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>
<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.
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, & Nemeroff, 1995; Spolettini 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; Breibart et al., 2000; 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).

**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 unrelieved 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 [Chochinov, 2001]), oncology nurses should proceed with procedures established by their employers to promote patient safety. These may include safety measures such as removing sharp objects and one-to-one observation while instituting an urgent consultation with a psychologist, psychiatrist, or an advanced practice nurse specializing in psychology (NCCN, 2010). Consultation with a social worker or chaplain may be needed. For outpatients, the nurse may instruct the concerned family member or friend to bring the patient directly to the emergency department for evaluation. If the patient has an existing therapist or psychiatrist, the healthcare provider

**Professional Goals**
- Explore personal views and beliefs about suicide.
- Explore goals of oncology care, noting the change from palliative care to survivorship.
- Obtain education on behavioral and demographic factors that increase suicide risk.
- Compile a list of community resources and crisis hotlines.
- Review your institution’s policies.
- Discuss suicide and mental health disorders such as depression to decrease stigma.
- Educate the community about risk factors for suicide.
- Be active in public policy related to suicide prevention.

**Patient Interventions**
- Take a thorough psychosocial history, including history of depression, anxiety disorder, or post-traumatic stress disorder, as well as history of use of antidepressants and other psychotropic medications, past suicide attempts of patient or a family member, access to lethal means, and being a victim of abuse or natural disaster.
- Assess routinely for depression and suicidal risk (thoughts, intent, and plan) using appropriate screening tools.
- Assess for symptoms of acute depression (e.g., hopelessness, despair, feelings of worthlessness or helplessness, excessive guilt, self-loathing, suicidal ideation).
- Reassess effectiveness of symptom management, particularly for unresolved pain or depression.
- Refer patient to appropriate resources (i.e., social worker, psychologist, psychiatrist, chaplain).

**If Patient Is at Risk for Suicide**
- Remain calm. Stay with the patient or continue talking to him or her by telephone.
- Institute suicide precautions immediately.
- Assess for plan and method; remove the method.
- Ensure a safe environment.
- Assess social supports.
- Alert the healthcare team.
- Refer patient immediately to appropriate resources (i.e., emergency room, social worker, psychologist, psychiatrist, chaplain).

**Figure 2. Oncology Nurses’ Role in Suicide Prevention**
*Note: Based on information from McCoy & Salerno, 2010; Valente, 2010.*

**Figure 3. Future Areas of Nursing Research on Suicide and Cancer Diagnosis and Treatment**
*Note: Based on information from Bebbington et al., 2009; Cousins & Harper, 1996; Janofsky, 2009; Lydiatt et al., 2008; Pukkala et al., 2003.*
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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