Assessing the Risk for Suicide in Patients With Cancer

Lisa B. Aiello-Laws, RN, MSN, AOCNS®, APN-C

The Joint Commission publishes its annual National Patient Safety Goals to guide accredited organizations in addressing high-risk, low-volume concerns related to patient safety. The 2010 list includes a goal to identify patients at risk for suicide, but do oncology nurses need to be concerned about the risk of suicide in patients with cancer?

As people with cancer are living longer after diagnosis, unassessed psychosocial concerns may cause prolonged emotional suffering during survivorship. In a landmark Institute of Medicine report, Adler and Page (2008) identified a lack of attention to psychosocial health needs in cancer care. In addition, research indicates that some oncology professionals report accepting or “understanding” suicide as a way for the patient to demonstrate autonomy by choosing how and when to die (Lester, 2006). O’Shea et al. (2002) described suicide as a way for patients to be relieved of suffering or a painful death. However, a suicide attempt usually occurs because of untreated depression, anxiety, or another psychiatric disorder. The patient loses the chance to self-actualize prior to death (O’Shea et al., 2002).

Because of advances in early diagnosis and treatment, cancer now is viewed as a chronic disease and not a lethal diagnosis. Oncology professionals need to reassess their previous beliefs and integrate them with this new concept of survivorship. The purpose of this article is to discuss suicide in people with cancer, not physician-assisted suicide, euthanasia, or suicidal intent related to those at the end of life.

Background

Suicide is defined as the act of taking one’s own life voluntarily and intentionally, particularly by a person of discretion and sound mind (Merriam-Webster Online, 2010). Most suicides are related to underlying psychiatric disorders, specifically mood disorders, including depression, anxiety disorders, and addictions (Sharma, 2008). Research indicates that most people change their mind about committing suicide after their depression is treated (Akechi et al., 1999; Emanuel, Fairclough, & Emanuel, 2000; Filiberti & Ripamonti, 2002). Wilson et al. (2000) surveyed patients in palliative care regarding their interest in hastened death. Of those who reported an interest, 63% met criteria for a psychiatric diagnosis.

When a person is diagnosed with cancer, intense feelings may occur such as sadness, shock, disbelief, emotional turmoil, anxiety, and fear, specifically fear of disability, disfigurement, intense pain, and death (Chochinov, 2001). Those responses are considered normal and are expected at diagnosis, recurrence, or change in prognosis. After several weeks, people usually experience dissipation in the intensity of their feelings and some resolution. However, for those with clinical depression, acute responses do not lessen. They may experience anhedonia (lack of pleasure in usual activities), fatigue, insomnia, weight loss, or difficulty with memory and concentration. Differentiating those symptoms from the normal responses can be difficult for a nurse. Asking a patient, “Are you having any thoughts about ending your life?” may be the first step in assessing how suicide may be a solution.

Table 1. Comparison of Standardized Mortality Ratios Related to Suicide

<table>
<thead>
<tr>
<th>GROUP</th>
<th>RATIO</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S. veterans</td>
<td>1.15</td>
</tr>
<tr>
<td>Former active duty veterans</td>
<td>1.33</td>
</tr>
<tr>
<td>Veterans diagnosed with mental disorders</td>
<td>1.77</td>
</tr>
<tr>
<td>People with cancer diagnoses</td>
<td>1.88</td>
</tr>
<tr>
<td>• First year after diagnosis</td>
<td>3.9</td>
</tr>
<tr>
<td>• One to five years after diagnosis</td>
<td>2.2</td>
</tr>
<tr>
<td>• More than five years after diagnosis</td>
<td>1.5</td>
</tr>
<tr>
<td>• Lung or bronchus</td>
<td>5.74</td>
</tr>
<tr>
<td>• Stomach</td>
<td>4.68</td>
</tr>
<tr>
<td>• Oral cavity and pharynx</td>
<td>3.66</td>
</tr>
<tr>
<td>• Larynx</td>
<td>2.83</td>
</tr>
<tr>
<td>• Breast cancer survivors</td>
<td>1.35</td>
</tr>
<tr>
<td>• more than 25 years after diagnosis</td>
<td></td>
</tr>
</tbody>
</table>

Note. Standardized mortality ratios compare observed deaths to expected deaths.
Note. Based on information from Kang & Bullman, 2008; Levi et al., 1991; Misono et al., 2008.

In the health care setting, nurses can be prepared to answer the question, “Do you ever wish you were dead?” The examiner should recognize that the patient is describing a feeling to which most people have been exposed at some time. The nurse’s role is to determine if the symptom has persisted and if it is possible to identify the underlying psychiatric disorder. A 14-point list of signs and symptoms of depression and other psychiatric disorders was developed by the American Psychiatric Association (2001). The first item stated is “feelings of hopelessness or suicide.” According to this resource, the nurse can quickly assess the suicide risk by asking these questions:

1. “Do you ever wish you were dead?”
2. “Are you feeling depressed?”
3. “Do you ever have thoughts of suicide?”
4. “Have you ever had any recent thoughts of suicide?”
5. “Have you ever acted on these thoughts?”
6. “Are you thinking about suicide or thinking how you will kill yourself?”
7. “Have you ever talked about killing yourself?”
8. “Have you ever written suicide notes?”
9. “Have you ever tried to kill yourself?”
10. “Have you ever taken action to help you die?”
11. “Do you ever feel that life isn’t worth living?”
12. “Do you feel that you want to just give up?”
13. “Do you check for terms like ‘depressed,’ ‘sad,’ ‘lonely,’ or ‘hopeless’?”
14. “Do you feel that life is no longer worth living?”

Patients who answer yes to any of these questions need further assessment by a mental health provider. Nurses need to recognize the importance of assessing suicide risk in their patients and be responsible for ensuring that appropriate care is provided. Nurses that go on to have a career in psychosocial oncology will be better prepared to help patients in survivorship.

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associated with cancer diagnosis and treatment can be difficult.

**Distress, Depression, and Cancer**

Depression and distress are underdiagnosed and undertreated in people with cancer (Bottomley, 1998; McDaniel, Muselman, Porter, Reed, & Nemerooff, 1995; Spoletini et al., 2008; Stiefel, Trill, Berney, Olarte, & Razavi, 2001). The prevalence of depression in this population ranges from 13%–85% (Akechi et al., 2000; Akechi, Nakano, et al., 2001; Breitbart, 2001). Dugan et al., 1998; Lloyd-Williams, Dennis, Taylor, 2004), whereas significant distress has been reported at 35%–50% (Jacobsen & Ransom, 2007; Zabora, BrintzenhofeSzoc, Curbow, Hooker, & Piantadosi, 2001). This heightened distress can lead to poor adherence to treatment, poor satisfaction with care, and lower quality of life. In cancer survivors, suicide typically is caused by distress and depression and may occur anywhere along the cancer continuum (Sharma, 2008).

### General Population
- Access to lethal means (e.g., guns, drugs)
- Anxiety disorders
- Depression
- Despair
- Diminished mood
- Distress
- Family history of suicide
- Fear of death
- Feeling restless
- Feelings of being a burden
- Few or poor social support systems
- History of psychiatric disorders, particularly those associated with impulsive behavior (e.g., borderline personality disorder)
- Hopelessness
- Opioid use
- Past suicide attempts
- Poor coping
- Poor physical functioning
- Poor sleep quality or insomnia
- Post-traumatic stress disorder
- Recent death of a friend or spouse
- Sedatives or hypnotics and benzodiazepine use
- Substance abuse
- Suffering, aloneness
- Suicidal thoughts
- Unrelieved pain

### Patients With Cancer
- All factors listed for general population
- Advanced age
- Advanced stage of disease
- Confusion or delirium
- Diagnosis of oral, pharyngeal, and lung cancers (all of which often are associated with alcohol abuse and tobacco use)
- Exhaustion or fatigue
- Loss of control or helplessness
- Physical impairments (e.g., loss of mobility, vision, or hearing; incontinence; amputation; paralysis; inability to eat or swallow; exhaustion; fatigue)
- Poor prognosis
- Poor social support
- Recent loss
- Uncontrolled pain

### Suicide Prevalence

The public has begun to speak out about depression and suicide. Suicide has become more visible in the media because of celebrity suicides, bullying and suicide, suicide clusters at high schools and colleges, and the increasing rate among active veterans. In the United States, suicide is the 11th leading cause of death, with a rate of 11.5 per 100,000 people (Xu, Kochanek, Murphy, & Tejada-Vera, 2010). A study of depressed veterans reported a suicide rate seven times higher than the general population (Kang & Bullman, 2008), causing the Veterans Administration to launch a campaign to address this serious issue (National Defense Authorization Act, 2009). Current oncology literature reports the suicide rate for people with cancer to be 31.4 per 100,000 person-years (higher than the rate among veterans) (Misono, Weiss, Fann, Redman, & Yuch, 2008). In addition, the suicide rate is even higher among specific subgroups, such as older adults and those with specific cancer sites or specific time frames related to diagnosis (see Table 1). Suicide rates appear to be higher at the time of diagnosis, recurrence, and change in prognosis and in those with advanced disease with a known poor prognosis, such as pancreatic cancer (Misono et al., 2008). Although the rate may decrease as the time from diagnosis increases, one study of breast cancer survivors indicated the risk may remain elevated for more than 25 years after diagnosis (Schairer et al., 2006).

### Risk Assessment

Oncology healthcare providers need to routinely assess patients for factors that may indicate an increased risk of suicide and suicidal intent. Assessment needs to occur frequently from diagnosis through survivorship (Quill, 2008). Assessments should include patient and family history of suicide, suicidal attempts, history of drug or alcohol use or abuse, and psychiatric disorders, specifically previous episodes of depression. The assessment also should include physical symptoms such as unrelied pain, insomnia, and functional disabilities. If concern exists about suicidal intent, patients should be asked about their access to lethal means, such as a gun in the house or unused bottles of medications.

### Measurement Tools

Many measurement tools are available to assess for depression (e.g., Beck Depression Inventory, Hospital Anxiety and Depression Scale, Brief Zung Self-Rating Depression Scale); however, many are lengthy and time consuming (Ransom, Jacobsen, & Booth-Jones, 2006). In a survey of 200 advanced practice nurses, 67% of respondents reported not using any tool to screen for depression (Eaton & Tipton, 2009). In a study of terminally ill patients, Chochinov (2001) reported that a single question, “Are you depressed most of the time?” was diagnostically significant for identifying depression and had excellent sensitivity and specificity. This simple screening question may assist in identifying patients requiring measurement with an established tool or a more extensive psychiatric evaluation.

The National Comprehensive Cancer Network (NCCN) introduced the Distress Thermometer for its ease of use by patients and clinicians. In its clinical...
practice guidelines on distress management, NCCN (2010) uses the word distress instead of depression to avoid any stigma and facilitate discussion. This tool consists of 36 yes or no questions, with 0 indicating no distress and 10 indicating extreme distress, and a visual thermometer. The Distress Thermometer has been validated and compares well to the Eastern Cooperative Oncology Group's Performance Status Scale, the State-Trait Anxiety Inventory-State Version, and the Center for Epidemiologic Studies-Depression Scale (Ransom et al., 2006). The greatest sensitivity and specificity of the Distress Thermometer is with scores of 4 or higher, which indicate clinically significant depressive symptoms (Ransom et al., 2006).

The literature from both psychiatry and oncology has described possible factors that may be associated with suicidal intent, thoughts, and attempts (see Figure 1). Therefore, patients must be reassessed minimally at the time of diagnosis, recurrence, or change in prognosis. In addition, changes in medications and dosages should prompt reassessment, with specific attention to any potentially mood-altering medications such as antidepressants. Healthcare providers prescribing antidepressants should be identified in the medical record. The patient’s therapist, membership in support groups, or pastoral counseling also should be noted. Family members and significant others should be assessed for distress and depression because they can experience the same or greater amounts of distress as the patient (Adler & Page, 2008).

The best primary intervention for depression is pharmacotherapy combined with psychosocial support and counseling (Chochinov, 2001; Fulcher et al., 2009). The goal is to develop and maintain a supportive alliance between the healthcare provider and the patient and to work with the patient to improve coping skills, reshape negative thoughts, and mobilize a support system. If a patient is experiencing a high level of distress, new or worsening depressive symptoms, or any symptoms of acute depression (e.g., sense of hopelessness, despair, worthlessness, or helplessness; excessive guilt; suicidal ideation), the patient should be assessed for distress and depression because they can experience the same or greater amounts of distress as the patient (Adler & Page, 2008).

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should contact that individual to facilitate immediate intervention.

Conclusion

Healthcare professionals need to relinquish cancer stereotypes and view cancer as a chronic disease, not an understandable reason to commit suicide. Oncology nurses should explore their own feelings and increase their knowledge and comfort in assessing suicidality (Valente, 2007; Valente & Saunders, 2000, 2004; Valente, Saunders, & Grant, 1994). Tools such as the Distress Thermometer should become part of everyday practice (NCCN, 2010) as a means to assess distress in people with cancer. Assessment and management of distressing symptoms need to be a major focus of cancer care to enhance quality of life and decrease patient distress (see Figure 2).

With little research in the nursing literature, many opportunities exist to study suicide in people with cancer. Many questions need to be studied, including clarifying specific patient groups at risk for suicide, as well as exploring nurses’ views about suicide and comfort with addressing this issue with their patients (see Figure 3). This is a prime area for oncology nursing research and will encourage the development of evidence-based interventions and improve patient outcomes.

In summary, oncology nurses must become aware of their institution’s policy related to the Joint Commission’s (2010) National Patient Safety Goal to identify patients at risk for suicide. Nurses must be able to have conversations with patients regarding their risk of suicide, assess patients’ risks, and provide referrals, community resources, and a crisis hotline number.

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