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A Neglected Field in Cancer Care: Identification and Management of Suicide Risk

Kanser Bakımında Gözden Kaçırılan Bir Alan: İntihar Riskinin Tanınması ve Yönetimi

Sevda Öztürk [1], Duygu Hiçdurmaz [1]

Abstract
Suicide is on the agenda of a number of countries in the world. In this respect, studies on suicide prevention pay special attention to the risk groups among which there are also cancer patients. Physical and psychosocial difficulties experienced during the disease process and some demographic characteristics might be the predictors of suicidal ideation or attempt. Oncology nurses are the members of health care team who provide continuous care for physical and psychosocial needs of cancer patients, and thus they are the ones who can identify suicide risk. However, their lack of knowledge and skills in the assessment and evaluation of suicide, negative attitudes and false beliefs are among the important obstacles of nurses in this area. The aim of this work is to raise awareness on suicide risk in cancer patients and to reveal the roles, responsibilities, problems and needs of oncology nurses regarding this issue.
Keywords: Suicide, cancer, risk prevention

Öz
İntihar Dünya'da birçok ülkenin gündeminde olup, riskli gruplarda önleme çalışmalarına büyük önem verilmektedir. Kanser hastaları da bu riskli gruplardan biridir. Hastalık sürecinde deneyimlenen fiziksel ve psikososyal zorluklar ve bazı demografik özellikler intihar düşüncesinin ya da girişiminin yordayıcısı olabilmektedir. Onkoloji hemşireleri kanser hastalarının fiziksel ve psikososyal gereksinimlerine yönelik 24 saat kesintisiz bakım veren sağlık ekibi üyeleridir ve bu nedenle intiharı tanılayabilmektedirler. Ancak, intiharı tanılama ve değerlendirme konusunda farkındalık, bilgi ve beceri eksikliği, olumsuz tutum ve yanlış inançlara sahip olma hemşirelerin bu konuda önemli engelleri arasında yer almaktadır. Bu makalenin amacı, kanser hastalarındaki intihar riski konusunda farkındalık oluşturmak ve hemşirelerin bu konudaki rollerini, sorumluluklarını, yaşadıkları sorunları ve gereksinimlerini ortaya koymaktır.
Anahtar sözcükler: İntihar, kanser, risk önleme

[1] Hacettepe University, Ankara, Turkey

Sevda Öztürk, Hacettepe University Faculty of Nursing, Ankara, Turkey
sevda92sea@gmail.com

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SUICIDE risk is considered as a significant community health problem for the general population. In this respect, attention has been given to researches and social initiatives aiming to identify and prevent suicide risk all over the world (Chan et al. 2009, Tsai et al. 2011). There are significant groups in the general population who carry this risk, and cancer patients are one them (Hem et al. 2004, Dormer et al. 2008, Misono et al. 2008, Robinson et al. 2009, Ahn et al. 2015, Vyssoki et al. 2015, Anderson et al. 2018).

Cancer is a chronic disease that presents in stages, and a number of factors affect its etiology. In the course of long-term treatments, along with considerable side effects, physical symptoms and psychosocial problems also emerge (Birol et al. 2005). The difficulty coping with patient-specific psychosocial and physical problems may cause cancer patients to consider the idea of suicide as an option (Mertz et al. 2012, Körner et al. 2016, Troy et al. 2018). In addition, patients have to adapt to a dynamic condition that constantly change due to the nature of the treatment process. And when they fail to adapt to this condition, they might be faced with a crisis and see ending their lives as an option (Mosleh et al. 2018, Oh and Cho 2018, Tang et al. 2016). Although each patient has their unique reasons for suicide, certain factors such as the type and stage of cancer and the individual's access to social resources can be significant precursors of suicidal ideation or attempts (Hem et al. 2004, Miller et al. 2008, Misono et al. 2008, Robinson et al. 2009, Ahn et al. 2015, Vyssoki et al. 2015).

Encountering suicide risk in cancer patients causes uneasiness among healthcare professionals since they do not know how to handle it; and thus it remains a taboo (Brunero et al. 2008, Granek et al. 2018, Morrissey and Higgins 2018). The researches have revealed that nurses, which comprise a significant group among healthcare professionals, lack the skills and knowledge in identification and management of suicide risk and that they have negative attitudes and false beliefs about the issue (Valente 2007, Wang et al. 2016, Granek et al. 2018). Such problems hinder nurses' attempts to prevent suicide and manage suicide risk and bring about negative outcomes in patient care (Wang et al. 2016). However, it was argued in previous studies that the trainings given to nurses on suicide issue were effective in solving such problems (Brunero et al. 2008, Chan et al. 2009).

It was reported that the majority of oncology patients have an encounter with health professionals shortly before committing suicide (Lin et al. 2009, De Leo et. al. 2013, Aboumrad et al. 2018), which reveals the fact that suicide risk could be detected and prevented by healthcare providers. It might contribute to preventing suicide among cancer patients if oncology nurses are aware of suicide risk, identify and manage it. In this respect, determining the roles, needs and problems of nurses on the issue might contribute to the planning of necessary initiatives since such practices will raise awareness and sensitivity.

The aim of the present work is to point out the importance of the issue within the framework of roles, responsibilities and needs of the nurses working with cancer patients and the problems they face concerning this issue by means of creating awareness on suicide risk among cancer patients.

Suicide in the context of cancer and psychosocial problems

Suicide is a phenomenon that comprises an individual's desire to die and the act of death due to no longer having any purpose in life. Suicide has psychological, sociocultural and

socioeconomic dimensions, which makes it a complicated concept (Stuart and Laraia, 2001). A problem that many countries face, suicide is a worldwide community health problem. The WHO (World Health Organization) reported that approximately 800.000 people die due to suicide every year (World Health Organization 2018). European region, which includes Turkey, has the highest suicide rate in the world (15.4/100.000). When the suicide statistics of Turkey is examined, it can be seen that the suicide rate is 7.3 out of 100.0000 people. A comparison of suicide rates in Turkey according to gender reveals that suicide rate in men is almost 4 times higher (11.4/100.000) than in women (3.3/100.000) (Global Health Observatory 2018). Also, Turkish Statistical Institute reported that 2463 of all suicide attempts in 2018 resulted in death (Turkish Statistical Institute 2018). Therefore, actions to be taken for creating awareness on suicide and preventing suicidal acts have gained importance these days (Chan et al. 2008, Chan et al.2009). Identification of risk groups, raising awareness of the individuals encountering these groups, identification and management of the risk are some the topics being studied on this issue. Suicide risk is higher in cancer patients compared with the general population, though the rates of risk vary (Hem et al. 2004, Dormer et al.2008, Misono et al. 2008, Robinson et al. 2009, Ahn et al. 2015, Vyssoki et al. 2015, Anderson et al. 2018).

Cancer is a disease which has a number of stressors and needs to be treated with an integrated approach. Any failure to fulfill the physical and psychosocial needs that has a meaning and gravity specific to the patient may cause the emergence of problems which affect the individual psychologically, biologically and socially (Birol et al. 2005, Mertz et al. 2012. Körner et al. 2016, Troy et al. 2018). Defined as an outcome of these problems, distress is a feeling that makes it harder for cancer patients and their families to cope with the changes caused by cancer and diminishes their sense of security. The problems that cause cancer patients to experience distress include the negative feelings such as anxiety and fear, poor management of drug side effects, concerns about their bodies and future, fatigue, and sleep disorders (Mertz et al. 2012, American Cancer Society 2015, Körner et al. 2016, Troy et al. 2018). In addition to these problems, pain is also a defined as a significant problem increasing the distress of patients and decreasing their life quality (Walker et al. 2008, Troy et al. 2018). Distress and pain in cancer patients are considered to be important precursors of suicidal ideation (Walker et al. 2008).

Cancer is a disease that presents itself in an indefinite and turbulent manner (Zhang ve ark. 2017). When patients go from stable stages through a stage in which the interventions increase, the stressors they try to cope with also increase. Therefore, treatment processes such as surgical interventions (Mosleh et al. 2018) or chemotherapy elevate their psychosocial burden (Tang et al. 2016, Mosleh et al. 2018, Oh and Cho 2018). Furthermore, failure to obtain expected outcomes in the course of treatment, disappointment with the treatment and poor management of physiological symptoms may cause patients to fall into a mood state in which they find life meaningless (Zhang et al. 2017). Besides, problems such as loss of autonomy and roles, inability to perform prior functions and pursue self-care, anxiety of becoming a burden for the caregiver (Shim and Hahm, 2011, Zhang et al. 2017), and inability to provide care for their dependents (Zhang et al. 2017) might cause uncontrolled anxiety and emergence of depressive symptoms in patients (Banyasz and Gregorio 2018).

Cancer is a process which also brings about losses, both literally and figuratively. Patients experience a variety of subjective and objective losses in this process including

organ loss, loss of function, losses concerning body image, losses in the quality of life, or losses of roles and dreams that they feel they can no longer realize; and their reactions to them vary. Kübler-Ross (1997) classified these reactions in five stages, which are denial, anger, bargaining, depression and acceptance. In denial stage, patients deny the loss and this provides them time to protect themselves against the devastation of pain. In the second stage, asking themselves the question "Why me?", the patients might exhibit certain feelings such as guilt, embarrassment and hopelessness. They might direct their anger to their families, themselves and healthcare professionals. In the bargaining stage, patients tend to seek reconciliation with spiritual sources. They promise a God or spiritual powers to soothe their anger in exchange for painless days or recovery. However, when they see that their losses are not over and they are unable to overcome this tough disease, they mourn and grieve over their losses. During this stage, defined as the depression stage, patients find life meaningless and lose their hope for the future. Symptoms such as social isolation and recession can also be observed. Provided that patients receive adequate social support, make sense of the disease process and make use of effective coping mechanisms, they can reach the stage of acceptance (Kübler-Ross 1997). Nevertheless, if maladaptive responses to loss such as distorted grief are exhibited, pathological depression might occur due to the patients' directing their anger to themselves (Townsend 2016). The stressors and losses caused by the disease might turn into a state of psychological tension which is defined as psychological pain and characterized by feelings such as decrease in self esteem, obstruction, disappointment, guilt, grief, defeat, and anger. Patients use coping mechanisms to get over this psychological pain (Orbach et al. 2003). However, if the patients are unable to cope with these stressors by using such mechanisms and fail to alleviate their pain, a crisis that may result in suicide could emerge (Stuart and Laraia 2001, Orbach et al. 2003).

Suicide prevalence in cancer patients

Prevalence of suicide in cancer patients have been studied worldwide for a long time, and replicated studies have been conducted on this subject. A review of the literature in Turkey has shown that there is no available prevalence study in this area. Although our country lacks statistical data on the issue, the results obtained out of population studies in the world literature are interesting. It was reported in those studies that suicide rates are higher in cancer patients compared with the general public (Hem et al. 2004, Dormer et al. 2008, Misono et al. 2008, Robinson et al. 2009, Ahn et al. 2015, Vyssoki et al. 2015, Anderson et al. 2018). In their study where they investigated the prevalence of suicide in patients with cancer, Misono and colleagues (2008) found that the prevalence rate in the general US population was 16.7/100,000 and that the prevalence of suicide for an age, sex, and race-adjusted rate was 31.4/100,000 among cancer patients. They found the standardized mortality ratio (the ratio of observed death to expected death) as 1.88, which illustrates that there were much more deaths than expected. This difference between the general population and cancer patients might vary depending on demographic factors such as age and sex, time of diagnosis, the type and stage of cancer (Hem et al. 2004, Misono et al. 2008, Robinson et al. 2009).

Risk factors for suicide in cancer

When the risk factors increasing the probability of suicide among cancer patients are

examined, it can be seen that evaluation of a number of factors concerning the patient and the disease are important. The type and stage of cancer, time of diagnosis, demographic characteristics, social challenges and psychopathology are the factors which healthcare professionals need to take into account while determining suicide risk. It was reported that patients with pancreas, lung (Hem et al. 2004, Miller et al. 2008, Misono et al. 2008, Ahn et al. 2015, Vyssoki et al. 2015), gastrointestinal system (Hem et al. 2004, Miller et al. 2008, Misono et al. 2008), central nervous system (Vyssoki et al. 2015), and prostate cancer (Miller et al. 2008) have higher suicide risk than patients with other types of cancers. It was found that respiratory system cancers (bronchus, trachea, and lung) have the highest suicide risk among men, while cancers in the buccal, cavity and pharynx are more likely to result in death due to suicide than other types of cancers in women (Hem et al. 2004). Besides, suicide risk in advanced-stage cancer was found to be higher than in early-stage (Miller et al. 2008, Misono et al. 2008, Robinson et al. 2009, Akechi et al. 2010, Kim et al. 2013, Ahn et al. 2015, Vyssoki et al. 2015). However, some studies have revealed that the strong effect of advanced-stage cancer on increasing suicide risk was evident only in women (Robinson et al. 2009).

The commonly held opinion in the researches conducted on suicide risk is that the risk is highest within the first months after diagnosis and in the first year of disease (Hem et al. 2004, Dormer et al. 2008, Robinson et al. 2009, Yamauchi et al. 2014, Ahn et al. 2015). Dormer and colleagues (2008) asserted that suicide risk was highest in the first three months after cancer diagnosis and they demonstrated it with a standardized mortality ratio of 5.75. Ahn and colleagues (2015), on the other hand, proposed that there was no difference between the general public and cancer patients in terms of their suicide risks one year after cancer diagnosis. Considering the reactions given to the disease, it can be suggested that patients usually experience a shock upon being diagnosed with cancer, and the subsequent processes such as surgical operations and chemotherapy bring about physical and psychosocial changes and challenges, all of which cause them to find themselves in a complicated situation and to have difficulty in keeping control. In this respect, risk assessment to be carried out within the first months and the first year of cancer diagnosis might play a big role in the prevention of suicide.

Socio-demographic risk factors associated with suicide in patients include age, sex and marital status. When the demographic factors were examined, it was seen that patients aged over 65 had higher suicide risk (Walker et al. 2008, Misono et al. 2008, Robinson et al. 2009, Costantini et al. 2014). Robinson and colleagues (2009) reported the mean age at diagnosis of first cancer in the patients committing suicide as 67.9 and 63.4 in men and women, respectively. On the other hand, Robinson and colleagues (2009) reported the mean age of general population committing suicide as 69.9 and 65.9 in men and women (Robinson et al. 2009). This demonstrates the fact that being diagnosed with cancer reduces the mean age of suicide. The findings of researches have shown that male cancer patients have higher suicide risk (Dormer et al. 2008, Misono et al. 2008, Robinson et al. 2009, Leung et al. 2013, Massetti et al. 2018). Not only suicidal intentions are higher in men compared to women (Leung et al. 2013), but also their mortality ratio due to suicide is higher than that of women (Robinson et al. 2009). In addition, suicide risk was found to be high in the groups of women who are socio-economically deprived (Robinson et al. 2009). Marital status, on the other hand, is generally associated with social support, and it was reported that cancer patients who are single and divorced

or the ones living alone have an elevated suicide risk (Hem et al. 2004, Turaga et al. 2011, Kim et al. 2013).

It was reported that patients with suicidal ideation tend to experience financial challenges and difficulty making sense of their disease, making decisions on its treatment, communicating with healthcare team and handling their daily lives (Leung et al. 2013). Family support is thought to be important in coping with cancer, and previous researches revealed that suicide ideation is more likely to be observed in patients receiving care from caregivers other than their spouses and children (Tang et al. 2016). Also, the likelihood of suicidal ideation and attempts are higher in patients who lead a stressful life (Kim et al. 2013, Massetti et al. 2018). As was reported in a study, cancer patients committing suicide asserted that they had experienced a crisis two weeks before their suicide (Massetti et al. 2018).

Questioning the presence of a psychological disorder is a factor to be taken into account concerning suicide risk. Patients with psychiatric disorders are likely to have suicidal ideation more than the ones who don't, and this condition is associated with depressive emotional state (Tang et al. 2016). Suicidal ideation is more likely to be seen in cancer patients with a prior diagnosis of anxiety disorder and/or depression (Miller et al. 2008, Akechi et al. 2010, Shim and Hahm, 2011, Kim et al. 2013). It was found that 40% of cancer patients with major depression have suicidal ideation (Akechi et al. 2010). Likewise, Massetti and colleagues (2018) asserted that 40% of the patients with a cancer history were in a depressive mood at the time of their suicide.

Suicide risk assessment and the role of nurses

Identification and assessment of suicide risk is a significant component of suicide prevention. Healthcare professionals could be the first to assist in the identification and assessment of suicide cases or the first ones that the society and healthcare institutions ask for help. The researches have revealed that cancer patients are in contact with healthcare professionals shortly before attempting suicide (Lin et al. 2009, Aboumrad et al. 2018). It was reported that independent of presence of any psychological disorder, approximately 90% of people committing suicide were in contact with a healthcare professional three months before their death (De Leo et al. 2013) and that 67% of them received medical service from a healthcare institution a week or less before committing suicide (Aboumrad et al. 2018). Lin and colleagues (2009) found that almost half of the patients who die by suicide commit suicide within 14 days following their discharge from hospital. In the light of these findings, it can be concluded that it is possible to identify suicide risk while providing healthcare service and to take necessary actions in the meantime. However, healthcare staff has some fundamental problems one of which is their seeing suicide as a dreadful and ominous concept. Identifying suicide and even talking about the presence of such a risk could create uneasiness among them (Granek et al. 2018). Another problem is healthcare professionals' lack of skills and knowledge in suicide risk identification, assessment and intervention. They feel themselves incompetent in this area and consider their lack of training, cognitive readiness and helping skills as a challenge in the prevention of suicide (Muñoz-Sánchez et al. 2018). One other problem is that healthcare institutions do not have an institutional strategy for identification and assessment of suicide. When faced with suicide risk, professionals have nothing else but to act out of their own knowledge and experience as there aren't any protocols or guide-

lines to which they can refer. Such acts may lead to performing improper interventions and adopting arbitrary and subjective practices rather than a mutual teamwork approach. This could make healthcare professionals feel less secure in identifying and assessing suicide risk while delivering healthcare service (Coppens et. al. 2018, Granek et al. 2018).

The fact that cancer is a disease with a big physical and psychosocial burden requires oncology nurses to be competent in providing psychosocial care. Compared with other healthcare staff, nurses are more advantageous in psychosocial assessment of patients since they provide a non-stop 24-hour healthcare service to them. In their study where they examined the perspective of oncology nurses on psychosocial care, Güner and colleagues (2018) found that the majority of nurses believe they could provide the best psychosocial care since they are the health professionals who spend the most time with patients. However, although nurses acknowledged their significant role in the delivery of psychosocial care and asserted their willingness to provide it, they stated that they lack the knowledge and skills in the delivery of this care. Such problems are also witnessed in nurses' identification and management of suicide risk, which is a component of psychosocial assessment. One of the problems to be dealt with in this respect is the nurses' failure to identify suicide risk (Wang et al. 2016, Granek et al. 2018). Nurses have difficulty assessing the indications of suicidal ideation during their encounter with patients. Wang and colleagues (2016) found that nurses can observe certain abnormalities in patients who have suicidal ideation. They revealed that although nurses noticed the mood changes in patients and observed that they talk as if they were saying farewell or ask questions that might imply a suicide contemplation, they didn't treat such behaviors as suicide risk. The reasons for such behavior changes could be understood and interpreted only after patients' suicide (Wang et al. 2016). Some nurses, on the other hand, do not deem patients' explicitly expressing their suicidal ideations as a risk. They think it is normal for cancer patients to express their wish to die in the course of their treatment process, and it was emphasized that not all of the patients asserting their wish to die have suicidal intentions (Granek et al. 2018). This demonstrates that nurses do not see patients' expression of suicidal ideation as suicide risk.

Communication with the patient, which is an important factor in suicide risk assessment, is considered as one of the obstacles that nurses face. Lack of communication skills that will help nurses discover patients' concerns and not knowing what to say in communication are the leading problems that oncology nurses experience (Valente 2007, Wang et al. 2016, Granek et al. 2018). While assessing suicide risk, nurses tend to abstain from asking patients whether they have any suicidal ideation fearing that they might give them discomfort or it may be a sensitive issue for them (Wang et al. 2016). However, the research findings have revealed that questioning their suicide risk do not produce a negative emotional impact on individuals (Crawford et al. 2011, Harris and Goh 2017). Crawford and colleagues (2011) argued that screening of suicide risk among patients with signs of depression doesn't arouse negative feelings such as seeing life as not worthy of living. This suggests that the underlying reason why nurses fail to assess suicide risk is their false beliefs about this issue.

Another problem concerning nurses' suicide management is their fear of suicide as a concept, which increases their anxiety level. Such anxieties affect their interaction with the patient and the quality of healthcare negatively, influence their own psychological state, and create a significant pressure on them in the working environment. Nurses

might ignore suicide risk fearing that they cannot cope with it (Valente, 2007, Wang et al. 2016, Granek et al. 2018). They experience a huge disappointment when faced with a suicide attempt (Wang et al. 2016). At this point, nurses exhibit certain distress symptoms due to realizing their failure to identify suicide risk and inability to intervene and prevent suicide from occurring. As a result, nurses might experience psychosocial problems such as anxiety, feeling of guilt, reluctance to work, reluctance to go into the patient's room, unwillingness, nervousness and lack of sleep, all of which might affect their delivery of healthcare either directly or indirectly (Wang et al. 2016).

It is thought that negative attitudes of individuals who are in contact with people having suicide risk hinder prevention of suicide. Such attitudes, a considerable amount of which stem from cultural beliefs, constitute an important obstacle for nurses in the assessment of suicide risk. They might deem the idea of suicide as a moral deficiency or a sin in a religious context, and this could cause them to attribute negative thoughts and feelings to the individuals with suicidal ideation (Osafo et al. 2012, Jones et al. 2015, Barnfield et al. 2018). Nurses could adopt some negative attitudes towards them; they might think people committing suicide are "evil" (Osafo et al. 2012), irresponsible, and too weak to cope with life (Barnfield et al. 2018). As a consequence of such attitudes, far from being empathetic, nurses tend to give people with suicidal ideation certain messages such as telling them religious figures (God, prophet etc.) has the solution to this problem (Jones et al. 2015). Such kind of attitudes and behaviors of nurses might arouse feeling of guilt in patients and obstruct them from receiving the support they need in time.

Creating awareness and identifying the psychosocial problems in patients are crucial for nurses to assess suicide risk. Research findings suggest that some oncology nurses do not have awareness on suicide risk (Wang et al. 2016, Granek et al. 2018). Granek and colleagues (2018) found that oncology nurses are not informed about the fact that cancer patients have higher suicide risk. Besides, they don't regard suicide as a psychosocial problem. In a study, nurses asserted that when they think the patient will not recover or doesn't get better, they sometimes believe the patients has no other option than suicide, and thus see it as an acceptable act (Barnfield et al. 2018). This highlights the need to raise nurses' knowledge about psychological health and their awareness on suicide risk.

It can be seen that the underlying reason for these problems are cultural learnings and nurses' lack of knowledge. According to the literature, education contributes to development of positive attitudes towards suicide. It was found that negative attitudes toward suicide decrease as the nurses' education level increase (Sun et al. 2007, Carter et al. 2018). Receiving training on this subject contributed to seeing suicide as a psychosocial problem and helped health professionals adopt positive attitudes (Chan et al. 2009). It was reported that as a consequence of trainings given on suicide risk assessment, nurses not only made a change in their attitudes, but also improved their knowledge and skills in this area (Chan et al. 2009, Tsai et al. 2011, Wu et al. 2014). Wu and colleagues (2014) carried out a study with a sample of 117 nurses and they found that nurses improved their skills to assess suicide risk as a result of the trainings offered to them. In a similar study, Chan and colleagues (2009) revealed that at the end of trainings on suicide management and prevention, nurses' attitudes towards suicide changed in a positive direction, their awareness on suicide phenomenon was raised, and they felt themselves more competent in the management of suicide. Another study demonstrated that nurses having received suicide-awareness trainings had higher awareness compared with the

ones who didn't and that they were more willing to refer patients for counseling (Tsai et al. 2011). As can be concluded from these findings, besides being effective in improving nurses' suicide risk management skills, training programs also make them more willing to play a more active role in managing this risk and making appropriate referrals.

The World Health Organization reported that early identification of people with chronic pain and acute emotional distress is a step in the prevention of suicide (WHO 2018). In this respect, it can be suggested that oncology nurses who provide healthcare services to cancer patients – the patient group that experience the biggest distress and pain – play a key role in suicide prevention. For nurses, establishing a healthy and safe physical, social and psychological environment for patients is the center of nursing care, and they perform their duties and take responsibility in the delivery of care in accordance with this notion (Official Gazette, 2010, 2011, Townsend 2016). Such an integrated philosophy allows them to regard people as biopsychosocial creatures and be sensitive to their needs in all spheres. Oncology nurses' knowledge and experience in this area and their responsibilities such as increasing patients' quality of life with an integrated notion of care, managing the symptoms, alleviating their pain and building effective communication with the healthcare team might facilitate suicide management. Nevertheless, as was mentioned above, suicide is a phenomenon that oncology nurses are not fully aware of or do not have enough knowledge and skills (Wang et al. 2016, Granek et al. 2018). Therefore, raising the knowledge and skills necessary to identify and assess suicide risk in patient care could be an important step for preventing suicide attempts of the patients receiving treatment and care at oncology clinics.

In addition to oncology nurses, consultation liaison psychiatry nurses also play a significant role in identification and assessment of suicide risk (Sharrock and Happell 2000). They are the specialized psychiatry nurses within the care and treatment team, and they try to solve the psychosocial problems of patients hospitalized for their physical problems and provide psychosocial care to patients or counseling and training service to the healthcare team. They plan trainings in order to improve nurses' knowledge and skills in psychological health, make it easier for them to identify patient reactions and provide psychosocial assessment in the delivery of care, and they evaluate the outcomes of these trainings (Stuart and Laraia 2001). Thanks to their their knowledge and skills in psychological health, consultation liaison psychiatry nurses are the key source persons to whom oncology nurses might refer for assessment of psychosocial problems and suicide risk. In this respect, consultation liaison psychiatry nurses can work in collaboration with oncology nurses on subjects such as suicide risk assessment, management and intervention, they can improve nurses' knowledge and skills in this area, and they can intervene in psychosocial crises that patients and nurses experience. In this way, it could be possible to accomplish a more effective suicide prevention system since oncology nurses would be able to identify, assess and manage cancer patients' suicide risk.

Suggestions for facilitating suicide risk assessment

Although identification of suicide risk in cancer patients and planning the interventions are significant components of psychosocial care, they are often neglected due to the above mentioned problems concerning nurses. However, there are skills, knowledge and tools that might help nurses identify suicide risk in their clinical practices. Suggestions as to those skills, knowledge and tools are as follows::

1. It is believed that the type and stage of cancer, time of diagnosis, demographic characteristics, social challenges and psychopathology are the factors needed to be taken into consideration both by nurses and other health professionals while assessing suicide risk (Hem et al. 2004, Miller et al. 2008, Misono et al. 2008, Ahn et al. 2015, Vyssoki et al. 2015). Therefore, it is imperative that data on these factors be collected in a detailed and meticulous manner.
2. The patients expressing their suicidal ideation explicitly in statements such as "I don't want to live any longer," should be treated as high-risk group, and psychological health professionals should be consulted for this problem (Granek et al. 2018).
3. Patients' statements and the questions they ask should be evaluated in terms of suicide risk. Patients might ask questions in order to find out the ways that will facilitate their suicide attempts. Wang and colleagues (2016) reported that patients committing suicide gave some signals such as asking how to measure pulse or questions about places (e.g. windows, heights) where they could potentially give harm to themselves.
4. The emotional changes in patients with suicidal ideation and contemplations should be paid regard to. A quiet and sad patient might seem comfortable since he/she has decided to commit suicide. In addition, patterns of behavior such as attempts to finish incomplete tasks and saying farewell to relatives and health workers (e.g. thanking for no reason and giving away their belongings and money) may also be observed (Wang et al. 2016).
5. If the nurse is suspicious that the explicit and implicit messages of patients signal suicidal ideation, he/she can ask them if they have any suicidal thoughts by means of telling them about his/her observations and adopting a normalizing attitude towards suicide. To give an example, they may tell the patient "Some of our patients going through harsh times like you might think of ending their lives," and ask them "Have you ever had such thoughts?" (O'Reilly et al. 2016, Joint Commission 2018).
6. Today, the use of scales that enable identification of suicide risk not only allows for systematic assessment but also saves time. Previous researches revealed that making use of scales for identifying suicide risk will fulfill the needs of both the nurses working with risk groups and the patients they offer care service (Taur et al. 2012, Lucas et al. 2015). In our country, there are some scales (their validity and reliability were tested with psychiatry patients, young adult and the general population) that can be used for determining suicide risk. Beck Suicidal Ideation Scale (Özçelik et al. 2015), Suicide Probability Scale (Atlı et al. 2009), Psychological Pain Scale (Demirkol et al. 2018), Suicide Cognitions Scale (Guzey-Yiğit and Yiğit 2017), Suicidal Behavior Scale (Bayram et al. 1995), Columbia Suicide Severity Rating Scale (Güneş 2015) are among those scales that can guide nurses and other health professionals in suicide risk assessment.
7. When suicide risk is evident, both the healthcare team and the family should be informed about this risk (Muñoz-Sánchez et al. 2018). Taking the suicide risk into account, nurses should monitor patients frequently, remove materials (e.g. drugs, sharp tools, glass materials and hooks) which has the potential to be used for suicide attempts (Joint Commission 2018), and make sure that outward-opening windows and doors are locked (Wang et al. 2016). Similar safety mea-

sures should be taken while transferring the patient to other divisions of the hospital (Joint Commission 2018).

8. In societies where suicidal ideation is a taboo, patients might feel uncomfortable when they have suicidal thoughts or they might experience such feelings as guilt, shame (Santa Mina 2009, Osafo et al. 2012). Therefore, nonjudgmental and collaborative attitudes of nurses and other health professionals towards patients might reduce the patients' distress caused by suicidal ideation and help them access to support resources much more easily (Santa Mina 2009).
9. Nurses' and other health professionals' lack of knowledge should be eliminated by means of incorporating suicide prevention and suicide risk identification subjects into orientation and in-service training programs or through special trainings/seminars (Valente 2007, Granek et al. 2018).
10. Clinical practice guidelines which provide information about suicide risk assessment, suicide prevention and care are the sources developed with the aim of improving nurses' attitudes towards patients with suicide risk and delivery of care to them. In this respect, it might be suggested that nurses and other health professionals benefit from guidelines such as Guideline for Assessment and Care of Adults at Risk of Suicidal Ideation and Behavior (Santa Mina 2009) and Emergency Nurses Association Clinical Practice Guideline: Suicide Risk Assessment (Brim et al. 2012). In addition, there are also guidelines prepared by various institutions including European Psychiatric Association (Wasserman et al. 2012) and American Psychiatric Association (2013) that address to psychiatric processes and treatments used for suicide risk prevention and treatment. Although these guidelines do not provide information about suicide in the field of oncology, they might raise oncology nurses' awareness about false beliefs and improper practices concerning suicide risk management and contribute to the development of therapeutic approaches, and thus might contribute to suicide prevention.

Conclusion

Cancer patients experience significant psychosocial problems arising due to the nature of the disease and the treatment procedures, and poor management of such problems may elevate suicide risk. This risk could be prevented by oncology nurses who provide care services and treatment to cancer patients and spend the most time with them. However, nurses have certain obstacles in the identification and assessment of suicide risk. These obstacles include their lack of knowledge and skills in suicide phenomenon, lack of awareness, feeling of fear, and negative attitudes towards patients. As was reported in the literature, these problems could be eliminated through training programs. Determining health professionals' needs regarding risk identification and planning trainings to improve their knowledge and skills in this area might not only enable patients' quick access to psychosocial support before committing suicide, but also help healthcare providers increase their competencies in psychosocial care. In this context, consultation liaison psychiatry nurses' specialized knowledge in the field of psychological health might make a great contribution to improving oncology nurses' knowledge and skills in suicide risk management. As a consequence, it can be suggested that oncology nurses should work in

collaboration with consultation liaison psychiatry nurses, and their competencies in this area should be increased.

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