

Suicide Risk Factors and Prevention in Cancer Patients

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Key words: suicide; cancer patient; suicide risk; prevention.

Summary. Generally suicide is defined as a voluntary intentional action, on occasion – as an impulsive, sudden and not planned act. Since 1993, Lithuania has had the highest suicide rates in the world among men and topped the ranking of women's suicide rates in Europe.

Despite promising progress in oncology health care services, the data of foreign authors indicate suicide being more prevalent among cancer patients than among the general population. At this moment, data on the incidence of suicide among cancer patients in Lithuania are not available.

The aim of the literature analysis was to identify the main suicide risk factors and consider aspects significant to the prevention of suicide in cancer patients.

Methods. The review was based on the recent literature obtained through a PubMed search (covering period from February 2001 to January 2011). During the first screen, 483 potentially eligible citations were identified, and 35 articles met the eligibility criteria for this review and were retrieved.

Results. In various literature sources a described about 60 suicide risk factors. Depression has been identified as the main and most prevalent suicide risk factor, whereas cases of other mental pathology have been regarded as less common. Experienced symptoms such as pain, dyspnea, or reduced physical activity play a significant role in the risk of suicide. Tumor localization and post-diagnostic period are also influential on suicide risk. Suicide is induced by demographic, social, and economic factors both in cancer patients and the general population. A long-term and regular care, corresponding to the needs of patients at risk, must be available and patients' close people should be involved. However, medical staffs, working with cancer patients, do not feel very strong in assessing and managing patients' psycho-emotional problems, among them suicide intentions. In some studies it was vindicated that poor psychological knowledge and lack of consulting skills of medical staff improves suicidal risk of the patients, so it is crucial that every health care specialist could assess suicidal risk and react effectively.

Conclusions. Cancer patient's suicide should be characterized as an interdependent network of numerous, diverse circumstances rather than an isolated cause. As no single factor is universally causal, no single intervention will prevent all suicides. United, easily applied, and patient-orientated system for the evaluation of suicide risk of cancer patients is crucial improving psycho-emotional health of cancer patients.

Introduction

Suicide (lat. *sui*, oneself, + *caedere*, to kill) is a purposive, intentional self-murder or self-destruction. Suicide is generally understood as a voluntary and deliberate action and on occasion – as an impulsive, sudden, and not planned act. Another phenomenon sometimes resembling suicide is parasuicide, or quasi-suicide. It is a manipulative act, consciously aiming for sympathy, benefit, etc., blackmailing close people and other persons. Until the 18th century, suicide had been related to melancholy and partially tolerated by society. In the 20th century, suicide was defined as a deviation from a

normal mental state but caused not only by mental pathology (1). Suicide is a multifaceted act, significant from the point of view of an individual and society. It is not a mere mental health problem but generally, a serious issue of health care (2).

In Lithuania, death rate from external causes is 156.4 per 100 000 population, whereas the EU average is 42.4 per 100 000. In Lithuania, high rates of self-harm include excessive alcohol consumption and careless driving, but suicide is one of the most prevalent external reasons of death in our country. Since 1993, Lithuania has had the highest suicide rates in the world among men and topped the rank-

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ing of women's suicide rates in Europe. Mortality rates caused by suicide are about twice as high in Lithuania as in the majority of the developed European countries (3, 4). Worldwide a million people, i.e., 16 per 100 000, commit suicide annually (3–5).

However, it should be noted that the situation in Lithuania has been changing and suicide rates have been decreasing. The incidence of suicide was 40.2 per 100 000 population in 2004, 38.6 in 2005, 30.4 in 2006, 30.9 in 2007, 33.1 in 2008, and 33.4 in 2009 (4). This favorable tendency could have been influenced by a number of various factors. Despite the fact that the establishment and implementation of a united, scientifically based suicide prevention program is still problematic, the mental health care system has been changing in Lithuania. The foundation of mental health centers has brought assistance closer to the inhabitants. Prevention programs have also played an influential role in reducing the suicide rates. Moreover, public attitudes have been changing: a person with a mental disorder is less stigmatized and more confident in seeking assistance (2).

The data of international studies indicate that suicide is more prevalent among cancer patients than in the general population. Research performed by Japanese scientists showed that 35% of suicides had cancer (6). However, there are people, including medical staff, who consider suicide as a justifiable and rational decision for a cancer patient who is confronted with strong emotional or physical pain (6, 7). The identification of patients at suicide risk and the determination of factors conducive to suicide are very important in the care of cancer patients (6).

The aim of this article was to analyze literature data, identify the main suicide risk factors, and review suicide prevention in cancer patients. This review is based on recent literature data obtained through a search in the PubMed using the keywords "cancer patients suicide." All scientific articles covering the period from February 2001 to January 2011 were included. During the first screen, a total of 483 potentially eligible references were identified. Then references involving children, studies on suicide gene therapy, case reports, and opinion pieces were excluded. A total of 81 citations were identified during the second screen as relevant for full-text screening. Of these, 46 basic science studies, editorials, and abstracts were excluded, and 35 articles met the eligibility criteria for this review and were retrieved.

Risk Factors of Suicide. Various literature sources describe about 60 suicide risk factors (8), with mental pathology being the main and most prevalent factor. The majority of suicides had previous diagnoses of mental disorders, with depression being most common (45%–80%) (6, 9–12) and psycho-

sis and specific identity disorders being less common (2). Every second depressive patient attempts to commit suicide at least once in his/her life, and approximately every sixth person becomes a suicide victim (1, 9, 13). Therefore, suicide risk in such patients is 3.5–4.5 times greater than among patients with other mental disorders and 22–36 times greater than in the general population (1). Oncologic disease is one of the most common death causes in Europe and Lithuania, with mental health problems being one of its clinical aspects – mental disorders are more prevalent among cancer patients compared with the general population (14–16). About 30% of all oncology patients experience pathological adjustment reactions, and 17%–25% develop mental disorders, with depression being the most common among them, as already mentioned (14–18). In cancer patients having suicidal thoughts, advanced age and severe depression have been identified as the main suicide risk factors (13). Almost 25% of patients with disseminated cancer are diagnosed with moderate or severe depression (14–17). Research carried out in the Netherlands found that suicide risk was four times greater among patients who declared a depressive and sad mood than those without such declaration (19). It should be noted that about 80% of psychological and psychiatric problems remain undiagnosed and patients are not provided with assistance in this regard. One of the reasons may be the patients' reluctance to declare their problems, assuming they are not worth the attention of medical staff. Health care specialists may also lack self-confidence in diagnosing depression in cancer patients, leading to undiagnosed problems. A consistent system needs to be established to ensure early diagnosis of depression in cancer patients.

While feelings of fear, desperation, and guilt experienced by cancer patients are disruptive and have a negative effect, physical complaints cannot be ignored. Once somatic symptoms were eliminated from the evaluation criteria, the occurrence of depression declined from 42% to 24%. Therefore, specialists who assume causes to be psychological are not always correct – somatic symptoms are significant in cancer patients' depression (8, 15, 20). The majority (88%) of cancer suicides had a diagnosis of severe physical disability (11).

Chronic noninfectious diseases including cancer are classified among factors inducing self-destructive behavior and increasing suicide risk from several to some tens of times. Often patients with chronic diseases experience many physical, psychological, and social problems (1, 6, 18, 21). They may be overwhelmed by denial, resistance, and despair, experience fear about the course of disease and limited treatment opportunities, and increasing socioeconomic problems (2). On the one

hand, international research indicates a tendency for suicide reduction among cancer patients (19); on the other hand, scientists in the United States state that cancer patients commit suicide twice as often (31/100 000) as representatives of the general population (16/100 000) (22). Analysis carried out in the United Kingdom showed that every twelfth cancer patient had suicidal thoughts at least once in two weeks (16). Less than one-third (22%–30%) of patients with disseminated cancer claim desiring a hastened death and considering suicide (14–17). Paradoxically, patients undergoing intensive treatment are not prone to commit suicide. That may be because intensively treated patients are usually more frequently hospitalized and patients, having agreed on radical treatment, may be more active and more optimistic participants in the treatment process (23). Data collected during hospitalization demonstrated that feelings of despair were among the factors having a direct association with the incidence of suicide (1, 24, 25). Suicide risk is greatly increased by somatic diseases that cause strong pain, other physical complaints, and functional disorders (21). With increasing pain, the patient's condition worsens, depression deepens or develops, the probability of chronic depressive disorders increases, physical activity is reduced, every-day efficiency decreases, usage of pain medications with opium increases, and the number of visits to doctors increase (16, 25). The development of mental disorders is often enhanced by somatic diseases and results in a vicious circle: the emergence of conditions of depression, anxiety, or psychosis is frequently followed by drug and alcohol abuse (8, 26). In more than half of suicides, alcohol dependence and abuse of psychotropic substances are found. Both directly and because of troubled family relationship, excessive alcohol consumption has a negative influence on mental health and a direct effect on suicide (27, 28).

One of the risk factors in cancer patients is time after diagnosis. An extremely intense crisis is experienced during the diagnosing process and the first days after confirmation of the diagnosis: patients experience doubt (Am I ill?), anxiety (What kind of disease is it, what is the prognosis, what are the chances to recover...) (23, 29). Research carried out in Australia showed that the first 3 months are the most dangerous, especially for the patients with a poor prognosis. Patients with the most pessimistic prognoses are most vulnerable (8, 29). In England, the highest standardized mortality rates were found during the first year after the diagnosis of oncologic disease (29), whereas American scientists reported an increased suicide risk remaining even for five years (22). Moreover, suicide risk increases after leaving the hospital. Research carried out in Japan reported that almost half of suicides were commit-

ted two weeks subsequent to patients' hospitalization. In discharged patients, suicide risk decreases if a patient had been hospitalized several times before. Social aid received during hospitalization may be considered an influential factor. Additionally, contact with other patients reduces the feeling of isolation (19, 23). Suicide risk significantly decreases with time. This may be due to gradual mental adjustment to the life-threatening disease, to be treated for the rest of one's life.

Suicide rates differ in accordance to tumor location. The highest suicide rates are found to be among patients with bronchus and lung cancer and slightly lower in cases with cancers of oral cavity, pharynx, and stomach (8, 22). These tumors are often related to smoking and alcohol consumption, and such a lifestyle – with depression. Men with a diagnosis of primary tumor of exact location were found to be at higher suicide risk. Such dependence was not observed among women (8).

Research indicates that sleep disorders also increase suicide risk (21, 30). Constant insomnia can provoke the emergence of a new depressive episode (30, 31); a direct link has been identified between cancer-related sleep disorders and fatigue experienced by patients (31). Sleep disorders such as difficulty getting to sleep, poor sleep quality, frequent and early awakening, shortened general sleep length, troublesome somnolence during the day are often present among cancer patients. From 25% to 50% of medications prescribed to cancer patients are sedatives. Such problems can last for months or even years and may not disappear after the treatment of cancer. Sleep disorders in cancer patients may emerge because of several reasons, such as cancer treatment, tumor growth and metastases, pain, fatigue, or depression (30, 31).

It has been noted that social factors also influence suicide. The most important factor among them is singleness: unmarried and divorced persons are more likely to become suicide victims (8, 13, 16, 21). This is related to the fact that patients living in families have better opportunities to receive prompt radical treatment and the family often provides better social support and financial security (21).

Changes in the economic situation, loss of social guarantees are important factors increasing suicide risk. In Lithuania, a complicated economic situation is caused by a gradual decline of general level of workforce activity, significant levels of poverty, especially in certain groups of the population (persons aged more than 65, inhabitants living in rural areas, the unemployed), large income disparities (in comparison to the EU averages), vast regional inequalities in the level and quality of life as well as social status, increasing demand for social and health care services, and insufficient accessibility and quality of

services (28). Additionally, unemployment is one of the socioeconomic suicide risk factors both in the general population and cancer patients (26). According to the data of Japanese scientists, one of the suicide risk factors is the fear to become a burden. Decreased functional capacity also influences the emergence of depression in cancer patients (14). In addition, oncologic diseases often evoke disability, unemployment, and limit social life (2). Moreover, discontent with social support can be the reason for the development of depression followed by its later outcomes (8).

Gender is also significant in the assessment of suicide risk. Males are found to be at higher suicide risk (1, 8, 22, 29, 32). Suicide rates are approximately three to four times higher among males than females; however, attempts to commit suicide are four times more frequent in females. Despite more cases of depression diagnosed among women than men, females are inclined to search for support among close people, friends, or health care system, which may result in fewer suicide cases among women (6, 32). The same tendencies have been identified among cancer patients (1, 6). During the analysis of male and female suicide aspects, it has been stated that the methods of suicide are different. Research carried out in Norway indicates that women usually poison or drown themselves, whereas men use shotguns to commit suicide (33). A study performed in the United States also indicates that both cancer patients (63%) and representatives of the general population (42%) use firearms most often, with hanging being in the second place (16% and 24%, respectively) (11). In Lithuania, the most frequent method of suicide is hanging (about 90% of suicides) (29).

Contradictory results are obtained analyzing the influence of age on suicide attempts. A study carried out in the United Kingdom showed that age had no influence (16). In contrast, Australian research indicated that the incidence of suicide was higher in the age group of 40–49 year olds and among people who are aged more than 60 years of age (19). Suicide risk in cancer patients depends on their mental adjustment to the disease. Researchers in the United States reported that older cancer patients tolerated stress better and adjusted to life with cancer more easily. The research data indicated that aging was inversely correlated with patients' anguish and anxiety, and directly correlated with the quality of emotional life (7). However, certain studies show that an increase in the suicide rate with older age is not necessarily related to oncologic disease, as the suicide rate is higher in this age category in general (8, 11, 18).

Meteorological changes also have an effect on human health. There are some links between certain atmospheric phenomena (such as immedi-

ate increase in humidity and temperature) and the emergence of diseases. Various meteorological conditions increase the number of suicides, i.e., there is a higher suicide risk in hot season. Air temperature and the number of suicides have been registered in England and Wales for 10 years on a daily basis. It has been proved that air temperature higher than 18°C is not a big but nevertheless a significant factor influencing suicide; in such cases, suicides are characteristically violent. The mechanism of the high temperature effect is not clear. Possibly, serotonin changes may play an influential role as serotonin concentration fluctuates during the year in cycles, reaching its lowest level in the summer months. During the pathoanatomic examination of suicides, low serotonin concentration has also been found (34).

Impulsive cases of deliberate self-harm (planned for less than 3 hours, committed in the presence of others and in quite open places) are less dangerous than long planned and secretly performed self-harm acts (21).

Intervention Principles of Suicide Prevention. Such preventive interventions could be classified as either "selective" or "indicated." Selective preventive interventions target individuals or subgroups of the patients with a higher than average risk of suicide. Indicated interventions target high-risk individuals, those in more immediate danger.

According to the data of research carried out in Sweden, nursing staff lacks skills to communicate with patients about death. According to nurses' behavior and their communication style, scientists have distinguished the following categories and sub-categories:

Staff members who talk with patients about death:

- try to listen to patients' experience in relation to death;
- hear out the patients and give their opinion on patients' thoughts;
- encourage patients to talk about death.

Staff members who avoid the topic of death in communication with patients:

- try to change the topic of the conversation;
- try to cheer the patients up.

The researchers found that the nurses' choice of one or another behavioral model, in most cases, was intuitive, trying to find the easiest way out of the situation. The majority of nurses were not sure how to communicate regarding death. Consequently, behavior and communication were determined not by the situation or patient's needs but by nurse's personal values, experience, and attitudes (35).

It is known that both doctors and nurses are not sufficiently prepared to communicate with patients at risk of suicide (18, 35). Multiple research analyses

indicate that insufficient knowledge about psychological assistance and consulting skills of medical staff increases suicide risk in cancer patients (36). Therefore, the ability to assess suicide risk and to provide an appropriate reaction is extremely important for medical staff (1, 18). In this aspect, oncology is a specific sphere. If a patient at a primary health care facility mentions suicide, he or she gets a psychiatrist's consultation or is hospitalized. Whereas the reactions of medical staff towards cancer patient, who talks about the desire for a hastened death, remains quite passive. A dilemma emerges because oncologic disease itself can be the cause of death (37).

There are limited opportunities to anticipate suicide. Short-term and simple methods that might help in foreseeing which patients are going to commit suicide do not exist. When assessing suicide risk, it is most important to evaluate reasons encouraging a patient to commit suicide and to apply timely preventive actions (21). In case of suspicion, it is necessary to show interest in a patient's mood, feelings such as sadness, fault, despair, disability, fear of dependence on others, and suicidal thoughts (15).

One should not fear to question patients about their intention to commit suicide (1, 15). It is mistaken to think that such questioning may encourage suicide (21). The most obvious warning signal is an open declaration of suicidal intentions or suicidal hints. Two-thirds of suicides reveal their contemplations in advance (1). It is also worth mentioning that denial of suicidal thoughts does not yet guarantee that a patient will not commit suicide. Sometimes patients do not reveal their experiences and intentions, feeling that close people will not support their suicidal thoughts (37). Open and sincere conversation with the patient is very helpful in assessing suicide risk factors and the significance of suicidal thoughts (21). Professional assessment of a psychiatrist is necessary for some patients; however, the majority of patients could be properly assessed by a nurse or doctor, having basic knowledge of this issue. An integrated system should be established enabling mental health care specialists to immediately receive such information in a written form (15).

It is essential to pay proper attention to identify and control depression when providing health care services for cancer patients and seeking to reduce suicide risk (8, 12, 13). This is one of the most important problems facing cancer patients. Depression control is especially complicated among older patients and patients with terminal cancer, as decisions have to be immediate. Therefore, early recognition of the first signs of depression is extremely important when seeking early management of the disorder (19, 38). Patients' complaints may also be aid in early recognition of depression and identifi-

cation of adjustment difficulties (14). It should be noted that older patients have more somatic complaints that they find difficult to define. Moreover, such patients are not willing to analyze their psychological and psychical problems. They also prefer medicinal means to reduce their complaints (18). According to data of some authors (18), cancer symptoms and side effects of treatment partially cover signs of depression, such as pain, anxiety, reduced sleep, weight loss, etc. A study carried out by Mitchell indicates that it helps to ask two questions to evaluate the probability of depression. Questions about sad mood and loss of interest show a high reliability in the assessment of depression: a sensitivity of 91% and a specificity of 86%. According to the same author, with high tempo health care service and big specialists' workload this could be an effective means for reducing depression and suicide risk among cancer patients (12, 39, 40).

Medical treatment is necessary for the majority of depressive patients. However, psychological support also has a huge impact on patients' recovery and condition (14, 15, 41). Lately, in spite of better accessibility to psychological consulting, only a few test results show a significant influence on the reduction of suicidal thoughts. Psychological consultation has to be immediate, continuous, and long-term, applied several times a week. According to some authors' data, psychotherapy should last for 3 months. Four psychotherapy components that are most topical for cancer patients have been distinguished: social support, especially in the case of group psychotherapy, management of emotional expression, rearrangement of cognitive function (restructuring), and strengthening powers to tackle difficulties. Research shows psychological support to be topical for patients with any form and stage of cancer (14, 15, 40, 41). In some research, new psychotherapy forms such as meaning-centered psychotherapy and dignity psychotherapy are recommended (14).

It is also recommended to involve people close to the patient to reduce psychosocial factors that increase suicide risk. On demand, the issues of accommodation and social support need to be considered. Access to tools needed for the commitment of suicide should be reduced. Individual, family, and marital psychotherapy aid to properly solve problems of interpersonal communication (21) ought to be provided.

Inside a person intent on suicide there is a "part" that desires to live. Medical staff should strive to strengthen this "part" in a person as well as discuss and emphasize factors for suicide prevention such as effective overcoming of previous crises, responsibility to family members, and religious beliefs. An agreement ("no self-harm") between medical staff and a patient helps to improve cooperation even

though it has not been shown to reduce suicide risk (21).

The desire for a hastened death is being more frequently discussed as a rational decision in oncology. Outcomes of unsuccessful treatment increase anxiety; a patient has no alternative or is unable to make decisions (33). A dilemma also emerges because of patient's complaints, changes in the quality of life and social role, and prognosis of the disease. This view may be strengthened by a prevailing estimation that oncologic disease implies strong suffering and unavoidably ending in death (6, 7). Therefore, the desire for a hastened death may also influence an unusual response in oncology (37).

Discussion

The relevance of suicide is well known in Lithuania; however, data on the incidence of suicide among cancer patients are scarce. The data from international studies indicate suicide being more prevalent among cancer patients than in the general population. Depression is the main and most prevalent suicide risk factor followed by less common factors – other mental pathology. Symptoms such as pain, dyspnea, or reduced physical activity play a significant role in the risk of suicide. Suicide risk is also influenced by tumor location. In cases of lung and bronchus, head and neck tumors as well as disseminated cancer, patients should get more attention for the prevention of the problem. The first months after the confirmation of oncologic diagnosis are most dangerous, especially for patients with poor prognoses. There is a second suicide increase after one year following diagnosis. The posthospitalization period is complicated as patients experience social isolation and increased need for social and psychological assistance.

There is a need for outpatient support services. Men as compared with women are at higher suicide risk. There is a need for the development of better gender norms and perhaps gender-specific scales designed to better differentiate psychological symp-

toms between men and women. Older single men should receive particular attention, as they are the most frequent suicides. When compared with young adults, older adults who commit suicide give fewer warnings to others, use more violent and potentially lethal methods to commit suicide, and apply those methods with greater planning and resolve. These findings suggest that preventive efforts instituted after the onset of a suicide attempt may be less successful with older, versus younger, adults.

Epidemiologic risk factors can only guide the evaluation of suicide risk in an individual patient. Good communication among all health care personnel involved in the treatment of a cancer patient is crucial. When patients report “sad mood” or “loss of interest in pleasurable activities,” or when they appear to be depressed, questions about death and suicide intention should always be asked. This is the most obvious way to anticipate the problem. Patients at suicide risk should be provided long-term, regular care and assistance. However, according to the data of international studies, medical staff is not always prepared to work in this sphere. Death and suicide are discussed intuitively, on the basis of previous experience and prevailing system of values among medical staff, but not in accordance with the individual patient's needs.

Conclusions

Suicide of cancer patients should be characterized as an interdependent network of numerous, diverse circumstances rather than depending on a single cause. As no single factor is universally causal, no single intervention will prevent all suicides. Development of a uniform, easily applied, and patient-oriented system for the evaluation of suicide risk in cancer patients is crucial for improving the psycho-emotional health of cancer patients.

Statement of Conflict of Interest

The authors state no conflict of interest.

Sergančiųjų onkologinėmis ligomis savižudybės rizikos veiksniai ir prevencijos priemonės

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Raktažodžiai: savižudybė, sergantysis onkologine liga, savižudybės rizika, prevencija.

Santrauka. *Įvadas.* Savižudybė suprantama kaip savanoriškas, iš anksto apgalvotas veiksmas, kartais – impulsyvus, nelauktas, neplanuotas poelgis. Nuo 1993 m. Lietuva pagal vyrų savižudybių skaičių pirmauja pasaulyje, o Europoje yra pirmoji ir pagal moterų savižudybes. Nors sveikatos priežiūros paslaugų progresas teikia daug vilčių sergantiesiems onkologinėmis ligomis, tačiau, užsienio autorių duomenimis, tokių pacientų savižudybės yra dažnesnės lyginant su savižudybėmis bendrojoje populiacijoje. Koks onkologinėmis ligomis sergančių ligonių savižudybių skaičius Lietuvoje, šiuo metu nežinoma.

Tyrimo tikslas – analizuojant literatūros duomenis, išskirti pagrindinius savižudybės rizikos veiksnius bei apžvelgti onkologinėmis ligomis sergančių ligonių savižudybės prevencijos aspektus.

Medžiaga ir metodai. Literatūros šaltinių buvo ieškoma naudojantis „PubMed“ duomenų baze. Pirma- jame etape buvo atrinkti 483 straipsniai, 35 iš jų atitiko šio tyrimo tikslą ir buvo analizuojami.

Rezultatai. Įvairiuose literatūros šaltiniuose aprašoma apie 60 savižudybės rizikos veiksnių. Pagrindi- nis, dažniausiai pasitaikantis savižudybės rizikos veiksnys yra depresija, rečiau – kita psichikos patologija. Daug reikšmės savižudybės rizikai turėjo paciento baimė tapti našta kitiems ir neviltis. Svarbus vaidmuo savižudybės rizikai – patiriami somatiniai simptomai, pvz., skausmas, dusulys, sumažėjęs fizinis pajėgumas. Įtaką savižudybei daro ir naviko lokalizacija, laikas, praėjęs nuo diagnozės nustatymo. Tiek bendrojoje populiacijoje, tiek ir tarp onkologinėmis ligomis sergančių ligonių savižudybei įtakos turėjo demografiniai, socialiniai bei ekonominiai veiksniai. Savižudybės riziką turintiems pacientams turi būti teikiama ilgalaikė, reguliari, paciento poreikius atitinkanti pagalba, joje turėtų dalyvauti ir pacientų artimieji. Tačiau medikai, gydantys onkologinėmis ligomis sergančius ligonius, nėra gerai pasirengę atpažinti ligonių psichoemo- cines problemas ir jas valdyti. Kai kurių tyrimų duomenys rodo, kad nepakankamos medicinos personalo psichologinės pagalbos žinios ir konsultavimo įgūdžiai didina onkologine liga sergančių ligonių savižudybės riziką. Todėl labai svarbu, jog kiekvienas medikas sugebėtų įvertinti savižudybės tikimybę ir tinkamai reaguoti.

Išvados. Onkologinėmis ligomis sergančiųjų savižudybė dažniausiai sąlygota ne vienos priežasties, bet daugialypio jų komplekso. Kadangi savižudybės rizikai įtakos turi ne viena priežastis, negali būti ir visiems atvejams tinkamos prevencijos. Siekiant pagerinti sergančiųjų onkologinėmis ligomis ligonių psichoemocinę būseną, turi būti sukurta bendra, visiems sveikatos priežiūros komandos nariams lengvai praktiškai pritaiki- koma, individualius paciento poreikius atitinkanti savižudybės rizikos vertinimo sistema.

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