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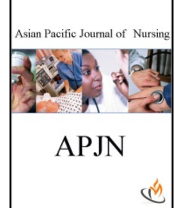


# NURSES' PSYCHOSOCIAL PROBLEM TO SUICIDE RISK MANAGEMENT IN CANCER PATIENTS

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**ABSTRACT**

Suicide relics a serious health care problem and a sentinel event tracked by The Joint Commission. Nurses are crucial in evaluating risk and preventing suicide. Analysis of nurses' barriers to risk management may lead to interventions to improve management of suicidal patients. These data came out from a random survey of 462 nurses' attitudes, knowledge of suicide, and justifications for euthanasia. Instruments included a vignette of a suicidal patient and a suicide attitude questionnaire. The survey results provided the following facts that psychological factors (emotions, unresolved grief, communication, and negative judgments about suicide) obscure the nurse's judgment and management of suicidal patients. Some nurses (*n* = 167) indicated that euthanasia was by no means justified and 14 were uncertain of justifications and evaluated each case on its merits. Justifications for euthanasia included poor quality of life, poor symptom control, incurable illness or terminal illness, terminal illness with inadequate symptom control, permanent disability and or impending death, and clinical organ death. The nurses indicated some confusion and misunderstandings about definitions and examples of euthanasia, assisted suicide, and double effect. Strategies for interdisciplinary clinical intervention are recommended to identify and resolve these psychosocial barriers.

**Key words:** Suicide, euthanasia,

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## INTRODUCTION

### Psychosocial Problem to Suicide Risk Management

Patients with a life-threatening illness such as cancer are in increased risk of suicide, and this study observes the nurse's psychosocial problems in managing suicide risk. Nurses have a key role to participate in patient safety when they identify the warning signs, examine the patient's emotional state, offer a therapeutic relationship, and take safety measures to prevent suicide. Although 75% of people warn providers of their suicidal impulses, clinicians generally fail to take these warnings critically [1]. Therapeutic intervention can often successfully help to lessen the pain, symptoms, depression and reduce suicide risk. Psychosocial problems like nurse's emotions, beliefs, knowledge, or attitudes can weaken risk management. This article describes content analysis of nurses working with cancer patients' narratives about psychosocial problems in the management of suicide risk. Cancer patients have higher than average rates of suicide. Suicide rates have been projected to be as high as 31.4/100,000 person-years among the cancer or AIDS patients. [2]. Misono et al. found an age, sex, and race adjusted rate of 31.4/100,000 person -years which is almost double the general suicide rate in the US which was 16.7/100,000 person-years. Older & White men had higher suicide rates. Specific cancers had the highest suicide risks viz. lung and bronchi cancers (standardized mortality ratio (SMR) = 5.74; 95% CI, 5.30 to 6.22), stomach cancer (SMR = 4.68; 95% CI, 3.81 to 5.70), oral cancer and pharynx cancer(SMR = 3.66; 95% CI, 3.16 to 4.22), and larynx cancer (SMR =

2.83; 95% CI, 2.31 to 3.44). Suicide risk increases when cancer patients come across diagnosis, disease exacerbation, treatment failure, and advanced or terminal stage of illness. An estimated 2–6% and an average of 3% of terminally ill patients with cancer commit suicide or request assistance to do so [3]. A person's threats of suicide may indicate that the person wants to get away from pain, fears, and melancholy and they may consider suicide the only choice. Though, therapeutic intervention can resolve some of the painful and distressing symptoms.

**Purpose**

This article reports the investigation of the psychosocial factors (e.g., emotions, personal experiences, values, and opinion) that nurses identified as problems to their management of suicide risk of a suicidal patient illustrated in a vignette. These data appeared from a study that examined the nurse's attitudes and knowledge in managing suicide risk among the cancer patients.

## MATERIALS & METHODS

Four hundred and sixty two oncology nurses in clinical practice provided informed consent and agreed to participate. Clinical oncology nurses were selected as they cared for patients with increased risk of suicide. Study tools included a demographic register, a vignette of a suicidal patient with questions about nursing assessment and administration, a quantitative tool with 94 items measuring approaches toward suicide of the person, a loved one and a stranger in different situations, and a Suicide Attitude Questionnaire, a qualitative tool. The study tools were pilot tested, revised, and provided in random order to participants. Participants used a secret code and mailed back the questionnaires.

**Suicide Vignette**

A case study of a cancer patient with suicidal signs (e.g., older, widower, depressed, talks regarding suicide, conferred away prized belongings, and has no motive to live) was presented. It incorporated questions about evaluating risk assessment, evaluation, psychosocial judgment, suicide risk factors, depression and anxiety ratings, goals and interventions, skills and knowledge. In the development of these tools, both content validation and interpreter reliability were reviewed. The procedure utilizing content experts for content validation followed the usual protocol. A jury of experts with advanced training in psychosocial oncology and psychiatric nursing recognized content validity and scoring. Test-retest (95%) was measured and interpreter reliability (97%) in scoring and data entry was accomplished by having two people rate more than 30%of the vignettes. Vignettes simulate a real position and provide an effectual research tool to elicit respondent's attitudes, knowledge, opinions, interventions, and respondent's anticipated behavior in the circumstances [4]. Outcomes measurement in psychiatric postgraduate medical education: an exploratory study using clinical case vignettes [4, 5]. Vignettes can collect information concurrently from a large sample, manipulate variables, and avoid ethical problems that may occur in observational studies [4]. Vignettes have served to elicit diagnoses [6], pain [7], nursing knowledge [8], nursing performance [9], infection control [10], ethical decisions [11], and schizophrenia [12]. Expert jury has been used to legalize vignettes. The Suicide Attitude Questionnaire (SAQ) is a qualitative measure with items about care giving, ethical issues, knowledge and assessment, and open-ended questions about the difficulty responding to a patient who mentions suicide, circumstances that would justify euthanasia, circumstances under which a patient's request for assistance should be granted, concerns and conflicts, and questions about suicide knowledge and suicide assessment skill. Questions about euthanasia were added because the pilot study showed that nurses were confused about this issue and needed an opportunity to express these issues. Nurses answered these questions and rated their skill and knowledge in suicide assessment and management. Psychometrics for the tools are described in detail elsewhere [13].

**Qualitative Data Analyses**

Content analysis gave a systematic approach for analyzing narrative texts into categories and making sense of the data. All written narrative responses to SAQ items were entered verbatim for every question and typed into MS Word, a word processing program. We followed Wilson's procedures (Wilson, 1989) for semantic content analysis. We identified the units of analysis as the respondent's words. Our unit of analysis were words like fear, not difficult, phrases like "fear of reprisal by family", "fear of failure", or sentences like "due to chronic illness", "my parent committed suicide" that conveyed a cohesive idea. Six responses were not able to be coded because they were unclear. The investigators trained the data analysis team in qualitative data analysis. After the narrative data were entered in the computer and verified, the data analysis team individually read the narratives before meeting to discuss and identify categories. We framed the preliminary categories from the data, rationale, and illustrations to guide the coding. The entire research team met to improve the directions for coding until categories were accepted for coding the narratives. After describing each category for coding, the research team independently assigned the written narrative responses to these categories before meeting to discuss our coding and reach harmony. Final decisions about coding were reached by harmony through discussion. The following categories materialized: religious, spiritual, or other values and beliefs; painful

feelings; personal experiences with suicide; scarce skills, knowledge and experience (in suicide evaluation and treatment); weight of professional responsibility; not complicated to care for suicidal patients.

## RESULTS

***Demographics:*** In total sample, 98.4% were women. The modal age was 41–50 with a range of 20 to over 60 years old. Most of the sample had a diploma in Nursing or Bachelor degree (62.6%) or a Master degree (35.8%). Most nurses (92.4%) had worked more than 9 years in nursing. Although most respondents were educated in the India (99.3%), some were educated in abroad. We aimed for a sample of nurses in clinical practice. Most nurses reported spending at least 50% per day in clinical practice. Nearly 95% of nurses were close to one or more patients. Nearly all nurses had taken courses in cancer; approximately 10% had taken a course in suicide. The core concepts that derived from the interviews and focus group includes communication problems, judgments about suicide, unresolved grief, emotions, inadequate knowledge, and justifications for euthanasia.

### *Communication Problems*

They derived from the nurses' narratives about their difficulties concerned for a suicidal patient. Some nurses detailed that they lacked the expertise of psychiatrists and didn't know what to tell to a suicidal patient. Nurses also pointed out that they lacked skill and knowledge about suicide risk assessment. Others feared that asking about suicide risk may encourage suicidal acts & thinking. Some nurses also told they did not know how to tell if the patient was "serious" about these suicidal impulses and did nothing while trying to outline if the patient was serious. Some nurses spoken conflicts between their roles in suicide prevention and support for the patient at end of life who wanted to die with self-respect.

### *Judgements about Suicide*

Nurses gave a statement that suicide was a coward's way out and some nurses recognized religion as the source of their values, but others stated that spiritual or other beliefs led them to judge suicide as a bad option. Nurses expressed worry about what was morally right for the patient within the limits of what was obligatory by the legal and professional guidelines. Some nurses worried about its impact on the family and thought the patient was wrong for harming their family.

### *Unresolved Grief*

Nurses described on experience or lack of experience in their own family or personal life and shared their experiences. When a family member had committed suicide several nurses said that their response to a family member's suicide impaired their ability to care for suicidal patients.

### Emotions

Nurses described disgusting emotional responses of varying or unspecified intensity (e.g., related to fear and other feelings) that created difficulty.

### *Inadequate Knowledge*

Nurses highlighted shortfalls in their professional experience, skill, knowledge, or abilities for caring suicidal patients. The narrative was cognitive in tone and description. Some nurses told they lacked the skill and knowledge to work with suicidal patients. They did not know how to respond and wanted to avoid the risk of responding incorrectly. In this category, respondents focused on suicide.

### *Situations that justify euthanasia*

Asking about suicide in the perspective of end of life raises issues about euthanasia. Nurses struggle to evaluate patient rights with their personal values and professional beliefs about what are right. This is in no way an easy decision, as nurses see patients suffer at end of life unnecessarily and those who have invasive interventions despite their wishes to the differing as well as patients who really want to let nature to take its course. Nurses reported the situation that would justify euthanasia. For nurses ($n$ = 167) euthanasia was never justified. Other nurses indicated that euthanasia could be acceptable for poor symptom control or quality of life (not terminally ill) ($n$ = 75), terminal illness, impending death with qualifiers (pain, QOL, end-stage disease) ($N$ = 84); patient autonomy (informed choice, living will) $n$ = 50; incurable illness/permanent disability $n$ = 42; clinical death, organ donor, vegetative state, flat EEG $N$ = 15; terminal illness (no qualifier) $n$ = 20; not sure $n$ = 14.

## DISCUSSION AND CONCLUSION

The nurse's worries related directly to multifaceted professional and ethical issues that were entrenched in the various contexts of nursing care. Clinicians reported conflicts as they considered their duties to protect life and to respect the patient's autonomy, yet they did not report allowing for the patient's capacity to exercise autonomy. Some believed that their duty was to respect a patient's right and freewill to choose suicide instead of a life-threatening disease such as AIDS and Cancer that involved pain, fatigue, and constant suffering. On the other hand, nurses had a responsibility to protect patients from harm. In some instances, suicidal patients not have capacity to exercise autonomy because a severe psychiatric disorder such as major depression with cognitive deficit challenges their ability to think clearly. However, the prominent fact is

that nurses did not explain evaluating rational thinking in their contemplation of what justified euthanasia. Nurses respect to moral versions of the responsible nursing role in situations where the nurses were not the authority of power or decisions. In attempting to serve the best interests of all involved, nurses face difficult ethical problems. The nurse's strong support for the ethical principles of autonomy, or free choice, and self-rarely emphasized the limitations of their settings. They struggled to express their responses and actions with determination may conflict with non-malaficence, or the duty to avert harm. When a patient asks for the nurse's assistance in dying, the nurse must think about the conflicting ethical duties to prevent harm and respect the patient's choice. In addition the nurse needs to consider responsibilities to the family, hospital.

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