Oncologists', nurses', and social workers' strategies and barriers to identifying suicide risk in cancer patients

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Abstract

Objective: To identify oncologists', nurses', and social workers' strategies and barriers in identifying suicide risk in cancer patients.

Methods: Sixty-one oncology healthcare professionals (HCPs) at 2 cancer centers were interviewed. We used the grounded theory method (GT) of data collection and analysis. Analysis involved line-by-line coding, and was inductive, with codes and categories emerging from participants' narratives.

Results: The majority of oncologists and nurses reported that they had encountered at least 1 patient who had committed suicide during their careers (56% and 55%, respectively) and/or had suicidal ideation (65% and 75%, respectively). Social workers reported having fewer suicides in their practices (22%), but similar rates of suicidal ideation among patients (66%). Strategies to identifying suicide risk included paying attention to patients' verbal indicators, explicit actions, and mental health distress. In addition HCPs reported that mental health disorders and other patient characteristics increased their likelihood to assess suicidality among patients. Reported barriers to identification included patient factors such as patients giving no warning, patients concealing suicidality, and patients failing to come in. HCP barriers to identification included lack of training and awareness, difficulty in differentiating suicidality from mental health distress, lack of time with patients, fear of asking about suicidality, and lack of coping resources to deal with suicidal patients.

Conclusions: HCPs reports of their lack of training and awareness on identifying suicide risk is alarming given the higher risk of suicide among cancer patients. Training programs should incorporate the successful strategies used by HCPs and overcome barriers to identifying suicide risk.

KEYWORDS

cancer, grounded theory, nurses, oncologists, oncology, qualitative research, social workers, suicidal ideation, suicidality

1 BACKGROUND

It is well established in the literature that cancer patients are at increased risk for suicidality.1-4 The suicide rate for persons with cancer is estimated to be twice the rate in the general US population.5 Similar higher risk was documented in other countries such as Sweden6 and Israel.7 Suicidality can include suicidal ideation (ie, thoughts of ending one's own life), suicidal attempts (ie, trying to take one's own life), and suicidal acts (ie, taking one's own life). Suicide risk in cancer patients has been associated with disease-related factors such as type of cancer6,8,9 the occurrence of pain, physical impairment, and a loss of autonomy.10 Other factors associated with suicide risk in cancer patients include time since diagnosis (more suicides occur within the first year after the diagnosis),11,12 and a history of psychiatric disorders in the patient.10,13 Finally, research also indicates that socio-demographic factors, such as age (more prevalent between ages 40 and 50 years), gender (males commit suicide more often), perceived low social support,11 and religiosity,14 may affect the risk of suicide among cancer patients.
1.1 Oncology professionals and assessment of suicide risk in cancer patients

It is essential that oncology healthcare professionals (HCPs) know how to identify suicide risk in their cancer patients. Previous studies indicate that more than 83% of suicidal people have contact with their physician during the year prior to their death and 66% had contact within the last month.\textsuperscript{15,16} Although cancer patients are at an increased risk of suicide,\textsuperscript{1-4} and although oncology HCPs are in an ideal position to identify this risk, the research on oncology HCPs understanding, assessment, and recognition of suicide risk is limited. To date, we know of only 1 study that looked at how oncology nurses assess cancer patients for suicidal ideation. Valente and colleagues\textsuperscript{17-19} studied 454 nurses who responded to a survey that presented a hypothetical vignette with a suicidal patient. Few nurses were able to identify all the risk factors and many incorrectly assumed that normal symptoms such as worry and crying were risk factors.\textsuperscript{19} Moreover, although the nurses were concerned about the suicidal patient in the vignette, many chose not to intervene because they felt they were not knowledgeable enough, or had the skills to act, and that their personal values and discomfort about suicide were barriers to helping the patient.\textsuperscript{17,18}

Despite calls for improving suicide screening and assessment among cancer patients,\textsuperscript{20,21} no other research on the assessment of suicide risk by oncology personnel exists with oncologists, or with oncology nurses and social workers.

Given the life and death nature of this issue coupled with the paucity of research on how oncology HCPs identify suicide risk in their patients, this study set out to examine how oncologists, nurses, and social workers respond to this issue in their clinical practice. The purpose of this study was to identify both strategies and barriers to identifying suicide risk in cancer patients by oncology HCPs who have the most frequent and regular contact with cancer patients and who are the ones responsible for referring patients to psychosocial care when needed.

2 METHODS

2.1 Study design and participants

The grounded theory method (GT) of data collection and analysis was used.\textsuperscript{22,23} GT is an empirical, rigorous, and systematic qualitative method that is particularly appropriate for topics that have not been explored before and, thus, require an in-depth approach to data collection and analysis.\textsuperscript{22,23} Given that qualitative research aims to investigate the underlying aspects of behavior and is concerned with the richness rather than the representativeness of data, it requires smaller, focused samples instead of large, random samples. Sixty-one oncology HCPs at 2 cancer centers in central and southern Israel were recruited and interviewed about the challenges they face and the strategies they use in order to identify suicide risk in their patients. The sample included 23 oncologists, 18 social workers and 20 nurses.

2.2 Procedure

Approvals were obtained from the appropriate Research Ethics Board prior to launching the study (IRB numbers 2105-13 and 2345-15). Potential participants were e-mailed information about the study by the oncologist co-investigators and by 1 social worker at each site and asked to respond if they wished to be contacted about the research. Because of the small number of social workers at each of the 2 main study sites, 4 additional social workers were recruited from academic affiliated cancer centers in central Israel using the same methods. Sixty-one oncologists, nurses, and social workers responded and none declined to be interviewed after hearing more about the research. Participants signed a consent form and agreed to the interview being audio-recorded. A semi-structured interview guide (Appendix A) was used. This interview guide was developed by the research team that included psychologists, oncologists, and social workers who work with cancer patients. This was based on their clinical and research expertise and on an extensive literature review on suicide risk. The first 5 interviews were conducted together by the study PI, and a trained research assistant who has experience with clinical interviews and with qualitative methods. The remainder of the interviews were conducted by the research assistant at both study sites. Interviews were recorded and transcribed, with all identifiable information removed from the transcripts.

2.3 Data analysis

Data collection and analysis took place concurrently. Analysis involved line-by-line coding, and was inductive, with codes and categories emerging from participants’ narratives. Data collection stopped when the team determined that we had reached saturation meaning that no new themes emerged from the data analysis. NVivo 10 computer software was used to store and organize the data.

3 RESULTS

Sixty-one oncology personnel were interviewed (see Table 1 for demographics). The majority of oncologists and nurses reported that they had encountered at least 1 patient who had committed suicide during their professional careers either in their own practices or in their departments (56% and 55%, respectively) or had suicidal ideation (65% and 75%, respectively). Social workers reported having fewer suicides in their practices (22%), but similar rates of suicidal ideation among the patients they did see in their practices (66%). Many social workers also mentioned having terminal patients under their care that had passive suicidal ideation that they expressed as a “readiness” or willingness to die. HCPs reported on a number of strategies and barriers to identification of suicidality in their cancer patients presented below (see Tables 1 and 2 in online materials).

3.1 Strategies in identification of suicide risk

3.1.1 Verbal indicators

HCPs reported that the easiest and most straightforward way to identify suicidality in cancer patients was to pay attention to verbal indications. Potential participants were e-mailed information about the study by the oncologist co-investigators and by 1 social worker at each site and asked to respond if they wished to be contacted about the research. Because of the small number of social workers at each of the 2 main study sites, 4 additional social workers were recruited from academic affiliated cancer centers in central Israel using the same methods. Sixty-one oncologists, nurses, and social workers responded and none declined to be interviewed after hearing more about the research. Participants signed a consent form and agreed to the interview being audio-recorded. A semi-structured interview guide (Appendix A) was used. This interview guide was developed by the research team that included psychologists, oncologists, and social workers who work with cancer patients. This was based on their clinical and research expertise and on an extensive literature review on suicide risk. The first 5 interviews were conducted together by the study PI, and a trained research assistant who has experience with clinical interviews and with qualitative methods. The remainder of the interviews were conducted by the research assistant at both study sites. Interviews were recorded and transcribed, with all identifiable information removed from the transcripts.

HCPs reported that the easiest and most straightforward way to identify suicidality in cancer patients was to pay attention to verbal indications. Oncology nurses and social workers mentioned that when they notice statements such as “I want to die,” “I’m going to kill myself,” “I’ll decide when I want to end of my life,”
Help me die, and talking of concrete plans to commit suicide. This theme referred to patients actively threatening to commit suicide, asking to be euthanatized, and/or talking about concrete plans about ending their life.

Talk of wanting to die
HCPs reported that another warning signal was when patients spoke explicitly about wanting to die. This talk includes statements such as “I don’t see a point in living,” “I want to die,” “I wish I wouldn’t wake up,” “I don’t want to live,” “I have nothing to live for,” and so on. HCPs noted that they took these statements as a warning sign that their patients may be thinking about suicide.

Family concerns about suicidality
HCPs reported that another explicit signal was when family members expressed concern about the patient and indicated that they are thinking about suicide.

HCP staff concern about suicidality
This theme was reported only by oncologists and social workers and was not mentioned by nurses. HCPs reported that the team often discussed suspected suicidality in their patients so that if 1 HCP identified suicide risk in a visit, they notified the others on the team about the concern.

Assessing patient plans for the future
This theme was reported only by the social workers as a strategy to identify suicide risk. Social workers noted that they actively asked and listened for how the patient spoke about their future plans. For them, this type of talk about the future indicated that the patient was not suicidal.

HCP direct inquiry about suicide
HCPs reported that in some cases where they suspected the patient might be depressed or in great distress, they asked the patient directly if they had any suicidal thoughts or plans.

3.1.2 | Explicit actions
HCPs reported that explicit actions referred to concrete signals that a patient may be suicidal. One theme emerged in this category that pertained to stopping or rejecting treatment. Stopping treatment or rejecting treatment all together was considered a sign of suicidality in cases where patients had a good prognosis and where it appeared that cure or recovery was possible with treatments.

3.1.3 | Exhibiting mental health distress
Showing signs of mental health distress was reported to be an indicator of potential suicidality. HCPs noted that when patients showed signs of depression such as despair, sadness, difficulties with eating and sleeping, withdrawal, and impaired functioning, they took this as a signal that there may also be suicidal thinking or intent. In addition, HCPs reported that another potential indicator of suicidality in their patients could be found in people with psychiatric backgrounds with previous diagnoses of severe mental illnesses or people who had previous suicide attempts prior to their cancer diagnosis.

3.1.4 | Disease characteristics
HCPs reported that some disease characteristics were more likely to lead to suicidality in patients than others. In their view, these characteristics included receiving a poor prognosis, having a terminal status, and/or when a patient experienced a disease relapse.

Cancer type
Oncologists only noted that some types of cancer (ie, pancreatic cancer, brain tumors) were more likely to lead suicidality in patients than others (ie, breast cancer).

3.1.5 | Patient characteristics
HCPs reported that certain types of patients were more likely to exhibit suicidality than others. These included patients who had a high need for control over their bodies, lives, and destinies and patients who appeared to have poor social support networks and who appeared to the HCPs to be lonely and isolated.

### TABLE 1  Participant demographics

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>% (N = 61)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender % (n)</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>14.8 (9)</td>
</tr>
<tr>
<td>Female</td>
<td>85.2 (52)</td>
</tr>
<tr>
<td>Age,a mean (SD)</td>
<td>45.7 (10.8)</td>
</tr>
<tr>
<td>Oncologists</td>
<td>45.7 (11.3)</td>
</tr>
<tr>
<td>Nurses</td>
<td>51.2 (9)</td>
</tr>
<tr>
<td>Social workers</td>
<td>39.5 (8.3)</td>
</tr>
<tr>
<td>Family status, n (%)</td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>48 (78.7)</td>
</tr>
<tr>
<td>Single</td>
<td>7 (11.5)</td>
</tr>
<tr>
<td>Divorced, separated, or widow</td>
<td>6 (9.8)</td>
</tr>
<tr>
<td>Years in practice, n (%)</td>
<td></td>
</tr>
<tr>
<td>Less than 5 years</td>
<td>13 (21.3)</td>
</tr>
<tr>
<td>5-15 years</td>
<td>21 (34.4)</td>
</tr>
<tr>
<td>More than 15 years</td>
<td>27 (44.3)</td>
</tr>
<tr>
<td>Oncology Unit,b n (%)</td>
<td></td>
</tr>
<tr>
<td>Clinics</td>
<td>28 (45.9)</td>
</tr>
<tr>
<td>Day hospital</td>
<td>20 (32.8)</td>
</tr>
<tr>
<td>Ward or hospice</td>
<td>20 (32.8)</td>
</tr>
<tr>
<td>Radiation</td>
<td>11 (18)</td>
</tr>
<tr>
<td>Palliative care</td>
<td>6 (9.8)</td>
</tr>
<tr>
<td>Oncology ER</td>
<td>3 (4.9)</td>
</tr>
<tr>
<td>Caregivers clinic or psycho-oncology unit</td>
<td>3 (4.9)</td>
</tr>
<tr>
<td>No. of patients seen per week, n (%)</td>
<td></td>
</tr>
<tr>
<td>5-15</td>
<td>6 (9.8)</td>
</tr>
<tr>
<td>16-25</td>
<td>18 (29.5)</td>
</tr>
<tr>
<td>26-40</td>
<td>12 (19.7)</td>
</tr>
<tr>
<td>More than 40</td>
<td>25 (40.9)</td>
</tr>
</tbody>
</table>

*a50 participants answered: 18 oncologists, 17 Nurses, and 15 nurses.
*bSome HCPs work in more than 1 location.*
3.2 Barriers in identification of suicide risk

HCPS reported that barriers to identification of suicide risk in cancer patients fell into 2 main categories that included patient and HCP-related factors.

3.2.1 Patient-related factors

No noticeable indicators
One of the biggest challenges HCPs reported in identifying suicidality in their patients was when the patients themselves did not seem to exhibit any warning or signs of suicide in the healthcare setting before taking their own life. When speaking about patients who had committed suicide, HCPs expressed shock, dismay, and distress that these patients had taken their own life, seemingly without any indication that they would do so. While all 3 groups of HCPs reported on this barrier, the expressions of surprise were more robust among the oncologists and nurses than the social workers.

Patient doesn’t share intent
Related to having no warning signs was the challenge of having patients, who even when asked about their emotional well-being did not share about their emotional state openly. HCPs expressed frustration that some patients conceal suicidal intentions, and thus, make it especially difficult for them to identify suicidal intent.

Patients don’t come in
This theme was reported only by oncologists as a challenge to identifying suicide risk in their patients. They noted that if patients are experiencing suicidal thoughts, they may stop coming in for treatments altogether, and thus, the HCP staff would miss the opportunity to screen them for suicidal intent.

3.2.2 HCP-related factors

Lack of knowledge/training
HCPs, whether oncologists, nurses, or social workers, reported that they had a lack of training and knowledge about how to identify suicide risk in their cancer patients. HCPs reported that they learned from experience how to identify risk factors, rather than from any systematic or empirically based training.

Lack of awareness
Related to a lack of training and knowledge, HCPs also noted that they may lack awareness about the need to identify suicidality in cancer patients. On the whole, HCPs in this study did not know that cancer patients were at increased risk of suicide when compared to the general population. HCPs also reported that they did not have awareness of this being a concern in the clinic and was not something they looked for or inquired about in their day-to-day practice.

Difficulty in diagnosing suicidality
HCPs reported that an additional challenge in identifying suicide risk was the difficulty in differentiating between what they perceived to be “normative” mental health distress associated with the disease and treatments and “real” suicidality in cancer patients. Part of this difficulty stemmed from their perception that the vast majority of cancer patients are depressed and anxious as part of their disease, and second, that many patients may talk about suicidality and wanting to die, but in their view, this did not necessarily indicate they would actually commit suicide.

Lack of time
HCPs reported that due to their stressful jobs and the extreme overload in their clinics, they often lacked the time they needed to get to know the patients and to assess whether they are at risk for suicide.

Fear of consequences
Some oncologists (but no nurses or social workers) reported that they feared asking questions about suicide because it may prime the patient to either take their own life or, alternatively, that by asking, they may indicate to the patient that they have lost hope in the possibility of cure.

Lack of coping skills
Finally, oncologists and nurses, but not social workers reported that another barrier to asking about suicide had to do with their lack of coping skills on what to do if the patient indicated suicidal intent. In these cases, they felt that they did not have the emotional resources to cope with the patient’s answer, and/or the practical knowledge on how to respond to the patient’s needs.

4 DISCUSSION

To our knowledge, this is the first study to empirically examine how oncologists, nurses, and social workers identify suicide risk in their cancer patients and the barriers they face in this task. Our findings indicate that while oncology HCPs have a number of ad-hoc strategies they use, they by and large lack the training to systematically assess suicidality. The participants also reported a number of significant barriers to identifying this risk in patients. In the discussion below, we contextualize these findings in the extant literature on suicide risk in cancer patients in order to identify what oncology HCPs do well in their identification strategies and where the gaps remain.

Despite having little training in mental health assessment, our study found that HCPs used a number of successful identification strategies when assessing for suicide risk. These included collecting information on risk factors such as previous suicide attempts and the presence or history of psychiatric disorders and symptoms (particularly depression and hopelessness) as well as psychological characteristics such as cognitive rigidity, which the oncologists described as patients having a high need for control. We also found, however, that HCPs often waited for patients to bring this topic up, and/or only asked about suicidality when the patient showed a concerning warning sign. One important clinical implication from this finding is the need for oncology HCPs to take an active and systematic role in collecting diagnostic information from their patients on their mental and emotional well-being and not just rely on their patients to bring it up as did many of the HCPs participating in this study.
incorporating basic screening questions about suicidality and depression into regular care that will be asked of every patient regardless of whether they are showing any warning signs of suicidality or mental health distress. These basic screening questions can include inquiries such as “Have you thought of hurting yourself?” and/or “Have you thought of ways that you could hurt yourself?”

Moreover, the HCPs in this study did not identify some of the demographic characteristics associated with suicidality in cancer patients. It is thus critical that HCPs become aware of the additional risk factors associated with suicidality due to its multifaceted nature and that they be mindful of them while caring for their patients. These include demographic factors such as age (higher prevalence of suicides between the ages of 40–50), gender (male patients commit suicide more often than female patients), and ethnicity (Whites commit more suicide compared to Hispanics and Blacks), as well as psychological factors such as impulsivity.

Interestingly, the strategies and barriers to identify suicide risk were, for the most part, similar across different HCPs (oncologists, nurses, and social workers). The only exceptions included the barriers related to fear of consequences, in which some oncologists (but no nurses or social workers) reported that they feared asking questions about suicide, and lack of coping skills, in which oncologists and nurses, but not social workers, reported on their lack of coping skills on what to do if the patient indicated suicidal intent. These findings highlight the need for training models for oncology HCPs to better able identify suicide risk and education on suicide myths (eg, asking about suicide will increase risk of action) as well as for care to be delivered by an integrative staff that can refer out to appropriate resources (eg, mental health specialists) when necessary.

Suicide risk assessment can, and should, be part of the skills acquired by all oncology HCPs. Mental health treatment and management of suicidality can be championed by social workers who specialize in the delivery of mental health services. Indeed, the social workers in our study reported significantly less completed suicides in their practice as well as fewer responses indicating surprise when encountering suicidal patients compared to oncologists and nurses. These differences may be in part due to the differences in volume of patients cared for (social workers have a significantly smaller number of patients, and thus may be less likely to encounter suicidality) as well as a result of the different set of skills social workers are trained in, which emphasize the management of emotional distress, including suicidality.

### 4.1 Clinical implications

Although HCPs used a number of successful identification strategies as discussed above, they also reported a number of concerning barriers to identifying suicide risk in their cancer patients that have important clinical implications. First and foremost, HCPs’ reports of their lack of training and awareness on how to identify suicide risk is alarming given that the literature has robustly documented that cancer patients are at a high risk of suicidality when compared to the general population.

Given that assessment, management, and treatment of the suicidal patient is one of the most stressful tasks for mental health clinicians, it is thus not surprising that HCPs in our study who do not receive mental health training, expressed reluctance to engage with patients in the assessment of their suicidal thoughts. Although the available research has documented the high prevalence of suicidality among cancer patients, little has been done to ensure that HCPs working in the oncology context learn about how to identify and, thus, potentially prevent suicidal acts in their cancer patients. This curriculum on how to identify suicidal thinking, and when and how it should be addressed should become standard pedagogy for all HCPs, including oncologists, nurses, and social workers who have contact with cancer patients. Second, the HCPs in this study perceived depression and anxiety to be a normal part of the cancer trajectory and, thus, reported that they had difficulty in differentiating between these responses and suicidality. Although it is the case that a diagnosis of a life threatening disease can cause emotional turmoil, symptoms of depression and mental health distress in cancer patients can be effectively addressed and eradicated with appropriate psychosocial interventions and need not be taken as a given, or part and parcel of the disease trajectory.

Early integration of psychosocial care for cancer patients should become the standard of care for all patients in order to both improve the quality of life of patients, and to potentially prevent suicidal ideation and suicidal attempts in this population. Finally, our study findings indicate that HCPs working in oncology need more education on myths surrounding suicide. For example, some HCPs in our study reported that they feared asking about suicide because it may prime their patients to think about something they had not considered before, that it might take away the patients hope, and/or that people who talk about suicide are unlikely to commit the act. Moreover, some HCPs explained that they avoid the topic of suicide with their patients because they do not have the coping resources to deal with their responses. Educating HCPs on suicide myths and teaching them both emotional and practical coping resources for dealing with patient’s suicidality can be implemented in the form of HCP training. This training can and should become a standard part of the oncology curriculum, but can also be implemented in the form of mandatory educational workshops for all HCPs at all stages of their career.

Future research may develop a training module for oncology HCPs and test its efficacy in improving identification of suicide risk in cancer patients. The model can test the effectiveness of the systematic utilization of different strategies identified in the current study, particularly those that are already in use by HCPs. In addition, patients’ perspective can also be incorporated in future studies to guide the recommendations for effective and appropriate HCP strategies to assess suicidality. Moreover, given the dearth of research in this area, larger quantitative studies may also increase our understanding of this issue and inform development of empirically based interventions.

### 4.2 Limitations

The study included a convenience sample of HCPs, and it is possible that findings cannot be generalized to everyone. However, it is likely that HCPs who participated in the study represent those who are more willing to discuss issues related to mental health and suicide (potentially representing those who are more equipped to deal with suicidality in cancer patients). Thus, the problem of suicidal identification may be even more pronounced among the general oncology HCP community.
4.3 Conclusions

Given the higher risk of suicide among cancer patients,1-4 and the high prevalence of suicide ideation particularly among the terminally ill,5-9 systematic assessment of suicidality, including suicidal ideation, should become a part of regular oncology care. Evidence-based effective treatments to decrease suicidality exist and include psychosocial treatment and the use of psychopharmacological agents.10 On the systemic level, these treatments should become available to the team caring for the person struggling with suicidal thoughts, and if not possible, appropriate referrals should be made by the HCPs to mental health clinicians.

ACKNOWLEDGEMENT

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DISCLOSURES

None of the authors have any conflicts of interest to disclose.

REFERENCES

4. Walker J, Hansen CH, Butcher I, et al. Thoughts of death and suicide become a part of regular oncology care. Evidence-based systematic assessment of suicidality, including suicidal ideation, should become available to the team caring for the person struggling with suicidal thoughts, and if not possible, appropriate referrals should be made by the HCPs to mental health clinicians.

for general and psychiatric hospital admissions, contacts to general practitioners and practising specialists and drug prescrip


SUPPORTING INFORMATION

Additional Supporting Information may be found online in the supporting information tab for this article.

Data S1. Supporting info item

Table 1. Strategies in identifying suicide risk in cancer patients

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APPENDIX A

Selected questions from the semistructured interview protocol

1. Can you tell me a little bit how you identify signs of suicidal thinking in your patients?
   a. Can you give me an example of 1 patient where this happened? (ask to describe in detail)
   b. What specific symptoms stand out for you as needing attention?
   c. What words or statements stand out for you as needing attention?
   d. In your experience, how do patients talk about suicidal thinking? (i.e. implicitly or explicitly)
   e. Is suicidal ideation something that patients struggle with? If so, please describe. Ask for examples.
   f. What are some of the challenges or struggles you face in identifying suicidal thinking in your patients?
   g. Is there any official or formal protocol on how to identify suicide in your patients? Describe
   h. Have you ever gotten any education in school or in your training on how to identify suicidal thoughts in your patients? Describe

2. Have you ever had a patient that you knew (or suspected) committed suicide? Or tried to commit suicide?
   a. Can you describe the situation for me?
   b. How were you informed about their death?
   c. Were there any symptoms that you or anyone else recognized before?

3. Do you ever discuss suicide with your patients?
   a. If so when does this discussion occur?
   b. What is the conversation about? What do you say?
   c. Do you ever discuss suicide with your patients later in their care?

4. Do you ever discuss suicide with other colleagues?
   a. If so when does this discussion occur?
   b. What is the conversation about? What do you say?

5. Can you tell me a bit about your views about suicide in general?

6. Is there anything else that I haven’t asked you about that you think is important for me to know about this topic? Or anything else that we have already talked about that you want to expand on?

Thank you for taking the time to talk to me today.