attempted suicide, but have suicidal tendencies, if they are present , are hospitalized in a psychiatric hospital or a crisis hospital. Indications for hospitalization are: anxiety-depressive states in the elderly , hypochondriac raptoid states, hallucinatory-paranoid states with imperative hallucinations of self-harming content, acute states of fear with agitation, depressive-paranoid states with feelings of guilt or "threat to life". Indications for hospitalization are also severe dysphoric states with autoaggressive tendencies, depressive states in the presence of an unfavorable microsocial environment, acute depressive reactions to the psychotraumatic situation of procedural patients in remission, psychogenic reactions in neurotic and psychopathic individuals.

If it is necessary to determine the indications for hospitalization , they take into account the socio-psychological situation as a whole, and, no less important, the individual's anti-suicidal resources. It is not enough to take into account only the clinical characteristics of the condition, the presence of suicidal experiences. In addition , for all the above -mentioned categories of patients (with the , possible exception of the last two) , the criterion of danger to oneself can be used as a factor that makes it possible to justify the need for compulsory psychiatric hospitalization in accordance with the Law of the Russian Federation "On Psychiatric Care and guarantees of" rights in its provision" of 07.02.92 . As for the last two groups of patients, we can talk about the possibility of their placement in a crisis hospital and, therefore, the psychotherapeutic contact of a suicidologist allows you to get the patient's consent to hospitalization.

According to the above -mentioned rules, a suicidology doctor must:

- examine patients with suicidal thoughts on the referral of district psychiatrists; provide dynamic outpatient monitoring and treatment of these patients until the risk of suicide is eliminated; if the patient refuses treatment

with a suicidologist , provide the district doctor with detailed instructions for further treatment;

- actively identify patients who have attempted suicide in institutions and conduct medical follow -up within a year from the moment of the attempt;
- participate in the management and discharge of patients from the service area who are in a psychiatric hospital in connection with a suicide attempt; after that , observe them on an outpatient basis for a year;
- examine people referred from the social and psychological assistance offices of polyclinics and decide whether they need treatment in the suicidological office of the dispensary. If necessary , they are treated until the suicide risk is eliminated. In the absence of indications for treatment in a suicidological office , refer patients to district psychiatrists; issue temporary disability certificates to patients if necessary ;
- if there are appropriate indications , ensure that patients are hospitalized in a psychiatric hospital or in a crisis hospital;
- report on all cases of suicide and suicide attempts among patients under the dispensary's supervision at weekly meetings of dispensary doctors , with a brief analysis of them and a statement of preventive recommendations;
- coordinate the work of a medical psychologist, social worker , and nurse;
- at the end of the year , submit a report on the activities carried out to the head of the territorial suicide service and the chief doctor of the dispensary where the suicidology office is located.

A suicidologist should keep medical records in accordance with the following rules.

Upon admission to the suicide clinic , the district psychiatrist must make an entry in the outpatient card "sent to a suicidologist".

Cthe suicidologist should make notes marked "consultation with a suicidologist" or "conducted under the supervision of a suicidologist"; in the latter case , the patient is fully under the supervision of a suicidological office.

For patients under the supervision of a suicidologist, it is necessary to issue visit cards and arrange them by the dates of their next appearance.

When transferring a patient for further management to a district psychiatrist , make a note in the outpatient card : "removed from the suicidologist's register".

When examining patients with suicidal tendencies in a psychiatric or somatic hospital , put a warning in the medical history and when the patient is discharged , put his signature under the conclusion of the commission (together with the head of the department and the attending physician).

A medical psychologist in a suicide clinic must:

- participate together with the doctor in outpatient appointments of patients;
- conduct an experimental psychological examination of patients as prescribed by a doctor and record the results of the study in the outpatient card;
- participate in the organization and conduct of various forms of psychotherapy;
- conduct systematic work with the population to promote psychohygienic knowledge.

The social worker of the suicidology office must:

1. follow the instructions of the suicidologist on conducting social expertise and rehabilitation measures, establishing contacts between dispensary and industrial institutions, state bodies and relatives of patients;
2. ensure the provision of social assistance to patients under the supervision of a suicidal practice in cooperation with social protection agencies, refugee, family and youth affairs committees;
3. provide patients with job search assistance and the necessary legal protection in administrative and judicial institutions.

A nurse in a suicidal practice must:

- provide social assistance , to patients under the supervision of a suicidological office by communicating with social protection agencies, refugee, family and youth affairs committees;

- provide patients with employment assistance and the necessary legal protection in administrative and judicial institutions.

A nurse in a suicidal practice must:

1) prepare weekly reports on all cases of suicide and suicide attempts among residents of the service area based on emergency ambulance notifications , telephone inquiries from the duty department of the District Department of Internal Affairs and emergency departments of somatic hospitals of the district;

2) identify service areas for patients with suicidal tendencies , who are under observation in the HDP and taken under observation after a suicide attempt, by checking the information received with the dispensary's card file; at the same time, the date of the suicide attempt must be entered in the outpatient card of these persons and an entry should be made: " to see a suicidologist";

3) identify suicidal patients in the service area , who were hospitalized in a psychiatric hospital due to a suicide attempt by contacting the reception department of the corresponding psychiatric hospital by phone;

4) develop and maintain , based on the information received , a central suicide card file located in the suicidologist's office (patients under the supervision of a suicidological clinic should be recorded in the general journal);

5) ensure the primary and repeated appearance of patients in the office by personal contact with them within the time limits set by the suicidologist;

6) when visiting patients at home , fill out patronage lists;

7) together with the doctor , participate in outpatient appointments of patients, assist the doctor in maintaining medical records and preparing annual reports;

8) transmit weekly information about suicidal patients under the supervision of the polyclinic and those taken under supervision – to the doctor of the suicide office; those who are not under supervision in the polyclinic and are not under supervision - to the nurses of the social and psychological support offices located on the territory of the service.

The effectiveness of a suicidology clinic should be evaluated according to the following criteria:

- the rate of relapse of suicidal actions in mentally ill people (during the first year after a suicide attempt);

- an indicator of the number of completed suicide attempts in people with suicidal states who were under the supervision of the cabinet;

- an indicator of identifying patients at risk of suicide;

-the degree of coincidence of a number of parameters of persons with suicidal states and suicidal persons.

Crisis hospital

A crisis hospital is a structural subdivision of an emergency hospital or other somatic hospital designed to provide inpatient suicidal care and is intended for isolation from a psychotraumatic situation, short -term intensive care (2-4 weeks) and rehabilitation of persons in a suicidal state. The need to organize a Crisis hospital outside the structure of a psychiatric institution is due to the fact that among the suicidal population groups, a significant proportion are practically healthy people or people with borderline neuropsychiatric disorders, whose care in psychiatric hospitals seems inadequate and has known negative consequences.

The medical staff of a Crisis hospital is included in the staffing table of the hospital, on the basis of which it is deployed in accordance with the recommended staffing standards below, and enjoys the benefits of the staff of psychiatric institutions.

The crisis hospital is developed from the following calculation: in cities with a population of 300 to 500 thousand people - for 20 beds, from 500 thousand people to 1 million - for 30 beds, from 1 million or more - up to 60 beds. In cities with a population of less than 300 thousand , at least 10 rehabilitation suicidological beds are allocated in departments where suicidents are mainly delivered by Ambulance : toxicological, traumatological, psychosomatic , etc. .

The position of the head of the Crisis hospital (head of the department) is set for 30 or more beds; with a smaller number of beds , the functions of the head.

These services are performed by the department at the expense of an additional 0.5 doctor's rate.

Number of beds in a Crisis hospital for 1 position: suicidologist - 10 beds, medical psychologist – 15, social worker - 20, ward nurse (1 round – the – clock duty post) – -20, ward nurse (1 round – the-clock duty post) – 20, barmaid - 30, bath attendant- 30 . In addition , the department is allocated 1 position of senior nurse, procedural nurse and nurse hostess.

The main flow of Crisis Hospital patients is formed in the KSPP, but the referral of patients from the neuropsychiatric dispensary and the trust service is not excluded. Some patients are also being transferred from the intensive care and psychosomatic departments of city hospitals, where they were taken by ambulance in connection with suicide attempts.

Indications for referral to a Crisis hospital are:

- high relevance of a psychotraumatic situation with the preservation of suicidal tendencies in persons who have made a suicide attempt in a state of psychological crisis;

- neurotic situational reactions, situational decompensation of psychopathy, psychogenic and neurotic depression, reactive states accompanied by active autoaggressive tendencies in the subsequent post-suicidal state in endogenous patients in remission who are critical of their disease; the severity of somatic complications of a suicide attempt that requires inpatient treatment.

Contraindications for hospitalization in a Crisis hospital are severe somatic diseases, acute psychotic conditions, alcohol and drug addiction in a decompensated state.

Referral of patients to the Hospital de Crisis is carried out by suicidologists of outpatient clinics of the suicidological service, as well as directly by psychiatrists of outpatient consultation. Admission of patients to a Crisis hospital is carried out by the doctor of the Crisis Hospital through the emergency department of the hospital.

The main methods of treatment and readaptation in a Crisis Hospital are crisis psychotherapy and social rehabilitation combined with drug therapy; the department operates in an open -door mode with extensive use of home leave, and visitors can see the patient with their consent.

Specific tasks of the Crisis Hospital require maximum intensification of the work of all specialists, coherence in their work, which is facilitated by the method of managing patients in a team. At the same time, a team consisting of a psychiatrist (psychotherapist), a medical psychologist and a social worker, with the main role of the doctor, works with the patient. This form of care provides more effective work by collecting more complete information about the patient, localizing his problem and choosing the most appropriate tactics for resolving the crisis, as well as sharing overall responsibility for the patient.

In cases of acute psychopathological symptoms requiring intensive care in a closed department, patients are transferred to a psychiatric hospital in accordance with the Law of the Russian Federation No. 3185-1 "On psychiatric care and guarantees of citizens ' rights in its provision " of 02.07.1992 . To comply with ethical principles , it is not recommended to indicate a suicidological or psychiatric diagnosis.

After discharge from the crisis hospital , the following patients are referred for further outpatient follow -up:

1) those who are under observation in a neuropsychiatric dispensary or who need to be monitored – to the suicidological offices of the HDP;

2) those who are not under the supervision of the HDP and do not need to be monitored – in the KSPP. An extract from the medical history is sent to the specified outpatient service units within three days.

Suicidologists working in a crisis hospital (or in suicidological beds in the emergency room) advise all suicidal patients admitted to this hospital, determine further treatment and rehabilitation tactics for each patient , and select patients in critical condition for transfer to a crisis hospital or to suicidological beds.

Narcological sector of the suicidological Service

The narcology sector of the suicidological service is intended for the prevention of suicidal behavior in people suffering from chronic alcoholism, substance abuse, therapy and rehabilitation of suicidal drug users. This sector includes a suicidological practice for drug patients, a drug -related suicidological hospital , and a psychotherapy rehabilitation club.

In the suicidology office , , patients with alcoholism with an increased risk of primary and repeated suicidal actions are identified, registered and treated on an outpatient basis. The office operates in accordance with the principle of patient anonymity. Referral of patients to a suicidological office is provided by narcologists of inter -district narcological dispensaries, doctors of psychosomatic departments, KSPP and a Crisis hospital. Indications for referral to a suicidology clinic include:

- post-suicidal states in patients with chronic alcoholism, drug addiction and substance abuse who have made non-psychotic suicide attempts;
- suicidal thoughts and statements in a state of intoxication;
- persistent suicidal tendencies in the withdrawal and post-withdrawal periods;
- depressive and dysphoric type of alcohol intoxication;
- persistent depressive and dysphoric manifestations in the clinic of the disease;
- personally significant microsocial conflicts in patients in the initial stages of the disease;
- relapse of the disease after remission lasting 6 months or more.

1) A doctor, a psychologist , and a secondary health worker work in the office. outpatient examination, treatment and rehabilitation management of alcoholism patients with suicidal tendencies. The flow of patients is formed by an active call for suicide on the part of employees based on weekly reports of psychosomatic departments of hospitals about suicide attempts of drug patients;

2) organization of registration of the suicidal population among drug -addicted patients with active medical examinations at least twice a year;

3) outpatient examination, medical and educational care for patients with alcoholism and suicidal tendencies. The flow of patients is formed by actively calling suicidists from employees on the basis of weekly reports of psychosomatic departments of hospitals about suicide attempts of drug-addicted patients;

4) organization of registration of the suicidological contingent among drug - addicted patients with active medical examinations at least twice a year;

5) emergency hospitalization of patients in the acute post-suicidal period to a specialized suicidological service, as well as referral for hospitalization to drug treatment departments in case of relapse of the disease in patients who do not belong to the group of increased suicidal risk. Referral for inpatient treatment is carried out through the inpatient service of the hospital by issuing specially marked coupons;

6) provide patients with the necessary social and legal assistance;

7) conducting systematic lectures with doctors of drug treatment hospitals and drug treatment dispensaries on methods for detecting suicidal states in drug - treated patients and suicide prevention measures.

The functions of a medical psychologist include:

- participation in outpatient admission of patients with alcoholism, drug addiction and substance abuse together with a narcologist;
- conducting an experimental psychological examination of patients as prescribed by a doctor in order to determine the suicidal risk and identify anti-suicidal factors. The results of the examination in the form of a detailed conclusion with recommendations of psychotherapy and rehabilitation programs are entered in the outpatient card;
- participation in the organization and conduct of psychotherapy sessions and social rehabilitation activities.

The functions of a nurse include:

- collecting information about suicide attempts among drug -addicted patients in psychosomatic departments at least once a week;
- verification of the received information in drug treatment dispensaries;
- drawing up and maintaining a suicidological file of drug patients based on the information received;
- providing patients ' initial and repeated visits to the office within the time limits set by the doctor by calling them by mail, phone, and visiting them at home;
- carrying out social examinations and rehabilitation measures in cooperation with relevant institutions, organizations and relatives of patients registered in the narcological office (according to the instructions of a doctor and a medical psychologist);
- participate in the preparation of final reports.

A suicidological narcological hospital with e e e a 30 -bed department a e a is based on the department of the narcological hospital and reports to the head of the department. department. Indications for referral to a drug treatment hospital are:

- post-suicidal states with signs of maladaptation in drug -addicted patients,

who have made non-psychotic suicide attempts.

- postabsorption astheno-depressive disorders with a e suicidal tendencies;
- situational reactions and reactive depressions with suicidal tendencies in patients with alcoholism (including on the background of complete remission);
- relapses of the disease in the presence of personally significant psychotraumatic factors and suicidal tendencies.

Contraindications for referral to a suicidological narcological hospital:

- alcoholism in the final stages of the disease with a pronounced psycho - organic syndrome;

Referral of patients to a suicidological narcological hospital is carried out by employees of the Suicidological Center, a namely the narcologist of the suicidological narcological office, and narcologists of the reception department of the narcological hospital (in agreement with the head of the department). department).

The main method of therapy and readaptation in the hospital is individually selected individual, family and group psychotherapy in combination with pharmacotherapy. In case of alcoholic psychosis , patients are transferred to specialized departments or wards of a drug treatment hospital. If e symptoms worsen and require intensive care, patients are transferred to a psychiatric hospital.

Disability certificates are issued in accordance with the general rules for drug treatment departments. After discharge from the hospital , patients are sent on an outpatient basis for further observation to a suicidological narcological office or e a narcological dispensary at the place of residence. Extracts from the medical history are sent to the specified outpatient institutions within 10 days after discharge.

8. METHODOLOGICAL ASPECTS OF CRISIS THERAPY

Diagnosis of suicidal behavior

E. Ringel (1976) described a diagnostically important e a presuicidal syndrome based on a triad: narrowing, inversion of aggression , and suicidal fantasies. The syndrome includes the following signs:

- A sharp, sudden narrowing of the intellectual background, a restriction of thought processes, a narrowing of the content of thinking, a decrease in the ability to search for viable options that would normally come to a mind.
- Narrowing of perception, withdrawal , feeling of loneliness, meaninglessness and hopelessness. Strong confusion, that is , the aggravation e e a of a person's experiences, the presence of a feeling of complete collapse of his plans, hopes , etc .
- Impotent aggression, reproaches to a e others, " giving up", a message about the intention to commit suicide.

- a e ee, a e a ea ee, a, , a ee, ae, e, ae e e ee.
- e eae, a eae aee, ee e aa e a eee a a.
- e aa, a e ee ae a, aa ea aa, e e ee a e a.
- ea «ae ee e» e e, a ee e ae aaaae a aa ea.

