Exploring Oncology Nurses Attitudes Towards Suicide in Cancer Patients

Bonnie L. Hoover
St. John Fisher College

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Exploring Oncology Nurses Attitudes Towards Suicide in Cancer Patients

Abstract
Oncology nurses are recognized experts in the care of patients with cancer. As such, oncology nurses excel at the management of symptoms related to both the disease itself, as well as treatment, affecting the lives of patients experiencing cancer. These symptoms include physical, social, and psychological components.

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Exploring Oncology Nurses Attitudes Towards Suicide in Cancer Patients

By

Bonnie L. Hoover

Submitted in partial fulfillment of the requirements for the degree

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Supervised by

Dr. Dianne Cooney Miner

Wegman’s School of Nursing

St. John Fisher College

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Exploring Oncology Nurses Attitudes Towards Suicide in Cancer Patients

Chapter One: Problem Identification

Oncology nurses are recognized experts in the care of patients with cancer. As such, oncology nurses excel at the management of symptoms related to both the disease itself, as well as treatment, affecting the lives of patients experiencing cancer. These symptoms include physical, social, and psychological components.

Suicide among cancer patients is a phenomenon not discussed very openly in the oncology profession. Most discussion that does occur in the clinical area of oncology practice occurs because of an incident of suicide or a suicide attempt by a patient. When this happens, the resultant stress to both the professional caregivers and family of the patient who elects to commit suicide is enormous. The ensuing guilt and search for answers can be crippling. Not until a patient commits suicide do most professional cancer caregivers take the time to look into this phenomenon.

This study seeks to answer the question: What are the attitudes of practicing oncology nurses towards suicide in cancer patients?

For the purposes of this study, suicide is defined as intentional self-inflicted death. While there is a fair amount of research in the area of professional cancer caregivers’ attitudes towards patients who seek physician-assisted suicide, little can be found in the literature regarding spontaneous suicides, or those that are not physician-assisted. For the purposes of this study, the focus will be narrowed to non-physician-assisted suicide. Oncology nurses are defined as
registered nurses actively working with adult cancer patients for at least the past six months in either inpatient or outpatient settings. Suicide survivor is defined as an individual who remains alive following the suicide death of someone with whom they had a significant relationship or emotional bond (Midence, Gregory, & Stanley, 1996).

Multiple studies cite an increased incidence of suicide among cancer patients ranging from two to four times that of the general population (Bjorkenstam, Edberg, Avoubi, & Rosen, 2005; Hem., Loge, Haldorsen, Ekeberg, 2004; Schairer, 2006; Zeller, 2006). The majority of these studies were conducted in countries where suicide is less stigmatized. In the United States, underreporting due to social stigma, insurance and financial concerns, and lack of autopsy confirmation of suicide in terminally ill patients severely hampers the ability of researchers to accurately demonstrate the increased risk of suicide in cancer patients (Bjorkenstam, Edberg, Avoubi, & Rosen, 2005).

The impact of suicide on survivors is well documented and can last a lifetime. Multiple studies have identified guilt, blame, anger, responsibility, and abandonment in the aftermath of a suicide (Ellenbogen and Gratton, 2001). The Surgeon Generals Call To Action to Prevent Suicide (1999) notes that suicide evokes complicated and uncomfortable reactions in most of us. Often, blame is placed on the victim; the ensuing stigma can cripple survivors and create a barrier to support from outside resources, family, and friends. These reactions add to the survivors' burden of hurt, intensify their isolation, and shroud suicide in mystery. While there are multiple studies that look at the experience of suicide for survivors, there are no published research studies that look at how the experience of survivors of cancer patients who commit
suicide differ from the experiences of survivors of suicide in the general population.

Oncology nurses’ individual experiences with suicide, either in their personal or professional lives, can impact their attitudes towards cancer patients who are at risk to commit suicide and influence their ability to effectively interact with these patients (Valente, 2004). In their study in the aftermath of a young man’s suicide in 2000, Hilderley, Iwamoto, and Knobf interviewed the patient’s professional caregivers and found these caregivers saw the patient’s suicide as an effort to regain control in an uncontrolable situation in the setting of uncontrolable symptoms. In a later study looking at the same suicide, the case was presented at Schwartz Center Rounds to specifically explore professional caregivers feelings and attitudes after the suicide. The caregivers were overwhelmingly devastated by the violence of the patient’s death, feeling they had failed in helping him find hope in his terminal diagnosis. Many questioned what clues they had missed as to his intent. Some felt the patient had the right to choose how and when to die; others felt he had cheated his family out of the last moments of his life and the opportunity to say good-bye. (O’Shea, Lintz, Penson, Seiden, Chabner, & Lynch, 2002).

Further impacting this is the lack of formal training in identifying the risk factors for suicide that are unique to cancer patients, either in undergraduate nursing curriculum or in the oncology nursing certification curriculum. Despite this, little research has looked at oncology nurses’ attitudes towards suicide among cancer patients.

A logical starting point for looking at the part oncology nurses play in the identification of risk and interventions that may prevent suicide in cancer patients is to look at the attitudes of
oncology nurses towards suicide in cancer patients and how those attitudes may impact their interaction with cancer patients who may be at increased risk for suicide. If oncology nurses simply do not identify suicide among cancer patients as a valid problem, or if they feel it is a valid response to the terminal situation many cancer patients find themselves in, the process of increasing nurses effectiveness in caring for these patients must begin with education. If oncology nurses feel they are not well enough equipped to deal with the terminal cancer patients’ hopelessness and sense of despair, then educating nurses on the resources available to them in caring for these patients would be the next step. If oncology nurses believe that the tools now available to measure depression, hopelessness, and suicide risk in patients are not useful in the setting of terminal cancer, then development of a more appropriate tool for use in this specific population may be warranted. In each case, the first step is to find out what oncology nurses think about suicide among cancer patients.

By identifying these attitudes, attention can be given to identifying the needs of the oncology nurse caring for patients at increased risk for suicide, identifying possible educational deficits, and bringing the discussion of suicide into the forefront of oncology nursing. Once the discussion is initiated, perhaps the oncology patient contemplating suicide will find more open discussion with his caregivers possible, and some suicides may be averted, and the profound impact of suicide on survivors avoided.

Chapter Two: Literature Review

Literature review into this area began with establishing the increased incidence of suicide
among cancer patients. Several large retrospective studies looked at the incidence of suicide among cancer patients. From 1965 to 1999, researchers conducted a nationwide register study in Sweden looking at whether suicide is more prevalent among cancer patients than among the general population, whether the association changes over time, and whether the risk depends on the severity of the cancer disease (Bjorkenstam, et al, 2005). This was conducted within a similar time frame as an identical study in Norway (Hem, et al, 2004). Researchers looked at the Cancer Registries of Sweden and Norway respectively and linked it to suicide diagnosis in the Register of Deaths at Statistics Sweden and Norway. In each study, results were analyzed by sex, time periods, and five-year survival rates of the patient diagnoses. These studies found cancer patients do run a 2-3 times higher risk of suicide than the general population. Suicide rates are higher for several cancer sites with low survival rates, such as head and neck cancers and widely metastatic cancers. Suicide rates were also greater for men (three times greater) than women (two times greater) throughout the time period. The rate fluctuated through the time period for both sexes, but remained greater than that of the general population throughout the study.

In 2006, Zeller reports on an unpublished study by Misono and Yueh that looked at patients with single primary cancer sites entered into the national network of United States population-based cancer registries in the National Cancer Institute’s Surveillance Epidemiology and End Results program between 1973 and 2002. The study was presented at the American Head and Neck Society’s annual meeting in Chicago in August 2006. The researchers used retrospective chart review to identify suicides among the patient population, and calculated the
suicide rate among these patients. They found that the risk of suicide in patients with head and neck cancer was markedly higher than the overall cancer suicide rate, and more than four times the rate of suicide in the general population (Zeller, 2006).

Another retrospective study focused on the incidence of suicide in women with breast cancer. Researchers at the National Cancer Institute in Maryland looked at over 700,000 women diagnosed with breast cancer in America and Scandinavia between 1953 and 2001, and found over 800 had committed suicide. The study concluded that women with breast cancer have a suicide risk of four times that of the general population. The risk continues for years after diagnosis (Schairer, 2006).

In 1997, Grzybowska and Finlay presented findings from their study of the incidence of suicide in palliative care patients. The researchers undertook a postal survey of 42 palliative care units, asking them to report the number of suicides and attempted suicides, as well as the total number of patients admitted to their units, for a five-year period. The palliative care units selected had educational approval for higher medical training, and were specialist units as opposed to simply points of nursing services.

Results of the survey demonstrated that anecdotal reports from hospices showed a low incidence of suicide, yet depression is known to be 2-3 times more prevalent among cancer patients. Further, the diagnosis of depression in known to significantly increase any person’s suicide risk. Grzybowska and Finlay felt suicide, therefore, should have been expected to be more common in terminally ill patients.
The researchers were careful to identify the biases of the study, including the fact that the sample was not random and likely represented those with the poorest prognosis, and that the units most likely to respond were likely more “tuned in” to suicide as a phenomenon among cancer patients. The diagnosis of suicide is also a coroner’s verdict, so bias on the part of the coroner could impact the classification of the deaths; therefore, reporting relied on the memories of the units reporting. The researchers felt “it is not possible to draw conclusions from this study since the benchmark of data against which our figures would be compared is not based on the same criteria” (pg. 315, Grzybowska & Finlay, 1997) since reporting of incidence of suicide relied on reporter memory. They did cite a need for more accurate reporting of cause of death, even to the extent of requiring coroner postmortem examination to more accurately determine cause of death, but did not think the reality of more accurate reporting of suicide was workable given the complexities of the system.

Several case studies examining the suicide attempts and deaths of individual patients exist in the literature. Hilderley, Iwamoto, and Knobf (2000) present the case of a 31 year-old man with small cell lung cancer with extensive bony metastasis who ended his life with a gunshot wound to the head. The patient suffered from severe uncontrolled pain despite extremely high doses of narcotics whose side effects were crippling. He was evaluated for depression in the weeks prior to his death, but was felt to be coping adequately and not in need of intervention. In the aftermath of this patient’s death, experts were called upon to weigh in on the situation and provide recommendations as to what the staff missed or should have done throughout the course of the patient’s disease process. Some helpful recommendations were
made addressing opening the dialogue regarding the future with patients, as they are first facing a terminal diagnosis. Several caregivers recalled his fear of becoming a burden to his family and the fear of lack of control he associated with the end of life, and saw the patient’s suicide as an effort to regain control in an uncontrollable situation in the setting of uncontrollable symptoms.

In 2002, the same patient’s case was presented at the Schwartz Center Rounds where fellow staff members helped the staff who cared for this patient explore the events surrounding his death by suicide. The staff was overwhelmingly devastated by the violence of his death. They felt they had failed in helping him find hope in his terminal diagnosis. Many questioned what clues they had missed as to his intent. Some staff members felt that they were doing what they could do to manage his pain, but he was very limited in what side effects he was willing to endure. Some felt the patient had the right to choose how and when to die; others felt he had cheated his family out of the last moments of his life and the opportunity to say good-bye. All agreed he had lived and died on his own terms, in accordance with his own personality and values. The message the staff walked away with is that this may not have been a planned, premeditated suicide, but rather a response to that moment of unrelenting pain with opportunity (O’Shea, Lintz, Penson, Seiden, Chabner, & Lynch, 2002). This in and of itself could help professionals caring for patients with unrelenting pain in the setting on terminal illness identify patients at risk for suicide.

In 2004, Mayland and Mason of the United Kingdom presented a case study of a 74-year-old man with adenocarcinoma of the lung that attempted to commit suicide in the setting of unrelenting dyspnea and pain. This patient was part of a home hospice program, and was
actively being treated for depression at the point of his suicide attempt by drug overdose. While his assessment two weeks prior to his suicide attempt did reveal depression, it did not reveal hopelessness or suicide intent. After his suicide attempt, he reported that his overdose was, indeed, intentional; he felt he was a burden to others and that his situation was hopeless. The authors discuss the rationality of this patient’s suicide attempt as being impaired because of his depression. They also cited his failure to request to die in the weeks leading up to his suicide attempt and his failure to discuss his wishes with his family as signs of his lack of rationality (Mayland & Mason, 2004).

Many qualitative studies have been done looking at suicide risk factors in various disease processes. Little is reported, however, on the characteristics of a cancer patient that makes them at such an increased risk for suicide.

In their qualitative study, researchers from the U.S. Cancer Pain Relief Committee started to look at this when they performed psychological autopsies on five cancer patients who committed suicide while at home in a Palliative Care program (Filiberti, et al, 2000). To perform a psychological autopsy, researchers studied patients’ medical records for the patient’s report of symptoms at visits. They then conducted structured interviews of the patient’s caregivers, nurses, and physicians regarding their recollection of events surrounding the patient’s illness and death. Information was collected regarding the physical, emotional, and social suffering of the patients. The study was conducted to identify personality traits and situational vulnerability variables that placed cancer patients at higher risk for suicide. Several traits were identified. Among the most relevant of these vulnerability factors that were shared by all five patients were loss of, or fear of
loss of, autonomy and independence, and fear of becoming a burden on caregivers. Associated factors included uncontrolled pain, depression with a feeling of hopelessness, fear of suffering, serious body impairments, negative emotional reaction to treatment received, and the adverse physical consequences left by these.

Several researchers have looked at oncology nurses and how their attitudes towards suicide may affect their care of patients at risk for suicide. Valente and Saunders (2004) looked at barriers to suicide risk management by oncology nurses. Twelve hundred oncology nurses from the United States, Canada, and Puerto Rico were sent questionnaires to test their knowledge of and attitude towards suicide; 37% responded. Instruments used included a demographic inventory, a Suicide Opinion Questionnaire, a suicide attitude measure, and scenarios of suicidal patients. Results indicated nurses were able to identify only five out of nine suicide risk factors; almost fifty percent miscalculated the suicide risk of the patients. Despite moderate to high risk of suicide in patients presented, the nurses indicated minimal interventions. The researchers identified several barriers to management of suicidal patients, including deficits in skill, knowledge, referrals, patient teaching, advocacy, or consultation, as well as participants’ religious values, uncomfortable feelings, personal experience, and the weight of professional responsibility.

This is one of the only studies found that looked at professional barriers in nurses to identifying suicide risk in cancer patients. Sampling nurses from a professional organization may provide different results than if nonmembers were included. The response rate is low; sixty percent of those questioned did not provide feedback and therefore are not included in the
results. Questioning responses to a staged scenario may be less accurate than observing the nurses’ care provided to a patient in a clinical setting. Nurses were also asked to self-rate themselves, which could be less accurate that clinical observation. While the data obtained from this study provide no firm conclusions they do provide a direction for future research.

Research demonstrates a clear correlation between the diagnosis of cancer and an increased rate of suicide. What the research does not look at is any preexisting psychological disorders or comorbidities that may predispose this population to suicide. The research does show a correlation between suicide and the severity of the cancer diagnosis, with patients with more severe disease being at greater risk; yet, all patients with severe disease do not commit or attempt to commit suicide. There must be more to the story. The two studies that look at rate of suicide in specific cancer diagnosis are a start in beginning to identify which cancer patients are at highest risk. Much more work is needed to look at quality of life issues, pain and symptom management, relationships between the patient and caregivers, comorbidities and preexisting psychological disorders such as depression and other mood disorders and how each of these effects the rate of suicide in cancer patients.

Much work has been done in the area of depression and cancer. Many studies look at the incidence of depression in cancer patients and suggest this increased incidence of depression explains the increased incidence of suicide. Other studies suggest there is no increased incidence of depression in cancer patients over the general population, yet the increased risk for suicide remains. The amount of research in this area was overwhelming; for the purposes of this literature review, the focus was narrowed to suicide outside the setting of depression. An
interesting area for study would be a retrospective chart review of cancer patients known to have committed suicide to look at preexisting diagnosis of depression. This could include interviews of family members and professional caregivers.

Barriers to the study of suicide in the United States are many. Reporting of death from suicide is less likely to occur here due to the social stigma associated with suicide. The financial burden alone is significant; life insurance companies can refuse to pay survivor dividends to the family of a patient who commits suicide; this could be devastating to the families left behind. Coroners and medical examiners are cognizant of this when completing death certificates for cancer patients who have committed suicide. For this reason, just identifying patients who died by suicide could be difficult.

Suicide is an emotionally charged subject that many people are uncomfortable discussing. Overcoming the public’s preconceived ideas about suicide, as well as raising the oncology professional’s awareness of the problem are basic goals to be achieved in this area. More research is needed to clearly define the risk factors that specifically place cancer patients at greater risk for suicide, so that caregivers and professionals in the field of oncology can more quickly recognize the patients at risk and intervene for more positive outcomes.

Chapter Three: Research Variables

Introduction

Researching the subject of the oncology nurses attitude towards suicide in cancer patients
would be daunting for a researcher not familiar with the role of the oncology nurse. Lack of understanding of the role of the oncology nurse or preconceived ideas about the oncology nurse’s beliefs about death and dying in general, and suicide specifically could hamper the researcher’s ability to uncover underlying attitudes. Much time would need to be devoted to simply understanding the role of the oncology nurse in today’s healthcare setting before any understanding can occur of the attitudes these healthcare professionals hold towards cancer patients who commit suicide. However, for a researcher familiar with the culture of oncology nursing, research can be focused on exploring the attitudes these nurses may share regarding suicide in cancer patients.

Research Design

The research design for this study is ethnographic. Ethnography is a description of the patterns of behavior of individuals and groups of people within a particular culture (Roper & Shapira, 2000). For the purpose of this study, the culture of oncology nursing is the focus. In ethnography, from the behavior/materialist perspective, culture is observed through the group’s patterns of behavior and customs, what they produce, and their way of life. From the cognitive perspective, culture consists of the ideas, beliefs, and knowledge that are used by a group of people as they live their lives (Roper & Shapira, 2000). An underlying assumption is that oncology nursing has evolved a culture that guides the members’ view of the world and the way they structure their experiences (Polit & Beck, 2008).

Much ethnographic nursing research focuses on one distinct problem within a specific
context among a small group of people. This focused ethnography looks to answer specific
quizzes that are developed before the research is conducted, and is designed to provide useful
information that will have practical application for health care providers (Roper & Shapira,
2000). For the purposes of this study, the focus is on the attitudes of oncology nurses towards
suicide in cancer patients, with the goal of identifying what these nurses think about the subject,
what barriers to addressing the issue of suicide with patients exist for them, and how they can
best be supported in their day-to-day practice.

As a member of the oncology nursing specialty for over 20 years, this researcher is able
to take the emic perspective of how the members of this society view their world, with the goal
of identifying any tacit knowledge relating to suicide in cancer patient. The culture of oncology
nursing, by virtue of the patients being cared for, deals intimately with the subject of death and
dying. Much of the role of the oncology nurse centers on control of symptoms that affect the
patients’ quality of life, including alleviation of suffering at the end of life. Suicide seems,
inherently, to defy that role. Asking oncology nurses to identify the feelings and attitudes suicide
evokes may provide some direction for future educational programs, sensitivity training, or
simply improved awareness of the subject within the field of oncology nursing.

The ethnographic research approach allows this researcher to utilize her own extensive
experience in the field of oncology nursing to access these caregivers, increase their comfort
level with the discussion of this sensitive subject, and eliminate the researchers time spent
gaining understanding of the role of oncology nurses.
Participants

The sample for this study was drawn from staff of several local cancer centers. Eligible participants included both certified and non-certified nurses, advanced practice nurses and staff nurses, nurses who work with adult patients, nurses who work with both solid tumor and hematological cancer patients, all actively working with cancer patients. For the purposes of this study, participation was limited to Registered Nurses currently employed for at least six months in part- or full-time positions working with adult oncology patients. The care setting was both inpatient and outpatient. The population in each care setting was at least 50% cancer patients.

Exclusion criteria included nurses who work primarily with pediatric patients, nurses who have been in the field less than six months, and nurses who work in settings where the population is less than 50% adult oncology patients.

Participation was solicited by presentation of study objectives to 50-60 oncology nurses at two different monthly meetings of the local oncology professional organization, as well as personal contact between the researcher and past and present associates. Fliers were developed and displayed in three major health care settings where oncology nurses are employed locally. Interested participants were screened for eligibility and availability. Twelve potential participants were identified. Due to schedule and time constraints, ten nurses participated in the study.

Data Collection

Data for this study was collected using personal structured interviews with participants. In ethnographic research, interviews are used to gather data related to issues that have not, or
cannot be observed, in this case, the oncology nurses attitude towards suicide of a cancer patient. Formal interviews involve planning, with development of open-ended questions prior to conducting the interviews (Roper & Shapira, 2000). The personal interview allows deeper exploration of concepts and ideas. While individual interviews are time consuming, the value of the data obtained outweighs the time commitment. Interviews will be conducted at convenient sites at participants’ convenience.

Each participant was asked six questions: What do you know about cancer patients and their risk for suicide? What are your beliefs about suicide in cancer patients? How do your experiences with suicide influence your professional practice? What information have you received about patients at risk for suicide? What are the barriers you have when determining suicide risk in your patients? What resources do you have for yourself if a patient commits suicide?

These individual interviews were digitally recorded with participants’ knowledge and consent. The information was then transcribed by a professional service to ensure accuracy and completeness. Transcriptions were reviewed for accuracy and edited to reflect respondent voice inflection, nonverbal communication, and use of emphasis, strong emotions, etc.

Prior to each interview, participants completed questionnaires pertaining to demographic data. Demographic data that was collected includes age, gender, years experience in nursing, years experience working with cancer patients, practice setting, practice population, personal experience with suicide, professional experience with suicide, educational preparation, and
certification status (i.e. staff nurse, Oncology Certified Nurse, Advanced Oncology Certified Nurse).

Protection of Human Subjects

Approval for the study was obtained from the St. John Fisher College Investigational Review Board. Individual written consent was obtained from each participant. Participants consented to participate in a 30-90 minute individual interviews at a time and place of their choosing. Consent forms stipulated the participants allowed the researcher to use their words and ideas in a confidential manner in the final report of the study. Participants consented to having their interview audio-recorded and transcribed.

Due to the sensitive nature of the discussion of suicide, support for participants was available from the Employee Assistance Program (EAP), with offices throughout Rochester. EAP offers free counseling support for employees of participating businesses. Support is confidential, in the form of professional counseling and assistance to help employees and their family members to resolve problems that disrupt both their personal lives and their productivity at work (EAP, 2008). Distress in response to the death of a patient, particularly to suicide, could certainly impact the oncology nurse’s productivity.

Credibility

Participants were recruited through their involvement in the local oncology nursing organization, Genesee Valley Oncology Nursing Society. All interview participants were certified as oncology nurses. Experience as nurses ranges from 11-15 to greater-than 25 years;
experience as oncology nurses ranged from 6-10 to 21-25 years.

Member-checking may be conducted in qualitative studies. In member-checking, researchers provide feedback to study participants about study results and elicit participant feedback and reaction to those results. The belief is that if the researcher successfully captured the attitudes and beliefs of the group, participants should be given the opportunity to react to them (Polit & Beck, 2000). Some researchers may discount member-checking as unreliable, since some participants may fail to express disagreement with the researcher’s conclusions either out of politeness or in the belief that the researcher are more knowledgeable on the subject than they are (Polit & Beck, 2000). However, it remains one tool qualitative researchers have to validate research results.

A review of study results was conducted with several of the study participants. These oncology nurses expressed agreement with the study findings, declaring the results a validation of their “gut feeling” about the subject. These nurses expressed continued interest in improving their own competence in the area of suicide in cancer patients.

Chapter Four: Data Analysis

Demographics

Participants were exclusively female, ranging in age from 39 to 62 years of age (mean 52.5 years). Most were married (8/10), non Hispanic or Latino, and Catholic (6/10). Level of
nursing education was Diploma (1/10), Associate degree (1/10), Baccalaureate degree (5/10), and Master’s degree (3/10). Years of nursing experience ranged from 11-15 years to greater than 25 years. Years experience in oncology nursing ranged from 6-10 to 21-25. Participants identified the various sources of oncology nursing education as nursing school (4/10), workplace orientation (10/10), workplace continuing education offerings (10/10), self-study courses (3/10), formal educational offerings (7/10), and certification (9/10). Of the ten participants, four had experienced the death of a loved one from suicide, and two had experienced the known death of a patient from suicide. One participant reported both personal and professional experience with suicide.

Themes

Analysis of interview transcripts was done by the researcher to identify themes common throughout the interviews. Themes were identified as common if they appeared in at least half of the interviews.

The first theme identified was the threat to the nurse-patient relationship created by the context of suicide. Several threats were identified by participants.

The first threat to the nurse-patient relationship to appear is lack of knowledge about the risk of suicide in the cancer patients. Despite a collective >100 years experience in oncology nursing, few participants were able to recall any formal or informal educational offerings regarding the subject. One participant recalled receiving some information after a cancer patient committed suicide: “…..when I was working at (the place I was working when the patient
committed suicide), there was some brief… in-service, and somebody came in and talked to us”. Another recalled reading several articles regarding the subject of suicide in the cancer patient, initiated by another nurse in the practice setting following the death of a patient in that practice by suicide, “…snippets…that are in the journal articles…it has been far and few between that address that issue”. Several participants verbalized a belief that suicide risk in cancer patients would be greater than the general population, but felt that belief was subjective, not factual… “I can’t remember any information crossing my desk that tells me about patients at risk for suicide”. “I am not recalling any formal education other than maybe one or two inservices over the time that I’ve been a nurse. So, I get… I think it’s just…an awareness in a certain…group of clients, those that are depressed, those that maybe live alone don’t have many supports in their lives.”

Several participants admitted to never having thought about the subject of suicide in cancer patients prior to participating in this study- “I actually hadn’t thought too much about it because I really haven’t had a patient that I am aware committed suicide….I’ve never even heard conversations between the nurses about it before.”

Participants acknowledged that suicide may be a subject of interest in oncology patients and their caregivers- “I am sure that it crosses people’s mind, at least toward the end where - maybe they are afraid to suffer”, but felt they lacked the knowledge they needed to address the issue with patients and families. Lack of understanding of the process to take once identifying a patient as at-risk for suicide is part of this theme- “what would I do if I did figure out someone wanted to kill themselves?” “I’m not sure I’d know what to say if someone did tell me they wanted to kill themselves.”
This lack of knowledge was identified as a barrier to addressing the subject of suicide with cancer patients- “I don’t feel adequate to ask the right, you know, to ask the questions. I am not sure I know the questions to ask”; “I would say the barrier is probably first of myself not having that high on my radar” and “it’s just not on my radar like other symptoms are”. Another nurse shared, “I would say probably my own lack of thinking about it and not having information readily available in time will be my barriers.” One participant summarized this threat- “probably the biggest barrier is acknowledging that it is a risk factor.”

The second threat to the nurse-patient relationship this study identified, which ties in with the lack of knowledge about the problem of suicide in cancer patients, was a personal lack of comfort with the subject. Participants all acknowledged their own lack of comfort with the subject as a significant barrier, “I’m not sure I’d really know what to do if I did feel someone was at risk”. One nurse spoke of her own personal barriers to discussing suicide with cancer patients- “I guess potentially a comfort level when talking about something so intimate to a person.” Another participant shared “I would say probably in my patients it (a barrier to discussing suicide) would be, if I haven’t known them long enough to develop a good relationship where they feel they could be that open with me to let me know that they were considering that off hand.”

The third threat to the patient-nurse relationship was the lack of time and privacy inherent in participants’ practice settings. One participant shared “…time constraints, actually given (where) I work… there is really no privacy…probably the two biggest constraints are time and the lack of privacy.” Another spoke of her frustration with lack of time with patients “…we only
have so many minutes with the patient and we focus so much on physical symptoms that they are having.....so that the psychosocial things are not always high on...priority unless they're very teary or they have something that they bring up.” Another nurse from the same practice setting said “…we have a physical layout barrier in the facility that we work at is there is no privacy.”

Another nurse shared “…I think time would be a bigger barrier…in my setting. Time rather than privacy, because the room turnover is so great…you are bound to get that extra patient in there.”

One participant said “…I think a barrier could be busyness, we’re just too busy to spend the time to really do a thorough assessment.”

The second theme to emerge was the participant’s belief that suicide is a personal decision each patient is entitled to make. These nurses spoke to free will and self-determination in the setting of cancer, and expressed understanding why a patient may choose to commit suicide when faced with extreme suffering and pain as the disease progressed- “…it’s people’s choice and…freewill is a big part…I think that whatever our choice is, we have to deal with the consequences, but I don’t think you can make a wrong choice.” Another participant shared “…I do think people hit a level where they just are ready to go regardless of what they came here to do or whether they have achieved whatever their goals were. There is a time and they know that and they make that decision.” One participant shared “I have no problem ethically or morally with the thought that someone might want to speed up their death, especially at the end. I don’t have an issue in that, that at all in terms - I mean I can’t make a judgment about what somebody else is going through.”

Some participants acknowledged the devastating effect on loved ones when a patient does
commit suicide, “… I think families suffer immensely when somebody commits suicide in general, but when a cancer patient commits suicide, I think it’s very difficult for families to get beyond that.” Despite this, almost universally participants felt there were situations of extreme suffering where patients “taking matters in their own hands” was understandable and even acceptable. Participants had similar feelings about it, including “it shouldn’t be necessary but I can certainly understand why some patients would feel like it”, “I can understand and see how it happens”, “…it makes sense if you think about what people go through and have to deal with.’ and “…it depends on the patient situation…I don’t really fault him for it…” This empathy for the suffering of the cancer patient, developed through years of observing patients battle the indignities and pain of cancer, prevented oncology nurses from valuing the ability to identify patients at risk for suicide and to take appropriate actions to initiate discussions with patients regarding suicide.

Chapter Five: Interpretation and Discussion of Findings

Interpretation

Suicide among cancer patients is a recognized phenomenon. Oncology nurses are on the forefront of interaction with these patients and are recognized experts in their care, both physical and emotional. Yet this study supports earlier findings that oncology nurses are not experts at the identification of patients at risk for suicide, nor are they experts at the prevention of suicide in this population. This study’s findings suggest that lack of knowledge, lack of comfort with the
subject, barriers inherent to today’s health care setting, and feelings of empathy for the cancer patient prevent initiation of discussion with patients. The attitude of oncology nurses towards suicide in cancer patients is one of empathy, not action. Only one of the participants acknowledged the profound impact suicide has on survivors. Nurses with more advanced education were more likely to recall receiving some formal education regarding suicide, but none of these oncology certified nurses recalled formal education within their specialty preparation.

Lack of time in today’s busy healthcare delivery system further compromises oncology nurses ability to effectively assess for and intervene to prevent patient suicide. This includes actual time at each visit, but also historical time to establish therapeutic relationships with patients; many participants felt they didn’t “know patients well enough to discuss such a personal subject’. This is an indicator of the stigma attached to suicide since these same nurses are charged with discussing issues of death and dying on a daily basis, often with patients they are meeting for the first time. Further, oncology nurses are frequently the care providers who spend the most time with these patients throughout the care delivery system; if they are unable to find time to address suicidal ideation, a prime opportunity is lost.

Lack of privacy in individual care delivery settings further contributes to participants’ discomfort addressing the subject of suicide. As cancer centers are developed and spaces designed, more care needs to be given to the assurance of privacy for patients in this critical setting. As stated earlier, oncology nurses are frequently the care providers who spend the most time with patients within the care delivery system; ensuring them some level of privacy to thoroughly and effectively assess patients physical and emotional well-being, is critical to their
Participants did universally feel well supported in the event they had a patient commit suicide. While some identified family, friends, colleagues, and clergy, all had resources to call on if they felt they needed emotional or spiritual guidance.

**Recommendations for Future Research**

One further question to have asked in this study would have been what are your beliefs about suicide in the general population. This would have allowed direct comparison of oncology nurses beliefs regarding suicide in cancer patients versus the general population.

An additional question to ask is if these nurses would participate in an educational opportunity to learn more about identifying patients at higher risk for suicide, how to identify these patients, and what to do once you’ve identified a patient is at higher risk for or is contemplating suicide. This question could be asked in the form of a questionnaire distributed to nurses at nursing staff meetings at local cancer centers.

Another area of study would be gauging the impact of suicide in the cancer patient on survivors. This could occur in the form of interviews with survivors of cancer patients who have committed suicide, looking at their physical and emotional symptoms after the death of a loved on by suicide at measured time intervals following the suicide. These symptoms could be compared to known symptoms experienced by survivors of suicide victims from the healthy population. Identifying the unique experience of the cancer patient’s survivor may help validate the value of more diligent screening for and prevention of suicide in cancer patients.
Much attention has been given in recent years to horizontal violence in the nursing workplace. The attitude of blaming the oncology nurse whose patient commits suicide is one more form of this violence. Presenting an educational offering to this population of nurses regarding suicide in cancer patients, with pre- and post-tests addressing their attitudes towards the nurses who care for cancer patients who commit suicide may provide some insight into impacting this phenomenon. Developing a care environment where the subject of suicide in cancer patients can be freely discussed among colleagues without fear of judgment may improve care of this population of patients and provide them a more willing audience for discussion of this sensitive subject.

Implications for Nursing Practice

The first barrier to the nurse-patient relationship, lack of education regarding suicide in cancer patients, can be addressed by developing an educational offering targeting oncology nurses. Identification of which populations of patients are at greatest risk, when in the disease timeline is suicide most likely and verbal and nonverbal cues would need to be addressed. Established protocols and interventions for dealing with patients who are identified as at higher risk for suicide or whom have expressed thoughts of suicide would need to be addressed for each institution.

This educational approach may help address the second barrier to the nurse-patient relationship, lack of comfort with the subject of suicide in cancer patients. If oncology nurses feel better equipped to evaluate their patients, they may be more likely to incorporate suicide
assessment into their daily professional practice. The mere act of opening the dialog about suicide in this population may increase nurses comfort level with the subject. Encouraging nurses who have known patients who committed suicide to share their experiences may give a more personal face to the phenomenon and lessen the stigma that is attached to patient suicide among nurses.

Addressing the third barrier to the nurse-patient relationship, physical limitations of practice, i.e. time and privacy, is difficult. The healthcare delivery system in the United States requires patients be cared for as quickly and efficiently as safety permits. This has created a care environment where conversations with patients are frequently superficial, focused on the physical symptoms patients experience from both their disease and treatment for that disease. Nurses with busy schedules and heavy patient loads may begin to focus on efficiency of interaction over establishment of a therapeutic relationship. While patients certainly appreciate efficiency in the delivery of their care, we miss a unique opportunity to address psychosocial needs. There may be a place for incorporating assessment of psychosocial coping into our routine assessments, beyond the basic, “So how are you doing with all this?”

Empathy with the pain and suffering of the cancer patient, is more difficult. This empathy is an integral part of the role of the oncology nurse, honed through years of sharing the cancer experience with patients. It is, indeed, part of the art of oncology nursing. Discussion of the short- and long-term impact of suicide on survivors would need to be emphasized. These short and long term effects have a profound effect on the quality of life of suicide survivors, and are not to be taken lightly when counseling patients who are contemplating suicide. Interviews with
survivors of cancer patients who have committed suicide may provide valuable insight.

Interviews with patients who contemplated suicide but elected not to follow through may provide insight into what these patients are seeking when they consider taking the route of suicide. There is limited data available in this area that may be utilized for this purpose, but it would be invaluable information to have.

**Discussion**

The major barrier in conducting this study was recruitment of participants. The study was originally designed to utilize four focus groups of 8-10 participants each. The local Oncology Nursing Society chapter, with over 300 members and monthly educational offerings, was identified as the most efficient medium to reach potential participants. This researcher personally addressed this group at two of its monthly meetings, each with 50 or more attendees, where the study was explained and participation solicited. Emphasis was placed on any oncology nurse being invited to participate, regardless of experience with patient suicide. The interviewer was made available at a wide variety of times and locations to accommodate potential participants. Further, individual oncology nurses were contacted with emails and letters providing further details about the study and invitations to participate. Contacts were made at several local out-patient cancer centers to help disseminate invitations to participate.

Despite these efforts, only twelve oncology nurses volunteered to participate. Repeatedly nurses declined, citing lack of experience with suicide as the reason. Even with repeated reassurances that professional or personal experience with suicide was not a requirement for
participation, no further volunteers stepped forward. Eventually, the method was adjusted to personal interview to accommodate those nurses who had expressed interest in the study from the beginning.

This lack of willingness to even discuss the subject of suicide in cancer patients speaks volumes about the level of awareness oncology nurses have about the issue and its impact on care of cancer patients. It was disappointing to repeatedly find nurses unwilling to even engage in the discussion. The stigma of suicide was no doubt a contributor to this reluctance to discuss the subject.

A couple of participants spoke of a sense of professional failure if a patient commits suicide. “No patient should need to go there if the nurse is doing her job to treat symptoms.” This was most likely to come from nurses with the least years in oncology nursing, regardless of overall nursing experience. This tendency to blame the caregivers is inherent in nurses’ unwillingness to discuss the subject of suicide in their patients with one another. Because of this, those who have experienced the death of a patient to known suicide are unlikely to discuss the experience or events leading up to the suicide, lest they be viewed as less competent or less skilled. Those who suspect a patient has committed suicide are equally unlikely to discuss it for the same reasons.

Such a judgmental attitude stymies open discussion and eliminates our ability to learn from one another’s experiences. It’s easy to see that this attitude is one reason oncology nurses may be hesitant to delve further into the subject of suicide with their patients, or even hesitant to
Interestingly, at a local cancer center, soon after the interviews for this study were conducted, an incident occurred that illustrates the barriers to discussing suicide in this population. A young woman, whose very diagnosis put her at very high risk for suicide, walked into the cancer center for a routine visit with rapidly worsening symptoms from her disease. After lengthy discussion with her physician and husband, she made the decision to stop active treatment for her disease. This patient then said her goodbyes to each of the staff members who had cared for her so lovingly over the months since her diagnosis, and went home with a plan to die in the comfort of her own home. She died that very day. Her disease may very well have caused that rapid passing. The nurses most involved in her care over the preceding months spoke of the blessing of her passing so quickly, avoiding prolonged suffering. When it was suggested that the patient may have taken matters into her own hands, one nurse replied “I prefer to think she just fell asleep and never woke up”; another said “I’m focusing on what a blessing it is that her family didn’t need to watch her suffer any more.” No further discussion of the possibility of suicide was ventured; no lessons could be learned. Another opportunity to further our thinking on the subject was lost.


Appendix One: Participant Consent

St. John Fisher College

INFORMED CONSENT FORM

Title of study: Exploring the Attitudes of Oncology Nurses Towards Suicide in Cancer Patients
Name of researcher: Bonnie L. Hoover RN BSN
Faculty Supervisor: Dr. Diane Cooney-Miner
Phone for further information: 585-739-0071

Purpose of study: You are being invited to participate in an individual interview about suicide in cancer patients. The interview will be conducted by this researcher. Each interview will last 60-90 minutes. Each interview will be audio taped and the transcripts analyzed for common words, ideas and themes. You may be invited to participate in a follow-up interview at a later date.

Approval of study: This study has been reviewed and approved by the St. John Fisher College Institutional Review Board (IRB).

Place of study: St John Fisher College
Length of participation: 1.5-2 hours

Risks and benefits: The expected risks and benefits of participation in this study are explained below:

Discussion of sensitive issues may result in stress to participants.
Opportunity to discuss professional experiences with patient suicide may lead to greater understanding of the issue or greater recognition of the frequency of suicide in cancer patients.

Method for protecting confidentiality/privacy:
Participant demographic information will be kept in a locked file cabinet for three years and then destroyed. All identifiers will be removed from written transcripts and from the final document.
Your rights: As a research participant, you have the right to:

1. Have the purpose of the study, and the expected risks and benefits fully explained to you before you choose to participate.
2. Withdraw from participation at any time without penalty.
3. Refuse to answer a particular question without penalty.
4. Be informed of appropriate alternative procedures or courses of treatment, if any, that might be advantageous to you.
5. Be informed of the results of the study.

I have read the above, received a copy of this form, and I agree to participate in the above-named study.

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<th>Signature</th>
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<th>Print name (Investigator)</th>
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If you have any further questions regarding this study, please contact the researcher listed above. If you experience emotional discomfort due to participation in this study, please contact the Employee Assistance Program (EAP); contact information for the EAP will be handed out at each session.
Appendix Two: Letter to Participants

January 15, 2009

Dear Oncology Nurse-

I am currently a Graduate Nursing Student at St John Fisher College. As part of my graduate thesis, I am conducting a study entitled “Exploring Attitudes of Oncology Nurses Towards Suicide in Cancer Patients”.

In this study, I am asking registered nurses who work with oncology patients on a regular basis to participate in personal interviews. Each participant will answer a series of questions and will be asked to discuss their attitudes towards cancer patients who commit suicide, their knowledge and attitudes about suicide in cancer patients, and the impact they see suicide in cancer patients having on them and their practice.

Participation is strictly voluntary. All identifiers will be removed from the study data and finished document.

Please review to attached consent form and consider joining this study. Thank you for your time and consideration.

Bonnie L. Hoover RN BSN
Appendix Three: Demographic Information Sheet

Demographic Data Questionnaire

1. Age: ______

2. Gender: _____ Male      _____ Female

3. Marital Status: _____ Single         _____ Married         _____ Divorced
   _____ Separated     _____ Widowed

4. Ethnicity: _____ Hispanic or Latino    _____ Not Hispanic or Latino

5. Religion: _____ Catholic      _____ Protestant  _____ Jewish      _____ Muslim
   _____ Hindu         _____ Buddhist        _____ No Religious Preference
   _____ Atheist      _____ Other (Please list) ______________________

6. Level of Nursing Education: _____ RN – Diploma
   _____ RN Associate Degree in Nursing
   _____ RN - Baccalaureate Degree in Nursing
   _____ RN - Master’s Degree in Nursing

7. Years of Nursing Experience: ______ 0-5 years ______ 6-10 years ______ 11-15 years
   ______ 16-20 years ______ 21-25 years ______ > 25 years

8. Years employed in oncology nursing: _____ 0-5 years _____ 6-10 years _____ 11-15 years
   _____ 16-20 years _____ 21-25 years _____ > 25 years

9. Types of oncology nursing education (Check all that apply): _____ None
10. Experience with suicide:  
   _____ I have experienced the loss of a loved one from suicide  
   _____ I have not experienced the loss of a loved one from suicide  
   _____ I have experienced the loss of a patient to suicide  
   _____ I have not experienced the loss of a patient to suicide  

PLEASE REVIEW BOTH PAGES TO MAKE SURE ALL QUESTIONS ARE ANSWERED.  

THANK YOU!