

Suicide among people with cancer

Although most people with cancer don't commit suicide, the risk of suicide is higher among people with cancer than among the general population.¹ After surgery, patients who are male, white, and divorced or single may be at greatest risk of suicide.²

Main findings of a 2022 review:³

- Patients who received chemotherapy, radiotherapy, or surgery had the highest cumulative burden of psychiatric disorders.
- Patients treated with alkylating agent chemotherapeutics had the highest burden of psychiatric disorders, whereas those treated with kinase inhibitors had the lowest burden.
- All mental illnesses were associated with an increased risk of subsequent self-harm, where the highest risk was observed within 12 months of the mental illness diagnosis.
- Patients who harmed themselves were 6.8 times more likely to die of unnatural causes of death compared with controls within 12 months of self-harm. The risk of unnatural death after 12 months was markedly lower.

Daniel C. McFarland and colleagues offer some key points for knowing which cancer patients are particularly at risk, how to assess that risk, and what to do if you learn your patient is in danger of committing suicide. We summarize those points here; for a thorough discussion of suicide in cancer and how to assess and intervene, see their article: [Suicide in patients with cancer: identifying the risk factors](#) ›

Who is at risk?

Older age, chronic illness, multiple losses, and other reasons for suffering will intensify thoughts of suicide for people with cancer. Suicide in people with cancer most often occurs in these groups:

- Elderly age, especially older white unmarried men
- People with head and neck, lung, pancreatic, or stomach cancer, due to the morbidity of these cancers and their treatment, and especially among people who forego surgery⁴

¹ Hu X, Ma J, Jemal A et al. [Suicide risk among individuals diagnosed with cancer in the US, 2000-2016](#). JAMA Network Open. 2023 Jan 3;6(1):e2251863.

² Potter AL, Haridas C et al. [Incidence, timing, and factors associated with suicide among patients undergoing surgery for cancer in the US](#). JAMA Oncology. 2023 Jan 12.

³ Chang WH, Lai AG. [Cumulative burden of psychiatric disorders and self-harm across 26 adult cancers](#). Nature Medicine. 2022 Apr;28(4):860-870.

⁴ Chen ML, Gomez SL et al. [Surgery and suicide deaths among patients with cancer](#). JAMA Network Open. 2024 Sep 3;7(9):e2431414.

- People with depression, hopelessness, demoralization, pain, lack of social support, feeling like a burden to others, a strong need for control, or existential concerns

Spouses of people diagnosed with cancer may also be at increased risk of suicide, especially during the first year following diagnosis.⁵

Suicidal thinking

Suicidal thinking includes a spectrum from desire for hastened death (DHD) to actual suicidal ideation. DHD is “longing for death to occur more rapidly than it otherwise would.”⁶ Suicidal ideation (SI) “. . . often called suicidal thoughts or ideas, is a broad term used to describe a range of contemplations, wishes, and preoccupations with death and suicide.”⁷

Though suicidal ideation and history of suicidal behavior “are among the most salient short- and long-term risk factors for suicide,” a person can act impulsively without warning. It’s not unusual for a person with a chronic illness with significant morbidity to contemplate death and even suicide with thoughts such as “Maybe X would be better off without me.” These thoughts are related to a life adjustment and should be transient and not overtly bothersome or persistent. When these thoughts become ruminative or persistent, patients feel unsafe and may run a greater risk of attempting suicide.

MacFarland et al. explain, “Even at this point, few patients are truly sure of their decision and will often reach out through subtle gestures. These patients can be helped greatly by an astute clinician who notices changes in cognition, emotion, and personality.”⁸

A desire to hasten death usually increases as a person gets closer to death. People wish for death to come swiftly for many common reasons including feeling depressed, hopeless, like a burden to others, losing independence, and fearing pain and suffering.

MacFarland et al. explain that since DHD is so closely associated with depression, a good approach would include addressing underlying depression. DHD may respond to psychological support even over other forms of comfort care.⁹

⁵ Liu Q, Yang F et al. [Suicide attempt and suicide death among spouses of patients with cancer](#). JAMA Oncology. 2024 Aug 15:e243036.

⁶ McFarland DC, Walsh L, Napolitano S, Morita J, Jaiswal R. [Suicide in patients with cancer: identifying the risk factors](#). Oncology (Williston Park). 2019 Jun 19;33(6):221-6.

⁷ Harmer B, Lee S, Duong TVH, Saadabadi A. [Suicidal Ideation](#). 2021 Aug 6. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2022 Jan–.

⁸ McFarland DC, Walsh L, Napolitano S, Morita J, Jaiswal R. [Suicide in patients with cancer: identifying the risk factors](#). Oncology (Williston Park). 2019 Jun 19;33(6):221-6.

⁹ McFarland DC, Walsh L, Napolitano S, Morita J, Jaiswal R. [Suicide in patients with cancer: identifying the risk factors](#). Oncology (Williston Park). 2019 Jun 19;33(6):221-6.

You may have had one or more patients ask you to hasten their deaths. These requests can often lead to psychological and moral distress in health care professionals. You may need to examine and reckon with the thoughts and feelings this triggers in you. This reflection and reckoning will help you respond from a place of non-assuming, active listening, and discernment of what the person is asking you to do and what they need. Do they need more aggressive symptom management? Do they need reassurance that if they develop pain and other symptoms later, there are ways to control them and you will oversee this? Are they asking you to perhaps stop life-prolonging interventions such as chemotherapy or a ventilator? Do they want you to make sure they are allowed a natural death, even if that means not treating infection or not administering artificial nutrition and hydration? Or, perhaps they are talking about Medical Aid in Dying (MAID; formerly called Physician-assisted Suicide).

The latter request may not be legally possible in your state or the one in which a patient resides. You may want no part in this, even if you are in a state with a death with dignity law. If a patient is indeed asking for MAID, exploring this option is important, whether you explore it with them or refer them to another professional who is skilled and knowledgeable in having these conversations. A palliative care or hospice physician, nurse or social worker may be a good resource in this respect. Some patients in MAID programs don't go on to take the prescribed lethal dose of medicine.¹⁰ The reasons for that are unclear, but some believe that good palliative/hospice care may lead some patients to not exercise their option to take the lethal medication.¹¹ Our experience in working with hundreds of cancer patients in the Cancer Help Program is that openly voicing fears about unbearable suffering and exploring options for avoiding, relieving, or ending that suffering is helpful.

Assessment and Intervention

The oncologist and other members of the oncology team who see a patient regularly can play an important role in identifying patients who are at high risk for suicide and supporting them. Since thinking about suicide is the patient's way of wrestling with the will to live or to die, whatever can be done to "reduce suffering, restore connectedness, and maintain safety defuses suicidal thinking."¹²

Being able to assess suicide risk is an important skill for members of the oncology team. A basic risk assessment can be done by those who are not mental health professionals.

The oncologist and other members of the oncology team often are first responders to the psychological suffering of their patients. MacFarland et al. explain that a strong positive relationship between the patient and the oncologist can be protective against suicide; their recommendations:¹³

¹⁰ Public Health Division, Center for Health Statistics. [Oregon Death with Dignity Act. 2020 Data Summary](#). February 26, 2021. Viewed March 21, 2022.

¹¹ Schencker L. [Assisted-suicide debate focuses attention on palliative, hospice care | Modern Healthcare](#). Modern Healthcare. May 16, 2015. Viewed March 21, 2022.

¹² McFarland DC, Walsh L, Napolitano S, Morita J, Jaiswal R. [Suicide in patients with cancer: identifying the risk factors](#). *Oncology (Williston Park)*. 2019 Jun 19;33(6):221-6.

¹³ McFarland DC, Walsh L, Napolitano S, Morita J, Jaiswal R. [Suicide in patients with cancer: identifying the risk factors](#). *Oncology (Williston Park)*. 2019 Jun 19;33(6):221-6.

- Active listening, concern for patients' well-being, openness, and providing clear explanations
- Communication skills training to improve oncologist–patient communication
- Normalizing conversations about suicide in order to get appropriate resources to the right patients. Asking and talking about suicide can prevent it even when done by non-professionals

Additionally, your oncology practice needs to have a valid suicide risk assessment tool available. You will also need a list of mental health professionals and a plan for referring patients to these professionals, preferably those with whom you have developed a triage and referral plan.

Several assessment tools are available. MacFarland et al. consider the [Columbia-Suicide Severity Rating Scale](#) (C-SSRS) to be a valid and reliable suicide assessment tool. They list other tools as well. Any score other than “0” (considered a non-zero intent to die) should categorize the intent to die as suicidal ideation and trigger intervention, including referral to a mental health professional.¹⁴

Assessment tools

Two commonly used tools to assess DHD:

[Schedule of Attitudes toward Hastened Death >](#)

[Desire for Death Rating Scale >](#)

When your patient does complete suicide

A completed suicide takes an emotional toll on everyone close to the person, including those on their oncology care team. We often are diligent in making sure the person's loved ones receive “postvention” support. However, healthcare professionals need to be included in these interventions aimed at providing psychological care, destigmatizing suicide's tragedy, making sense of the confusing aftermath, assisting with recovery, and providing support services to survivors who may now be at higher risk for suicide. Not only for the patient's bereaved loved ones, but also for yourself and your staff, make sure that you offer options for mental health care.

¹⁴ McFarland DC, Walsh L, Napolitano S, Morita J, Jaiswal R. [Suicide in patients with cancer: identifying the risk factors](#). Oncology (Williston Park). 2019 Jun 19;33(6):221-6.