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Assessing the Risk for Suicide in Patients With Cancer

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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?

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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

Table 1. Comparison of Standardized Mortality Ratios Related to Suicide

Group	Ratio
U.S. veterans	1.15
Former active duty veterans	1.33
Veterans diagnosed with mental disorders	1.77
People with cancer diagnoses	1.88
• First year after diagnosis	3.9
• One to five years after diagnosis	2.2
• More than five years after diagnosis	1.5
• Lung or bronchus	5.74
• Stomach	4.68
• Oral cavity and pharynx	3.66
• Larynx	2.83
• Breast cancer survivors more than 25 years after diagnosis	1.35

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.

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Digital Object Identifier: 10.1188/10.CJON.687-691