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Substantiation of psychometric and clinical effectiveness of the methods used to assess thinking disorder in patients with schizophrenia
Assanovich M., Dziamianava L. 467

The role of endogenous intoxication and the level of serum macro- and microelements in acute extrapyramidal disorders in patients with schizophrenia
Gorgun O., Obyedkov V. 479

Clinical dynamics of organic mental disorder in individuals with comorbid cardiovascular pathology (the forensic-psychiatric aspect)
Vandysh-Bubko V., Tarasova G. 487

Features of motivation of alcohol consumption in persons with alcohol addiction of adolescence and young age
Kopytov A., Bychenko I., Glebko O. 496

Assessment of biopsychosocial potential in the mental ecology of personality using the psychovaleological index
Podlubnyi V. 507

Characteristics of the pathology of the mental sphere of a contingent of patients on an outpatient visit to a psychiatrist of the consultative and diagnostic center of the subarctic territory
Shapovalova L., Shapovalov K. 515

Transformation of psychoemotional sphere in infertil women with acne
Zadnipryanaya O., Tretyakova O., Zadnipryany I. 534

Diagnosis and treatment of mental and behavioral disorders
Modern problems of psychopharmacotherapy of depression
Kirpichenka A. 545

Peculiarities of suicidal activity and antivital experiences in patients with malignant neoplasms, and their psychotherapeutic correction
Mykhaylov B., Vasylyeva G. 552

Mental health of patients with vascular comorbid pathology: real medical practice and innovative approaches to problem solving
Khomazyuk T., Krotova V., Soya O. 559

Evaluation of CYP2C19*3 effectiveness and safety of fluvoxamine in patients with depressive disorders, comorbide with alcoholism
Zastrozhin M., Antonenko A., Grishina E., Ryzhikova K., Sorokin A., Ivanov A., Kubarev D., Romanov A., Pirogova A., Fedorova T., Anisimova A., Efimova A., Savchenko L., Brun E., Sychev D. 578

Reviews. Lectures. Training materials
Developmental language delay and emotional and behavioral problems in early age children. Literature review
Raeva T., Leonova A. 590

Actual issues of use ofapplying psychodiagnostic approaches in conducting forensic psychological examinations
Zaviazkina N. 599

Alzheimer's disease: standards of diagnostics and treatment
Trufanov Y. 608

The ethnocultural aspect of the epidemiology of mental illness
Kazakovtsev B., Trushchelev S. 615

Psychiatric and criminal-legal questions of insanity
Vorobei P., Savchenko A., Kryshevych O. 624

Legal and psychiatric aspects of euthanasia
Kirpichenka A., Adaskevich S. 637

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Peculiarities of suicidal activity and antivital experiences in patients with malignant neoplasms, and their psychotherapeutic correction

Особенности суицидальной активности и антивитальных переживаний у пациентов, страдающих злокачественными новообразованиями, и их психотерапевтическая коррекция

Abstract

In the article, there are presented the general peculiarities of formation of the suicidal activity and antivital experiences in oncological patients; the general ways and methods of correction of suicide behavior of these patients. The necessity of use of various methods of psychotherapy and psychopharmacology for prevention of suicide prevention is justified.
Keywords: suicidal activity, antivital experiences, autoaggressive behavior, cancer patients.

Резюме

В статье представлены характерные особенности формирования суицидальной активности и антивитальных переживаний онкопациентов, основные направления и методы коррекции у них суицидального поведения, а также обоснована необходимость применения различных методов психотерапевтического и психофармакологического вмешательства с целью профилактики совершения аутоагрессивных действий онкологическими пациентами.
Ключевые слова: суицидальная активность, антивитальные переживания, аутоагрессивное поведение, пациенты, страдающие злокачественными новообразованиями.

The cancer diagnosis leads to severe stress and perceived by patients as "the death message" [1, 3]. The patient, who diagnosed the cancer, falls into the most acute psycho-traumatic situation, consisting in the threat of severe surgery, prolonged debilitating treatment and prognosis

uncertainty. Oncology pathology refers to a group of diseases in which the conscious dying process is often accompanied by pronounced depressive reactions with autoaggressive trends. Cancer patients suicidal behavior manifests in the internal (antivital experiences, passive suicidal thoughts, suicidal ideation, suicidal intentions) and external forms – suicidal attempts and completed suicides. According to WHO, suicides among cancer patients consist of 15–18% of the total number of autoaggression cases among the population [6, 7] and suicidal readiness in this category of patients is significantly higher than in the general population. Currently, the frequency of realized suicide attempts at both early and late cancer stages are not exactly known, since the number of suicides in official statistics is dramatically underestimated, since many of them remain unrecognized [3, 4]. According to foreign researchers in oncology patients, suicidal readiness is significantly higher than in the general population. So, the suicide rate in men with cancer is 1.9 times higher than in men who do not suffer from malignant tumors, and the frequency of suicides among women with cancer is 1.6 times higher than in healthy women [29]. Among registered cancer patients in Western Europe and the United States, up to 0.32% of them attempt suicide, and in 0.13–0.24% of cases its end in a fatal outcome [12, 20].

A number of foreign authors confirm the view of a high risk of suicide during the first year after diagnosis [8, 11, 13, 14, 20, 21, 26]. Thus, most suicides occur within 3–5 months after the cancer diagnosis, usually shortly after discharge from the clinic. A high suicidal risk also has a period of recurrence and progression of the disease, accompanied by a steady deterioration of patients, the emergence of poorly controlled pain and other painful manifestations of advanced cancer, i.e. the risk of autoaggressive behavior in cancer patients increases with the disease progression (N.R. Dormer et al., 2008) [16]. Practically, real suicide cases, and especially suicidal thoughts, are not taken into account, as oncologists and relatives of a suicidal patient considered such actions and statements of the patient as aggravation. In other cases, suicidal attempts are dissimulated, and the cancer is indicated as the cause of death [4, 15, 28].

Prevalence of suicidal thoughts in cancer patients is sufficiently inconsistent. So, according to V.N. Gerasimenko (1988) [1] in a study of 53 patients aimed at surgical intervention for gastric cancer, any patient showed suicidal thoughts, while A.V. Gnezdilov (2001) [2] revealed suicidal thoughts in 80% of oncology patients examined by him. Such differences in the results may be due to both the different groups of patients, and the active detection of suicidal thoughts and trends in cancer patients. In general, it is believed that only a small proportion of patients with common forms of cancer, suicide seems rational and inevitable [3–5].

The study of groups of oncology patients with suicidal tendencies indicates the prevalence among them of middle-aged and elderly people; most of them are men [10, 12, 24]. Many researchers revealed the connection between the autoaggressive tendencies expression and certain personal traits. A.V. Gnezdilov (2001), studying the peculiarities of the cancer patients personality revealed an increased risk of autoaggression in persons with schizoid, epileptoid and hysterical features in premorbid [2]. According to the author's observations, oncology patients with schizoid and epileptoid

traits are able to commit true suicidal attempts, and in persons with hysterical features, suicidal behavior was demonstrative.

J.C. Holland (1998) among the factors that increase the suicide risk of in cancer patients, distinguishes the following: the presence of depression, a sense of isolation and abandonment by family members, terminal stages of the disease with severe pain syndrome [19].

A.V. Genzdilov (2001) connects the development of suicidal behavior with the stage of aggression that occurs in almost all patients in response to an oncology disease [2].

The basis of suicidal behavior is anxiety-depressive symptoms, which develops from 7–24% [12, 16] to 58–71% [17, 20] cancer patients. A special role in the autoaggressive behavior occurrence played by the antitumor treatment type and the sociopsychological adaptation success of the cancer patient. Extensive surgical interventions leading to significant cosmetic defects provoke strong emotional reactions [21, 26], and the lack of psychological support by the family contributes to patients isolation, deepening of depressive feelings and the appearance of suicidal thoughts and tendencies [10].

It is known that chronic pain has a close connection with emotional disorders. Pain syndrome, on the one hand, can act as a clinical marker of masked depression, and on the other, induce the development of psychopathological symptoms. In oncology practice, chronic pain usually leads to the development of depression. In studies of cancer patients with chronic pain by P.B. Zotov (2005), it was found that depression was detected in 70,9% of cases [3]. It is the chronic pain in these patients that was the leading somatogenic factor of suicidal activity. A more detailed analysis of analgesic therapy in these patients showed that at the pre-hospital stage in 96,0% of cases, pain-relieving pharmacotherapy was of an unsystematic nature and no one had complete pain control. The subsequent complex treatment, conducted in a hospital, allowed achieving complete control or a significant reduction in pain in the majority of patients, which helped to reduce the severity of emotional disorders and the suicidal readiness of these patients.

Uncontrolled pain is regarded by patients as an indicator of the lack of success of antitumor treatment and provokes some patients to consider suicide as the most optimal way out of the situation and getting rid of suffering [23], almost all patients in the terminal stage need analgesic therapy [22].

According to foreign researchers, cancer localization plays an important role in the formation of suicidal behavior of cancer patients. Thus, the greatest risk of suicide in lung cancer and bronchus, prostate, oral cavity and pharynx, esophagus, stomach and pancreas, head and neck, Kaposi's sarcoma in HIV-positive [7, 10, 27, 29]. Almost half of the suicides are in cancer patients with localized and potentially curable forms of malignant neoplasms [28], and 15% of patients who committed suicide had an "uncertain" prognosis [10].

Side effects of antitumor treatment can act as predictors of suicidal behavior of cancer patients. Thus, the use of corticosteroids, antitumor drugs, and some antihypertensive drugs can exacerbate depression in cancer patients and may indirectly increase the risk of suicide [7, 10, 27].

Extensive surgical interventions with crippling consequences (mastectomy, extirpation of the uterus, amputations), affecting the appearance and psychosexual perception with an increase in life expectancy provoke chronic emotional distress [2] and paradoxically increase the risk of autoaggressive behavior in a clinically cured patient.

An important indicator is the dynamics of suicidal behavior. It is known that the first suicidal ideas, as a rule, are formed at the stage of diagnosis of the disease and during the detection of tumor recurrence. In these cases suicidal actions are committed quite spontaneously (for others). In most cases, suicidal ideals that occurred one day persist for a long period, being actualized by suicidal factors [3, 24]. The long presence of suicidal ideation, motivated, mainly, by the somatic determinants of cancer, allows them to think carefully and plan suicide, to choose a method and means that guarantee, by the patient's opinion, a fatal outcome (these categories reflect the true nature of suicide).

Among motives of suicides in cancer patients, the following predominate: rejection of life; change others behavior or attract attention ("call for a help"); mixed, unconscious or ambivalent fluctuations between life and death [20]. In the prevalent cancer, intersecting and mutually potentating somatic (90–95%) and depressive (70%) factors dominate: the cessation of physical torment (95%), the idea of aimlessness and hardship (70%), inability to self-service (35%), desire to release relatives (30%), a sense of inferiority (10%) [3, 5].

Sufficiently important is the question of how to commit a suicidal attempt, which in the literature [10] is described primarily as "cruel" ways: hanging, gunshot wounds, falling from a height, cuts that are committed mostly by men. Women resort to more "soft" ways, such as poisoning [13]. The choice of a suicide method is not accidental and is caused by ethno-cultural moments, representations about the lethality and aesthetics of the method. All other things being equal, the oncology patient seeks to choose that method of suicide, which most corresponds to his concepts of acceptability and admissibility in a given social environment, taking into account the likely negative social consequences for his relatives and family members. The patient seeks to foresee what aesthetic experiences may be caused by the sight of his body after suicide and will prefer the way that, in his opinion, leads to the least disfigurement of the body [24, 29].

It is believed that suicide in cancer patients is rarely a spontaneous act. For oncology patients it is characteristic to think about their actions for a fairly long time – up to 80% of suicidal person attend oncologist, and indirectly or openly disclose their intentions, make it clear to family members that the only way out of the current situation for the patient is suicide [7, 25, 26]. Physicians, as a rule, know about the depressed state of their patients, but are inclined to minimize the degree of distress of oncology patients [27]. Many researchers [10, 23, 28, 29] note the necessity to actively identify suicidal thoughts in patients with cancer. So play a large role in revealing suicidal tendencies in cancer patients both for treating doctors and for nurses of oncology departments. According to their observations, up to 60% of nurses correctly identified the suicidal mood of patients.

The oncologist's duties should include not only immediate treatment of the patient's primary oncology disease, but also prevention of suicidal

behavior of patients with advanced forms of malignant tumors [22, 27, 29] involving psychiatrists, psychotherapists and medical psychologists in the treatment process. The leading role in the prevention of autoaggressive behavior in patients with advanced forms of malignant neoplasms has a correction of the emotional state of cancer patients [25]. So, psychotherapy is aimed at stabilizing the mental state, regardless of the stage of the oncology process, and is achieved through the formation of a healthy self-esteem, adequate emotional methods of protection, acquisition of communication skills and experience, and an optimistic vision of the future. Individual psychotherapy used in the structure of rehabilitation activities includes the following types: rational – it provides a new assessment of the psychotraumatic situation, forms new views and adequate responses; hypnosuggestion – creates emotional stability of manifestations (relieves anxiety, depression, fear of death, suicidal thoughts, algic manifestations, sleep disorders, loss appetite, etc.), optimizes the perception of the environment; cognitive – teaches patients methods and techniques of rational thinking. Cognitive psychotherapy, conducted in the group, is aimed at explaining the basic concepts of etiology, pathogenesis, clinical manifestations, treatment and prognosis of cancer and activating the patient's participation in the treatment process. Group behavioral psychotherapy is conducted with the aim of forming adequate active behavior for overcoming the disease, as well as overcoming the active pathological factors of the stressful state: anxiety, depression, suicidal behavior, various neurotic disorders caused by psychoemotional overstrain, sleep disorders, social maladaptation. Positive in the treatment process are meetings with patients who have already suffered such operations, overcame their fear and are in a state of compensation. In parallel with individual and group therapy, family psychotherapy (working with relatives) is conducted, which is aimed at providing mutual understanding, psychological support to the patient, and optimizing his situation. During the psychotherapeutic work should be identified and strengthen the effect of anti-suicidal factors. So, a negative attitude towards suicide of close relatives can help to prevent suicide in cancer patients. Religious views and beliefs play a large role in autoaggression preventing, since most patients with advanced forms of malignant tumors turn to religion. The spiritual help provided by the Orthodox Church significantly reduces the risk of suicide [24]. A number of researchers emphasize the importance of combining psychotherapeutic effects with other methods of treatment, in particular, with psychopharmacotherapy [25, 27].

Despite a large number of published works of foreign researchers devoted to the problems of autoaggressive behavior of cancer patients, many questions require more detailed study. Our experience shows that the use of timely complex of diagnostic, corrective and psychotherapeutic measures allows achieving significant results in the prevention of suicides among this contingent of patients.

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