



SOMATIC DISEASE, DISABILITY AND SUICIDAL BEHAVIORS AMONG ELDERLY PEOPLE

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Resume

Somatic diseases and functional disability are common in the elderly age and can lead to loss of autonomy, isolation, pain, increased stress on social networks and the development of depression. Elderly people who died as a result suicide, often consult their physicians for several weeks after of death. These visits often focus on physical ailments and mental disorders and suicidal feelings are often overlooked.

Резюме

Соматические заболевания и функциональная инвалидность распространены в пожилом возрасте и могут привести к потере автономии, изоляции, боли, увеличению нагрузки на социальные сети и развитию депрессии. Пожилые люди, умершие в результате самоубийства, часто консультируются со своими врачами в течение нескольких недель после смерти. В центре внимания этих посещений часто бывают физические недуги, а психические расстройства и суицидальные чувства часто остаются без внимания. Ключевые слова: соматических заболеваний, суицидальный мысли, суицидальный поведения, пожилых люди.

Rezyume

Somatik kasallik va funksional nogironlik qarilik davrida keng tarqalgan bo'lib, izolyatsiya, og'riq, ijtimoiy tarmoqlarda stressni kuchayishi va depressiyani rivojlanishiga olib kelishi mumkin. O'z joniga qasd qilishdan vafot etgan qariyalar, o'limidan oldin bir necha hafta davomida ko'pincha shifokorlari bilan maslahatlashadi. Somatik kasalliklar ko'pincha ushbu tashriflarning markazida bo'ladi, ruhiy kasalliklar va o'z joniga qasd qilish hissiyotlari ko'pincha e'tibordan chetda qoladi. Kalit so'zlar: somatik kasallik, o'z joniga qasd qilish fikri, o'z joniga qasd qilish harakati, qariyalar.

Keywords: somatic diseases, suicidal thoughts, suicidal behavior, older people



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Relevance

Previous reviews have considered the role somatic diseases and functional disability, none systematic review did not explicitly examine this in older people. We were aiming to analyze evidence systematically relationship between physical illness and functional disability and [1] death wish, [2] suicidal ideation, [3] non-lethal suicidal behavior and [4] suicide in the elderly (age 60 and over). The following questions were considered:

What physical conditions are associated with death wish, suicidal ideation, suicidal behavior and/or

suicide in the elderly? 1. What are the implications for prevent suicidal behavior in the elderly?

2. What areas need research?

Methods The selection criteria included a peer-reviewed publication in English aimed at people over 64 years old, study of death wish, suicidal thoughts, non-fatal suicidal behavior and rate somatic health. Research dedicated to cognitive disorders, including dementia were excluded, because they were considered psychic disorders according to diagnostic systems DSM IV / ICD 10. Quantitative studies in which there were no corresponding comparison groups, were also excluded. Significant relationship between cardiac diseases and suicidal ideation in one population study [3]. AT not found in another study connection with last year's death wish [4]. One registry study is not reported no association between cardiovascular disease and suicide after adjusting for other projected diseases based on univariate analysis [5-6]. Another study found no association between heart disease and suicide after adjusting for concomitant somatic and mental diseases [6]. Null results were found in another registry study that was focused specifically on recipients medical services [5-6]. Myocardial infarction in history was associated with suicidal feelings in representative sample of the population 75 years old [1-4] and with suicide in the study hospital register [5]. Myocardial infarction was associated with the desire to die in patients primary health care in the USA, also in multidimensional models, including a large number of factors [3-4]. Serious heart disease were observed in a similar proportion (10%) in cases of suicide and among persons compared with corresponding groups population [1-4].

Pulmonary Diseases

In a population study, a respiratory problem was associated with a wish to die [7-8], but this connection was not preserved in adjusted model, which included depression.

In another population study asthma was associated with suicidal ideas [8]. Small





increased chances of suicide observed in individuals with chronic lung disease in one study registers [8-9]. Chronic obstructive lung disease (COPD) has been associated with suicide in three other studies

Gastrointestinal and renal disorders. Digestive problems, often reported by the patients themselves were associated with the desire for death, but not in multivariate analysis [9-10]. Ulcerative disease was associated with three increased likelihood of suicidal experiences for the last month in the sample of 85-summer [10]. Prescribing medication for hyperacidity was not associated with suicide after adjusting for other prognostic diseases [10-11]. Liver disease has been associated with more high risk of suicide in two register studies [12]. No connection between kidney disease and suicide found in one study registers [13], but another reported association between end-stage renal disease insufficiency and suicide in adults aged 75 years and older [12].

Urogenital diseases. At adjusted disease models prostate and male reproductive organs were associated with suicide in two studies registers [5-8], but not in the third, in which for identifying these conditions were used recipe data [8]. Urinary incontinence was associated with desire death in primary care patients after adjustments for demographic data, but not after inclusion in the functional model status [10].

Endocrine disorders. Majority population [1-4] and based on research registries [8-9], reported no association between diabetes and suicidal behavior. It was exactly the same found little evidence of a link between suicidal behavior and thyroid gland or other endocrine disorders [12]. neurological conditions. Two registration studies demonstrated a two- to three-fold increase in the risk of suicide in older people with convulsive disorders [6-eight].

Cerebrovascular diseases hemiplegia has also been associated with suicide [8]. Association with stroke was observed in the adjusted analysis in two registries [11-12]. One a population study has shown an association between migraine headache and suicidal ideas [3-4]. Second explored a potential link between migraine headache and desire die, but no connection was found [4] [4]. From the side of the musculoskeletal apparatus. relationship between arthritis, rheumatism death wish was observed in population study [7-8]. Communication with suicide has also been found in one registry study, but not three other studies [9-11]. Osteoporosis was associated with an



increased risk of suicide among recently hospitalized elderly people who have been diagnosed [9]. From a number of fractures only fractures spine have been linked to suicide in adjusted analysis [8-11]. corrected analysis [8-11]. Link between arthritis and non-fatal suicidal behavior was found in one study that compared cohort of people hospitalized aftersuicidal act, and the population group[7-11].

Oncological disease. At nine registries have reported an association between cancer and various suicidal behavior [1,3,6,7,11,12,13,14]. In two lung cancer has been associated with increased risk of suicide [7-8]. Three prostate cancer research and sex organs have been associated with increased the risk of suicide in men [7, 8, 11]. the risk of suicide in men [7, 8, 11]. Age and sexual diseases. Hospitalization in the urology department has been associated with a high risk of suicide in men aged 80 years and older [8]. Other registry study showed increased risk of suicide in prostate cancer and genital organs in men aged 80 and older, but not in men aged 70 to 79 years [7-12]. Although gender differences are directly not studied, suicide risk analyzed separately in men and women for somatic disease [3-4], tumor of the gastrointestinal tract, and cardiovascular diseases diagnosed during recent years have been associated with a risk of suicide in men, but not in women. Against, an increased risk was observed in women with brain cancer and glaucoma, but not in men with these states. In studies from Taiwan, the Netherlands and Sweden [11-14], older people with a history suicidal thoughts or behaviors were questioned about the reasons for their suicidality, while time as in the Canadian study [3-4] older people were interviewed about preparing for of death. In a study conducted in Norway, the method used psychological dissection to understand the suicidal motives of a sample of the elderly people in terms of significant survivors others [13-14] . In this systematic review, it was identified 12 quantitative and 8 qualitative studies examining the relationship between various somatic diseases and functional disorders and suicidal behavior. Although in research on physical diseases as such, were obtained somewhat divergent results, they were more consistent with functional disability and some specific somatic conditions, including malignant diseases, neurological disorders, male sexual disorders organs, arthritis / arthrosis, COPD and diseases liver. Little support was found associations with cardiovascular diseases in general, but some studies have shown an increased risk myocardial infarction. In many studies studied the possible association between diabetes and suicidal behavior, but few found evidence of such a connection. Although results for kidney failure were unconvincing, not considered in this systematic review. A common theme across all studies was that illness and disability were suicidal when they threatened human independence, a sense of



usefulness, the value, dignity or pleasure of life .Before further discussion results of this review should be highlighted methodological considerations. Because of the difference in definitions of suicidal behavior and big difference in susceptibility somatic diseases, we could not conduct a meta-analysis. In addition, with the help our search strategy has been discovered several clinical research.

Alternative approach to search (for example, a search that includes names of diseases and using full text search), could give more research. Another problem is that the degree to which the results were adjusted for potential confounding factors, varied widely in different studies. In this review age limit used was 58-68 years. However, we understand that old age is a social construct. In some cultures, people in their 40s and 50s can be considered elderly and. Besides, only a few studies in this review provided estimates of the risk of suicide with breakdown by age. It is likely that Physical health affects differently the risk of suicidal behavior in people aged 70 to 60 compared to people over 70 years of age. Relatively a small amount of research presented results specific to gender. In many studies, the percentage women are not included in the sample. Those who this made the proportions differ greatly from research to research different from research to research. The reasons for this There can be many variations, including number of different sex ratios in the background population, the frequency of the particular somatic condition, geographical, cultural differences in sex ratios for a certain type of suicidal behavior, and differentiated case reporting suicidal behavior. suicide at women and men. Thus, on their views on the causes of suicide influenced them recent loss, as well as their relationship to deceased. This is not a problem for research, which also includes data obtained from medical records. With regard to quality psychological research autopsy cadaver included in this review should be note that the authors who were also interviewers showed what they thought suicide of the elderly acceptable choice for older people in their research. This position probably influenced to what the authors asked the informants and how they asked it, as well as on the interpretation and authors' conclusions

Quantifying degree or severity of medical illness or functional disability in the elderly patients does not allow to identify persons potentially prone to suicide. For example, controlled psychological autopsy, during which the last contact with health worker of persons aged 60 years and older who died by suicide or sudden death, showed that the severity somatic disease and functional violations do not distinguish suicide from cases of sudden death [13-14].

teaching sudden death [13-14]. Although this literature review found relationship between suicidal behavior and physical diseases and conditions disability, it should be noted that estimates risks were quite modest compared with mental assessments



diseases. comorbid problems with somatic and mental health common, especially in the elderly of people. A number of studies of psychological autopsies of the elderly, showed that major depression is present in about half of the cases [8,11,12,14].

Therefore, clinicians working with the elderly people with suicidal tendencies take into account both medical and psychiatric illnesses when choosing pharmacological treatment options. In time of clinical consultation survey older people about how they cope with medications and activities needed to their state of health, may give clues to unraveling the suicidal thoughts of these elderly of people. Low self-efficacy and feeling helplessness in the fight against functional disorders and self-care activities affect the quality of life, as well as adherence to treatment regimens. Integration of mental health care into primary, specialized medical care and geriatric care can be effective strategy for detection and treatment suicidal older people somatic diseases [1,4,7,8,10,11,13,14]. Joint Models aid usually includes: components: improvement of routine screening and diagnosis of depressive disorders; wider use providers of evidence-based protocols for proactive management of diagnosed depressive disorder; and improvement clinical and community support for involving patients in goal setting treatment and self-control. In spite of encouraging results have been expressed concerns about cost and sustainability joint treatment and potential workflow disruption and disruption continuity of care. The results of this review show that in specialized medical institutions need more attention and experience in the field of prevention suicide. Measures need to be developed interventions involving specialized medical workers especially oncologists and neurologists. Although elderly people seen in specialized medical institutions are also observed in primary health care facilities assistance, specialists with severe

Literatur

1. Ахмедани Б.К. Саймон Г.Е. Стюарт С. Бек А. Вайцфельдер Б.Е. Россом Р. Сольберг Л.И. Медицинские контакты за год до самоубийства. //Журнал общей внутренней медицины, 2014 г.; (6): 870–877.
2. Ан Э. Шин DW Чо Си Пак С. Вон Ю. Дж. Юн Ю. Х. Уровень самоубийств и факторы риска среди корейских онкологических больных, 1993-2005 гг. //Эпидемиология рака, биомаркеры и профилактика, 2010 г .
3. Алексопулос Г. С. Рейнольдс К. Ф., 3-й Брюс М. Л. Кац И. Р. Рауз П. Дж. Мулсант Б. Х. Тен Хав Т. Уменьшение суицидных мыслей и депрессии у пожилых пациентов первичной медико-санитарной помощи: результаты исследования . Американский журнал психиатрии





1. , 4. Аллебек П. Болунд С. Рингбэк Г. Повышенный уровень самоубийств у онкологических больных. Когортное исследование, основанное на Шведском реестре онкологических заболеваний и окружающей среды. //Журнал клинической эпидемиологии, 1989;
4. Алмейда О. П. Пиркис Дж. Керс Н. Сим М. Фликер Л. Сноудон Дж. Пфафф Дж. Дж. Рандомизированное исследование по снижению распространенности депрессии и самоповреждения у пожилых пациентов первичной медико-санитарной помощи. Анналы семейной медицины. 2012; (4): 347–356.
5. Осберг М. Монтгомери С.А. Перрис К. Шаллинг Д. Седвалл Г. Комплексная психопатологическая оценочная шкала. *Acta Psychiatrica Scandinavica Supplementum*, 1978: 5–27
6. Авата С. Секи Т. Коидзуми Ю. Сато С. Ходзава А. Омори К. Цудзи И. Факторы, связанные с суицидальными мыслями у пожилого городского японского населения: перекрестное исследование на уровне общины. //Психиатрия и клинические неврологии, 2005; (3): 327–336.
7. Bane C. Hughes CM McElnay JC Влияние депрессивных симптомов и психосоциальных факторов на приверженность лечению при сердечнососудистых заболеваниях. Консультации по обучению пациентов, 2006; (2): 187–193.
8. Барнов С. Линден М. Фрейбергер Н. Связь между суицидальными чувствами и психическими расстройствами у пожилых людей: результаты Берлинского исследования старения (BASE) //Психологическая медицина, 2004; (4): 741–746.
9. Ильген М.А., Уолтон М.А., Каннингем Р.М. и др. Недавние суицидальные мысли среди пациентов в отделении неотложной помощи в центре города. Поведение, угрожающее жизни суицидом. 2009; 39 : 508–517.
10. Клаассен К.А., Ларкин Г.Л. Оккультное суицидальное поведение среди населения отделения неотложной помощи. //Br J Psychiatry. 2005; 186 : 352–353.
11. Бец М.Э., Ариас С.А., Миллер М. и др. Изменение убеждений и практик сотрудников отделений неотложной помощи после использования новых протоколов для суицидальных пациентов. //Psychiat Serv. 2015; 66 : 625–631.
12. Суд Т.Р., Макстей К.М. Оценка психиатрического пациента. //Emerg Med Clin North Am. 2009; 27 : 669–683.
13. Гуд Б., Уолш Р.М., Александр Г. и др. Оценка острого психиатрического пациента в отделении неотложной помощи: судебные дела и предостережения. //West J Emerg Med. 2014; 15 : 312–317. 15. Шреверс М. Дж., Тео И. Отчёт о посттравматическом росте у Малазийских онкологических больных: взаимосвязь с психологическим дистрессом и копингстратегиями.