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Social death in seniors

Śmierć społeczna wśród osób starszych

Abstract

Dying and death are parts of the life and are unique and personal to everyone. People are afraid of death, often due the fear of the unknown, suffering and loss of the quality of life. Death as such is affecting seniors most, which is, of course; relating to the life cycle. With ageing people are clearly aware of the irreversibility of this cycle and especially in cases, when decreasing of quality of their lives is linked with hospitalization or other forms of social care, which are requiring them to leave their home and social environment. Palliative care is applied in the terminal stages of the disease in present time and the process of dying is an integral part of nursing care. Seniors assess life via the quality of life. This quality of life is judged on its own values, which are in different order for everyone: health, social networking, free time activities or financial situation. Hospitalization of the senior often leads to social isolation, which in many cases ends with social death, and it usually comes much earlier than biological death. The aim of the paper is to draw the attention of the professional and general public to the phenomenon of social isolation and social death of seniors, which in our society, and not only in Slovakia, is beginning to emerge as a more and more current issue.

Keywords: social death, social isolation, senior, nursing, palliative care, constitution guaranteed health care.

Abstrakt

Umieranie i śmierć są częścią życia i są unikalne i osobiste dla każdego. Ludzie boją się śmierci, często ze względu na obawę przed niewiadomym, cierpienie i utratę jakości życia. Śmierć jako taka najbardziej dotyka starszych, co jest, oczywiście, związane z cyklem

życia. Starzejąc się, ludzie są świadomi nieodwracalności tego cyklu, a szczególnie w przypadkach, gdy pogarszanie się jakości ich życia związane jest z hospitalizacją lub innymi formami opieki socjalnej, co wymaga od nich opuszczenia domu i środowiska społecznego. Opieka paliatywna jest obecnie stosowana w stanach terminalnych choroby, a proces umierania jest integralną częścią opieki pielęgnacyjnej. Ludzie starsi oceniają życie poprzez jakość życia. Jakość ta jest oceniana według własnych wartości, które pojawiają się w różnym dla każdej osoby porządku: zdrowie, powiązania społecznościowe, czas wolny lub sytuacja finansowa. Hospitalizacja osoby starszej często prowadzi do izolacji społecznej, co w wielu wypadkach kończy się śmiercią społeczną, i zwykle przychodzi dużo wcześniej niż śmierć biologiczna. Celem artykułu jest zwrócenie uwagi profesjonalistów i ogółu społeczeństwa na zjawisko izolacji społecznej i śmierci społecznej seniorów, które w naszym społeczeństwie, nie tylko na Słowacji, zaczyna pojawiać się jako coraz bardziej aktualny problem.

Słowa kluczowe: śmierć społeczna, izolacja społeczna, osoba starsza, pielęgnacja, opieka paliatywna, opieka zdrowotna gwarantowana konstytucją.

Introduction

The last stage of human life is ageing, which brings different economic, social, health and psychosocial changes that must be faced not only by senior but also by society (Horanska, Lizakova, 2017). Health changes require help form medical staff in many cases. A large part of health care is nursing care. The goal of nursing care is to provide biological, psychological, social and spiritual support and to perform activities that contribute to the maintenance of health, healing or securing a restful and dignified ageing. Nursing care is also an important part of overall care for the elderly. Its main objectives are to maintain functionality and self-sufficiency, to alleviate suffering, to respect the dignity of the personality, to prevent complications, to maintain the quality of life and to ensure peaceful dying (Bubenikova, et al., 2000). It is very important to actively involve and support the patient and patient family in the process of healing, regeneration and health promotion (Farkasova, et al., 2001). Social death of the seniors is very common in case when seniors are ripped out of the house and placed in institutional health or social care. Social death is becoming a topical issue not only for the Slovak Republic, but similar problems are visible in the Czech Republic as well, as it results from many studies. The extensive research carried out by Pro-Viaticus in Slovakia (Žáčková, 2016, Kohútová, 2017) clearly shows that seniors are particularly worried about the loss of social contacts, the absence of family

members at the time of death and fear of dying in a foreign environment instead of dying at home. In spite of these instances and provided studies, our society responds very vaguely to these problems. The three-generation family is already a past and the current trend of life is focused on individualism and the individual. The egoism of our society is also reflected in the care of the seniors and is manifesting with their shift from home environment into institutional social care facilities. A modern human does not like to identify with suffering, ageing and even not with dying. The aim of this contribution is to highlight the dying as such, the importance of accompanying persons, the possibility of palliative care, but on top of that the risk of social isolation of seniors, which hospital staff is significantly observing during hospitalization of seniors.

1. Death, death accompanying persons

The continuity of life includes dying and death, which is unique for every person (Hudakova, 2014). Dying is itself a very demanding process. Each person has own specific reactions to difficult life situations. Their distinction depends on a variety of external circumstances, on personal experiences and especially on the personality of the individuals. However, the certain patterns are preserved. The phases through which the patient passes, were observed and described very carefully by Dr. Elisabeth Kübler-Ross. There are five phases:

- The first phase – shock, denial of reality, reluctance to accept the truth and isolation: "Not me!" The first phase is the primary reaction to fate by a dying person. It is often experienced as a shock.
- The second phase – anger, riot: "Why me? Why I am sick, and you aren't?!" It is typical to begin the patient's propitiation with fate, which is manifested in anger, explosiveness and aggression. Often, their anger can also turn inside, sometimes with a pronounced tendency to self-tormenting and self-punishment. These explosions of anger essentially correspond to the "call for help" and come out of the helplessness of a person sentenced to death, which requires a deep understanding of the environment.
- Phase Three – negotiation: "Maybe not me, not yet." The patient's behavior changes at this stage, it seems as though a bit connected with the reality and begins to "negotiate" with fate about time.
- The fourth phase – depression, despair: "What makes sense to me, what that means to me?" The beginning of this phase varies greatly from the physical state of the dying person. This stage usually occurs when the

disease progresses significantly and the patient visibly loses physical strength, so that patient and they surroundings are aware that patient is incurably sick. The depressive mood is a dying person sometimes to ask for a "liberation injection" that would reduce the waiting for death or to sudden suicide attempt. There is no doubt that in this time it is important to recognize the depressive state and help the patient cope with fate.

- Phase Five – acceptance, reconciliation: "Yes, if it must be, I accept it." At the last stage before patient's own death, the dying person is coping with the disease, coping with the end of life, coping with retiring from the life. There is a new hope that the life, the survival and the death have a deep, hidden meaning. Believers put this hope in God, but other people find their own sense. It can be said that it is ideal for the patient to reach this state of reconciliation. Subsequently, the euphoria is replaced by a deadly coma. The dying person stops responding to the words, moving away from a life for which longer has no power. (Kübler-Ross, 1995).

These phases do not always have to keep this sequence, often some returning, changing between two or even three phases; phases can sometimes overlap in one day. They do not have the same length and, in addition, some of them may be missing. It is good to remember that there is often a time shift when you are experiencing individual phases. The dying person can be already in the reconciliation phase, while their relatives are still only in the negotiating phase (Matousek, 2005).

Svatosova (2001), as the founder of the hospice movement in the Czech Republic, expressed serious concerns about today's society. If people are confronted with suffering, dying and their own mortality, they feel quite uncomfortable. This way of thinking seriously jeopardizes the humanity of man. J. Komensky compares dying to art and his words inspired Svatosova (2001), which shifted the dying to new level and who talks about dying as the art of accompanying an affected patient. Student and team (2006) even specify an ideal companion as a family member. It draws attention to the fact that the needs of the companions and their relatives are closely related. If a dying person is feeling suffering, then a companion person is feeling suffering. In case the relatives do not work very well, the patient is also suffering. This connection is important but often burdensome. Facing the phases of reconciliation with death is not challenging the dying person only, but also the family that surrounds them. The problem arises if the family, unlike the patient, does not cope with the death and it significantly complicates they departure. It is nec-

essary to start working with the family before this phenomenon occurs. Here is space not only for doctors and other healthcare professionals, but also for social workers who represent the pillars with which sick people and their relatives can count on in difficult moments and at any time. Their job is to provide sincere hope, endless love and unbreakable faith. Matousek (2005) set several points for accompanying the dying person. It is essential to behave naturally, with not hiding insecurity and pain and it is definitely good to be authentic. Companions should have the ability to listen and understand and, in particular, they should prove to the sick that they have enough space and time for patient. An important role of accompanying is to participate in maintaining social interactions with a goal to prevent the social death.

2. Palliative care

Palliative medicine tries by its own approach to maintain the respect for the integrity of patient. The philosophy of respecting the integrity of personality can be represented by an example of pain. Physical pain is relatively well defined and controlled. Social pain is associated with the suffering from separation or loss of family or social role. Spiritual pain is defined as the most difficult. It concerns estrangements from the deepest self, which is often experienced as the fear of the unknown and the sense of loss of the sense of life. Dampening physical pain is certainly a very important moment. On the other hand, it is necessary to be aware that the reasons given by the people requesting euthanasia are mainly the fear of the unknown, the fear of dying, the fear of loss of dignity, the fear of loss of life, the fear of loneliness, the feeling of harassment of the environment and the subsequent as unbearable pain (Munzarova, 2005). Palliative medicine can help the senior and his family to cope with the process of dying.

Modern palliative care does not turn away from incurably ill patients, but places emphasis on the quality of life and protects their dignity. It specified certain principles and principles of palliative care. Care for incurable patients is geared to different age categories and with big proportion they are seniors. Basic Principles of Palliative Care by Slama and Spinka (2004):

- Don't turn away from the incurably ill, but protect their dignity with main focus on the quality of life;
- They can successfully manage the pain, relieve pain, coming out consistently from individual wishes and needs of patients, respect values and protect the right of the patient to self-esteem;

- Support the life and cope with dying as a normal process and do not intend to speed up or shunt the death;
- Use a team-based approach to address the needs of the sick and their families, including counseling in the case of grief over the loss of a close person.

To maintain the good quality of life, it is advisable to divide palliative care into general and specialized. General Palliative Care is comprehensive care, based on monitoring, influencing, and recognizing what is important for a patient's quality of life. It is performed in non-specialized or conventional facilities where palliative care is not a basic activity. This includes general nursing services, nursing homes, seniors' homes, and more. In the case of specialized care, interdisciplinary palliative care is provided not only for patients but also for their close relatives. This is a type of care provided mostly in specialized facilities. Palliative care can be divided according to the environment where care is provided to home, home for seniors, bed hospice, day hospice/stationary one, hospital (Recommendation REC No. 24, 2004). The goal of an advanced society should be to alleviate the suffering of the dying and at the same time maintain its dignity and social interactions. In such a case, the form of palliative care in the home environment appears to be the most appropriate. This method of care is also appropriate in terms of preventing social isolation of the individual and for society represents lower costs in direct comparison with institutional social care.

3. Social isolation, social dying, social death

The term "social death" first entered the vocabulary of social science by the study by Sudnow (1967) on social processes related to death. On the basis of observations, the authors have expressed the existence of differences between clinical, biological and social death (Kralova, 2015). Sudnow claimed that "social death" is the result of focusing on the body (Borgstrom, 2015), which many times reflects the current care.

Social dying refers to the condition where a person lives but is excluded from important social and interpersonal relationships, is isolated from society. Social death is by clinical psychologists and bioethics understood as a complete isolation of a living person with a conscious awareness from the contact with the environment (Vondracek, 2012). Social death is a situation where these changes are permanent and irreversible. It can emerge much earlier than biological death. Social death occurs when the quality of life of a person

is unsatisfactory. The consequence is often the desire to die. Social death includes, in particular, a feeling of being unnecessary for the environment, lack of quality free time activities, lack of social contact, poor health, resignation (Roberts, 2010).

The reasons cited by the people requesting euthanasia are mainly the fear of the unknown, the fear of dying, the fear of loss of dignity, the fear of loss of life, the fear of loneliness, the feeling of harassment of the environment, and then the unbearable pain (Munzarova, 2005). Svatosova states that the most frequent cause of the request for the end of life is the indifference and the disrespect for man. Pacovsky (1997) says," In line with aging the number of suicides that have been completed exceeds the number of suicide attempts, which has a rational background", (they feels it like "not worth living"). Social isolation of seniors usually occurs as a result of a serious life event and lasts until death. This serious life event is often associated with a significant deterioration in the quality of life. It can be loss of vision, limitation of mobility, loss of the life partner, placement of the senior in an unknown environment. This is the time when the senior resigned from his life and is waiting for death.

Seniors assess life based on its quality. This quality of life is judged on its own values, which are in different ways: health, social networking, free time activities or financial situation. If the quality of life falls below the individually determined limit of carrying capacity, there is social death. Social death suggests three strategies of end-of-life understanding: happy end of life, social isolation, displacement of the end of life. The happy end of life is understood as time not limited period where one lives in total well-being until death. Social isolation represents a state where on the basis of a certain life event a person resigns from the life and basically awaits death. The last strategy of understanding the end of life is displacement of the end of life. This can happen in an individual or social plane. Displacement of the end of life in an individual plane means that man tries not to think of they own fear of death. Social displacement understands death as a sociological danger in life and therefore puts it behind the society (dying in hospital, but not at home on the eyes of others). For the dying person this is putting behind, as isolation from the rest of society (Elias, 1998). Dying is also a stressful factor for healthcare professionals themselves, despite the fact that they encounter death much more often than others.

Cap says that there are a few reasons why doctors have the problem of talking about death: it reminds them of their own death, lacking of adequate training, survival of the patient's death as their own loss, failing to cope with the emotional response of the patient and patient family, and last but not least, they have no answers to all questions (Cap, 2016). For nurses working in departments,

where death is often a part of their work, it is very difficult to ensure the satis-
faction of not only biological but also psychological, social and spiritual needs
(Horanska, 2017). There is no need to make a scarecrow from the death. Rather,
we should keep in mind that a human is a social being and this is valid while
dying, as well. In human imagination, dying seems terrible. However, this per-
ception does not have to reflect reality. In two studies, the authors of Goranson
and team compared the affective experience of people facing imminent deaths
with people who are approaching death. The results suggest that the experience
of dying, even at the terminal stage of the disease, may be more pleasant than
the person expects (Garanson and team, 2017). It is important, however, to re-
spect not only the body but also the soul dying from the point of view of social,
psychological and spiritual needs.

Conclusion

If we think about the attitude towards old age, we will find that it is the ef-
fort of today's society to postpone this unpleasant life event somewhere in in-
stitutional care. Reasons are different, whether economic, social, those of per-
sonality or others. However, the result is still the same and the seniors will be
pulled out of their home and social environment. We often justify ourselves by
the better care in a specialized facility than in a home environment. On the
other hand, sometimes the presence of close persons is more important than
a special treatment. Many times we see that the numbers of visits of close peo-
ple are decreasing, with length of hospitalization proportionally. Despite the ef-
forts of medical practitioners, it is not always possible to ensure all needs and
adequate measures. On the other hand, if we want to respect people, we should
also respect the choice of social death and the strategy it practices. By adequate-
ly satisfying the bio psychosocial needs of the elderly, we can prevent the on-
set of social death and contribute to dying in dignity. This should be the effort
of all concerned (family, friends, health care professionals, nurses, state). It is
necessary to deal more closely with this issue in view of ageing of the popula-
tion throughout Europe and not only in Slovakia and in the Czech Republic. We
face with lack of the extensive qualitative and quantitative research and studies
focused on life of the seniors, unfortunately. As stated by Kačmárová (2013), the
Slovak or Czech version of the standardized questionnaire on the quality of life
of seniors still exists only for WHOQOL-OLD. These data could serve as the basis
for creating useful methods which would eliminate the social isolation of the
dying. We can build on the information and experience we have now, and we

are sure that there are simple measures that can bring the result in a relatively short time. The education of family, friends, health care professionals and others is offered as the first choice.

Measures relating to domestic care for the dying:

The fact that we have not even recognized the concept of "social death" in our country for a few decades, says everything. Three-generation families provided care not only for seniors, but for children, as well. It is necessary for the relatives of the senior to understand that their relative wants to die at home, not alone in the hospital or institutional social care facilities. It is essential that families must be supported from the state in case of taking care of dying seniors. Perhaps it would be enough to appreciate the work of caregivers who are providing care for seniors abroad and in this way return caregivers back home to do the same job in their families.

Promote the development of mobile hospices that allow for palliative care in the home environment.

In the case of institutional care, to educate health professionals, support volunteering, family and friends in maintaining social contacts. For example, we can list the seniors' Home in the Netherlands, where college students are receiving free accommodation in case when they spend a part of their leisure time with seniors (social games, PC work, walking assistance, etc.). Alternatively, we can create the small family houses for seniors which will follow their needs and will create new social interactions. This is just a draft of several measures, which can cope the dying in more human way. The whole society must realize that death is not our enemy.

There is no reason to hide death behind the walls of a hospital, hospice and home for seniors. Displacement of death into institutional care could be the reason why we are afraid of death and refuse to accept it. It is very important how we will face dying. Death is a part of the life cycle, and as such we have to accept it. Let's just keep in mind that it is up to us whether social death will be the part of the dying or not. Everyone has the right to decide, but our goal should be that no one has a reason to say "it is not worthwhile to live".

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