



Identifying Suicidal Ideation in Cancer Patients

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Abstract

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BACKGROUND: Suicidality among oncology patients in Slovenia is still a relatively unexplored topic. After a review of the literature, it was found that the risk of suicide among people diagnosed with cancer is higher compared to the general population.

AIM: Therefore, we wanted to determine the presence of suicidal ideation in patients undergoing cancer treatment.

METHODS: Qualitative research involved interviews (n = 5) with people undergoing cancer treatment. In this paper, the transcripts of the interviews are analysed using grounded theory principles.

RESULTS: Some of them had a plan. Anxiety, insecurity, need for antidepressants, and help from a psychologist were prominent. The very diagnosis and experience of the illness are extremely painful. They reported fear of starting treatment, a feeling of helplessness, of being affected, intertwined with a feeling of denial, and then hope for a cure. The most disturbing aspect of the initial treatment process was the waiting for treatment and treatment. The illness itself and the treatment also have an impact on self-image, all leading to mental consequences due to physical changes. We found that a previous history of mental illness has a significant impact, but nevertheless all participants expressed a desire to live. The category analysis showed the category of support from family and surroundings, and the high importance of an orderly family status. In the experience of the medical staff, all participants felt that the need for individualised treatment in terms of person-centredness and the need for a psychooncologist at the beginning of treatment were inevitable. Pain is also an important element. More than physical pain, they mentioned psychological, internal pain, which was linked to feelings of helplessness and suicidal thoughts.

CONCLUSION: Identification of suicidal oncology patients is a difficult process, as depressed mood and anxiety may be hidden during treatment. It is necessary to establish a trusting, empathic relationship with the patient. With mutual respect and trust, when suicidality occurs, health-care staff can work together with the patient to try to solve the problem. Nurses who are present at all times with the patient should be educated in the identification of risk factors that increase the potential for suicide and in the use of prevention tools (e.g., questionnaires and interviews) and screening programs that identify oncology patients at risk of suicidality at an early stage.

Introduction

Suicide is a serious global health problem. It is among the top 20 causes of death worldwide. More than 800,000 people die from suicide every year (World health organisation, 2019) [1].

Suicide is a major problem in Slovenia, and Slovenia is one of the countries most at risk from suicide. Despite the downward trend in the suicide rate, Slovenia is still above the European average (11/100,000 inhabitants). Similarly to the rest of the world, higher suicide rates in Slovenia are observed with increasing age. According to the National Institute of Public Health, in 2019, 394 people (307 men and 87 women) died by suicide, and the suicide rate (number of deaths by suicide per 100,000 inhabitants) was 18.86 (29.35 for men and 8.43 for women).

The reasons for suicidal thoughts and attempted suicide are multifaceted. People face different problems and challenges in life, but when a serious illness strikes, fear of an uncertain future arises. Changes in behaviour

and emotions can be observed in the individual. To understand this, it is good to know what the individual is facing. Unusual behaviours may be simply adaptations to the changes that the illness has brought into the person's life and may also be reflected at the level of emotion. Depression, tension, or even thoughts about the meaninglessness of life are more common in some illnesses than in the healthy population [2].

More than 15,000 Slovenians are affected by cancer; more than 8000 men and almost 7000 women, and more than 6000 die, approximately 3500 men and 2700 women. This means that there are already more than 100,000 people living among us who have ever suffered from a cancer (prevalence) [3].

A cancer diagnosis can cause significant psychological distress. Patients may fear death, treatment, a change in physical appearance, loss of function of a particular organ, or a change in family and social roles. This distress plays a role in the development of thoughts of suicide [4]. A review of the literature found an increased risk of suicide in cancer patients [5].

In this country and abroad, the number of cancer patients is increasing, as is their survival with improved cancer treatment and expanded screening [6]. Despite the benefits of diagnostic and therapeutic services for cancer and public health, and the aims of health campaigns to promote early detection of cancer, there are significant resource constraints for mental health services.

A problem seen in practice is the disconnect between hospitals and mental health services [7]. The focus should be on psychological support for distressed patients at increased risk of suicide, taking into account factors that influence risk levels such as age, gender, and cancer type [6].

An increased risk of suicide has been found in oncology patients with mesothelioma, pancreatic, lung, esophageal, and gastric cancers, especially in the first 6 months after diagnosis. However, the increased risk of suicide continues for 3 years after the diagnosis of cancer, and it is important to focus on the psychological health needs of patients during this period. Improved access to integrated psychological support for all cancer patients is needed [8].

No research has been done in Slovenia on how many cancer patients commit suicide or whether they have suicidal thoughts at all when they learn of their cancer diagnosis. Mental health and suicidal behaviour support services are used abroad. In Slovenia, several activities are organised every year and different organisations are involved, providing education and interaction on mental health, depression, stress, and suicidal behaviour for different target groups [9].

National guidelines set by the American College of Surgeons Committee on Cancer, American Society of Clinical Oncology, and National Comprehensive Cancer Network (NCCN) have identified anxiety and emotional distress as vital signs that highlight the recognition of suicidality in oncology patients [10].

Research from Thailand suggests a positive association between functional life and the likelihood of suicide among oncology patients. Of the total sample (105 oncology patients), 34.3% had suicidal thoughts. Of these, 1/3 of patients had suicidal ideation after diagnosis. Hopelessness and negative self-esteem were the main variables, and the psychological and physical domains were rated lower than other life domains. Having a dysfunctional lifestyle increased the risk of suicide [11].

Siracuse *et al.* [12] and Klaassen *et al.* [13] examined cancer patients' risk of suicide with a specific disease in American studies. In the first study, they looked at the association of suicide with bone and soft-tissue disease and compared the results with the general population. They found that the incidence of suicide in oncology patients is on average higher than in the general population. The most common risk factors were: male patients, white race, patients aged

21–30 years, patients aged 61–70 years, patients with spinal cord cancer, and bone cancer of the pelvic region. Erectile dysfunction further contributed to psychological disturbance [13].

Purpose and objective

The research involved interviews with people who have an oncological diagnosis. The aim is to analyse how patients have experienced and coped with a disease such as cancer and its treatment. We were also interested in how patients experience their illness and whether they receive psychological support in hospital. The paper looks at the experiences and lived experiences of people who have been/are still involved in the treatment process. The basic question is, when diagnosed with cancer, did they think about committing suicide?

We asked the following research questions:

- RQ1: When you were diagnosed with cancer, did you ever think about suicide?
- RV2: Did you have suicidal thoughts or suicidal tendencies during your treatment?
- RV3: In what ways did you cope emotionally when you were diagnosed with cancer and during the treatment itself?

Methods

A qualitative method of work – case study – was used. We did a literature review and used the grounded theory method to identify suicidal ideation in oncology patients. We wanted to find out the participants' perceptions of whether suicidal thoughts were present at the time of cancer diagnosis and treatment.

Description of the sample

We included adults undergoing cancer treatment in a non-probability purposive sample. Inclusion criteria were (1) age of majority, (2) confirmed oncological diagnosis, (3) voluntary and informed participation, and (4) signed informed consent to participate in the study and to consent to voice-recording of the interview and to the use of this voice-recording in further data analysis. The sample was small and purposive. The concept of theoretical saturation was applied to data collection, meaning that interviews were stopped when new data no longer helped to explain the emerging categories. The sample consisted of five persons, one male and four female. Four participants had lower level of education (primary and secondary school), and one was highly educated (university degree). The age of the participants ranged

from 27 to 71 years. Two participants were on sick leave (P2, P4), two were retired (P3, P5), and one was unemployed (P1). To protect personal data, we did not provide other sociodemographic characteristics of the participants, nor did we specify them at the individual level. Their underlying disease was cancer. All patients were in relatively good physical condition and treated as outpatients.

The method of sample collection was snowball sampling. First, we sought interviewees from our network of friends and acquaintances, who, in turn, forwarded our requests for interviews to their friends and acquaintances, with whom we arranged a suitable time and place through Email or Telephone. If potential participants decided to participate, they either contacted the researcher themselves or expressed a wish to be contacted by the researcher. First, the researcher explained to them the purpose and process of the research. There were more people in this network with a cancer diagnosis than expected, but not all of them were ready to talk about the topic. Personal data are anonymous, and we did not pay attention to the hospitals where they were or still are being treated, or the type of cancer they have. We talked in general terms about the diagnosis and the suicidal thoughts associated with it. The intention was to focus on their feelings and emotions.

Ethical aspects of research

No ethics committee approval or consent was required to conduct the research according to the chosen research methodology. Participation in the study was voluntary. Anonymity and confidentiality were guaranteed.

Description of data collection and processing

An unstructured interview was conducted. The questions on which the interview was based were prepared in advance. We decided to use an unstructured interview, because it is a more relaxed way to talk and to find out more about the individual's life. The pre-prepared questions were the basis for facilitating comparison and interpretation of the research questions. The interviews lasted between 1 and almost 2 h and were recorded by telephone. The text was then transcribed (transcription) and analysed in detail. The interviews were conducted in the afternoon. At the beginning of the interview, the participants were somewhat reserved, but as the interview progressed, the answers became more and more emotional.

The interviews were transcribed and then edited using a standard processing or coding procedure. We coded using the codes that had already emerged, while also paying attention to the emergence of new codes that were evident in each subsequent transcription of

the interviews. The initial codes were then grouped into superordinate codes and code families (subcategories). In the final stage, we identified seven categories, seven subcategories, and 43 codes. The codes and categories were further linked to the literature.

Conducting and transcribing the interviews

We collected data from March 23, 2022, to March 30, 2022. Participants first completed a sociodemographic questionnaire; then, we moved on to conducting the interviews. Voice-recording started when the researcher alerted the participants. At the end of each interview, we wrote our feelings, impressions, and comments in a reflective diary.

The average duration of the interviews was approximately 1 h to almost 2 h. The shortest interview lasted 61 min 49 s and the longest 115 min 42 s. Four interviews took place in the participants' homes and one outside in a park.

At the beginning of each interview, we checked whether the participants had any questions or concerns about the survey and stressed that they did not have to answer every question, that they could withdraw from the interview at any time without giving any reason, and that they had the option of deleting the data. We, then, asked questions relating to the circumstances of the diagnosis and the response to the diagnosis. This gave us an insight into their situation. We, then, moved on to more sensitive questions relating to the experience of psychological distress and thoughts of suicide.

The questions were asked in a random order, as they were adapted according to the answers given by each participant. This tailoring was done on the basis of active listening. In the final part of the interview, we checked the participants' well-being to be able to help relieve them if they felt worse. None of the participants reported any deterioration in their well-being.

Validity of results

The quality of the findings was ensured in the following ways: a reflective diary was kept after each interview, at the time of transcribing it verbatim and during the analysis process. The purpose of the reflective diary is to ensure the objectivity of the research. This way, the researcher can check the quality of the data based on his/her notes [14].

In addition, to protect the personal data of the participants, we have deleted certain parts of the text. Each participant is identified by a capital letter P (participant) and a sequential number. To protect personal data, the full transcripts of the interviews have

not been published.

The final results and their interpretations were also presented to two participants, who were contacted with their prior consent. We asked for their feedback. They said that they found the results and interpretations relevant. On this basis, we concluded that the survey was largely valid.

Results

Based on the analysis of the data collected from the participants, we have developed seven main themes, seven sub-categories, and 43 codes. The themes and sub-themes are described in Table 1 below.

Some quotations are also provided.

P1: age 27; single; unemployed; lives in a village, outskirts of the city, with parents.

“Oncological diagnosis in the process of treatment. Surgical removal of the tumour. Tumour first detected at the age of 2 years. Then again in 2018 (23 years).” When they told me that it was a relapse, I thought of suicide and planned with the thought of jumping from the 8th floor of the hospital. I told my GP, who was also a psychotherapist, about the thought. I was prescribed antidepressants. The thought passed after about 6 months. She occasionally thought about “cutting” because she had seen it in a friend of hers who was also being treated for cancer. However, she never did it. I joined various societies despite everything that happens to me, I like to live. Family ones are not appropriate. She only has support from her mother, her father and brother do not believe she is sick and she only pretends to be sick. Many times he has not let me go to the hospital for treatment. We have a farm. I have finished secondary medical school, I am not yet employed. I’m currently taking antidepressants and I’m fighting cancer. As for psychological treatment, I was lucky because I “met” a real doctor who took the time to listen to me.”

P2: age 57; married; on sick leave; lives in the city; currently lives alone.

“Oncological diagnosis in the treatment phase. Palliative radiation treatment, then surgical treatment planned. In employment, truck driver. I am currently on sick leave. When I got sick, I was working despite severe pain. Mum and dad, both died of cancer. During the treatment process itself, I never thought of committing suicide. I always think about my family who are in another country that I have to survive. I am not and do not need any antidepressants, nor do I bother about it. Edino, He is scared just due to the waiting, the waiting is killing him from the confirmation of the diagnosis itself, until the start of the treatment (it is a very long wait of a couple of months to get your turn)” and the tumour is growing. In the beginning, it was

a couple of millimetres, now they are talking about centimetres. If the treatment is not successful, I hope my wife will be a date.”

P3: age 65; widow; retired; lives in the village, alone.

“Oncological diagnosis under treatment. Waiting for a consult to see how to proceed. My husband died last year, then I found out I had cancer. I started radiation treatment, which went without any major problems. Then followed chemotherapy. Hair loss. Huge stress, anger, sadness, depression, and antidepressants. I get three chemotherapy treatments. I refuse the 4th chemotherapy “I can’t handle it,” I had no thoughts of suicide anyway, I love life. I live at home with a puppy, who will take care of him if I die? I lived thinking about my daughter and granddaughter and dog hugging trees, going to nature every day and getting through this difficult time. However, it’s not over yet. I confided my emotional distress to the medical staff, they listened, I guess it depends who you come to.”

P4: age 47; divorced; on sick leave; lives in the city with her daughter.

“Treatment for oncological diagnosis. Struggle with being overweight years ago. I had 1 child die

Table 1: Transcription method for unstructured interviews

Category	Sub-category	Code
Suicidal thoughts	Presence of suicide thoughts	- Presence of suicidal thoughts (P1, P4, P5) - Uncertainty (P1, P4, P5) - Presence of suicidal thoughts and plan (P1, P4, P5) - Assistance of psychologist/psychiatrist (P1, P4, P5, P3) - Antidepressants (P1, P3, P4, P5)
Cancer diagnosis	Surviving the disease	- Denial (P3) - Hope (P1, P2, P3, P4, P5) - Feeling helpless (P1, P2, P3, P4, P5) - Attachment (P1, P2, P3, P4, P5) - Distraction (P5) - Waiting for treatment (P1, P2, P3, P4, P5)
Cancer treatment	Body changes/self-image	- Long queues (P2, P3, P4, P5) - Nausea, vomiting (P3, P5) - Powerlessness (P1, P3, P4, P5) - Fatigue, exhaustion (P1, P2, P3, P4, P5) - Hair loss (P3) - Fear of pain (P1, P2, P3, P5) - Dependence on others (P1, P2, P3, P5) - Mental consequences (P1, P3, P4, P5)
Previous history of psychiatric illness	Psychological stability	- Depression (P1, P3, P4) - Anxiety (P1, P3, P4) - Fatigue (P1, P2, P3, P4, P5) - Tiredness (P1, P2, P3, P4, P5) - Hunger for life (P1, P2, P3, P4, P5)
Social environment	Family support	- Exclusion (P1) - Hard confrontation with death (P3, P5) - Stigma (P3, P5, P1, P4) - Disinterest (P1, P4) - Regulated family status (P2, P3, P5) - Good family support (P5) - Death of a family member (P3)
Medical staff	The experience of healthcare staff	- Feeling safe (P1, P2, P3) - Confidence (P1, P3) - Conducting dialogue (P1, P3) - Empathy (P2, P3, P1) - Infusing hope (P1, P3) - Need for individual attention (P1, P2, P3, P4, P5) - Inaccessibility (P2, P5) - Disobedience by the doctor (P2, P5, P4) - Need for a psychooncologist at the start of treatment (P1, P2, P3, P4, P5)
Pain	Type of pain	- Physical (P1, P2, P3, P5) - Psychological, internal (P1, P2, P3, P4, P5) - Suicidal thoughts (P1, P4, P5)

have 2 more, only contact with 1. Even before I got cancer I divorced my husband after 27 years, he was not violent, liked young people got depression. I've been on antipsychotic therapy since then. Soon after divorce I was diagnosed with a tumour, by accident they operated, they didn't do a good job, they did not do enough operated again, the tumour went everywhere. I thought about suicide, a plan with sleeping pills to make me fall asleep that now there was really no point in living anymore. I started seeing a psychologist for my children, the doctors in the hospital did not listen to my distress but antidepressants help and nature."

P5: age 71; married; retired: lives in the city with her husband.

"I go to the emergency room due to severe pain, after tests they confirm that I have cancer. I talked to my personal doctor for months and months and she did not listen to me. Cancer is everywhere. I can't believe it jax I love life so much, so many plans, always lived healthy. With the extremely strong support of my husband and daughter's family, and especially my grandchildren, despite the difficult chemotherapy treatment, I thought about suicide. Mainly in the sense of relieving the burden on my family, so that my husband, daughter, and grandchildren would not see her like this so that I would not burden them. Frustrated with the health-care system, the wait for treatment, the disinterest of doctors when problems were cited. I spend most of my time with my husband, grandchildren and I have taken up active cycling as long as it will work."

Discussion

Despite the limitations of the study and the small sample size, the results show that suicidal ideation is present in oncology patients. Suicidal ideation ranges from an innocent thought that merely flashes through a person's mind to actively contemplating, suggesting, planning, and carrying out suicide [15].

The diagnosis of cancer and the experience of the disease itself very often leads the patient to contemplate death, which can be a basis for stigmatisation, cause social isolation, and arouse various stressors in the individual [15]. Patients are mostly afraid of death, pain, and the adverse effects of treatments such as chemotherapy, radiation because it is an unfamiliar experience for them [8] and this can also be seen in the responses of our participants. The very diagnosis of cancer is extremely painful, but somehow they accept it and consent to the treatment. They cited fear of starting treatment, a feeling of helplessness, of being affected, intertwined with a sense of denial, and then hope for a cure. The most disturbing aspect of the initial treatment process was the waiting for treatment and treatment.

All respondents had had some form of treatment, or a combination of systemic treatment, radiotherapy, and surgery. During the treatment itself, they said that they were affected by the change in body self-image in terms of fatigue, exhaustion, and helplessness, some had very pronounced nausea and vomiting, fear of pain, dependence on others, and hair loss "P3 the loss of my hair was more horrible than the disease itself," followed by the mental consequences of the physical changes. Some people seek psychological help and treatment even before the diagnosis due to other life circumstances, such as loss of a child, loss of a partner, divorce, and addiction to illicit drugs and alcohol. The answers we received regarding previous history of psychiatric illnesses showed that some participants had been previously treated for depression, anxiety, and the diagnosis itself made the situation worse, but despite the fact that some of them reported suicidal thoughts, they still had a desire to live.

In addition, cancer patients may have pre-existing psychological or psychiatric illnesses that affect their ability to cope with cancer. Cancer patients who have completed treatment are about twice as likely to use medication for anxiety and depression as adults without cancer and 2–3 times more likely to commit suicide. Overall, research has shown that 20–52% of patients show significant levels of distress. The prevalence of emotional distress in individuals varies according to the type and stage of cancer and according to the age, sex, and race of the patient. Screening tools have been found to be effective and feasible to reliably identify distress and psychosocial needs of patients. The identification of emotional distress should be considered a quantifiable measurement and can therefore be included in quality improvement processes [16].

Suicide risk assessments should be continuously conducted in the cancer treatment process. Nurses are ideally placed to perform this type of screening on every patient when they present for inpatient care. Components should include a history of suicide by the patient and their family, suicide attempts, psychiatric disorders (especially depression), history of drug and alcohol use, and the presence of abuse. There are reliable screening tools for depression. If asked about suicidal intent, most patients will adamantly deny that they wish to harm themselves. However, if these patients are distressed by suicidal thoughts, they will confirm these thoughts [5].

Participants who had the social support of family and surroundings found it easier to cope with the very difficulties caused by cancer treatment. Suicidal thoughts at diagnosis and during the treatment process, out of five participants, three reported suicidal thoughts. Two participants had disordered family relationships and, in addition to suicidal thoughts, said they had a plan in place. Most participants cited anxiety, insecurity, some the need for antidepressants, and help from a psychologist. Most indicated that the stigma was still present and two

older participants found it difficult to cope with death. A variety of sociodemographic, clinical, and psychological variables have been found to be associated with suicidal ideation, for example: advanced cancer stage, poorer physical well-being, cancer pain, depression, anxiety, hopelessness, existential distress, and limited social support have consistently been shown to be risk factors for suicidal ideation in cancer patients [17].

Senf *et al.* [18] report on the exposure of health professionals to oncology patients at risk of suicidality. A large proportion of staff faced at least one patient in a year, and many staff also felt insecure, especially nurses. Anxiety and distress were experienced by nursing staff and they indicated a desire for further training. Granek *et al.* [19] report on strategies and barriers to addressing mental health problems in cancer patients by nurses. The focus of strategies is emotional accessibility, providing support, and counselling treatment of physical symptoms. Barriers are lack of training, workload, lack of time, unwillingness to participate, and lack of protocol.

Pain was expressed as a very important element. Pain makes you limited in carrying out activities of daily living. More than physical pain, psychological pain was mentioned, an internal pain linked to feelings of helplessness and suicidal thoughts.

When asked about the experience of the medical staff during treatment, they pointed out above all that you have to be "lucky." Some health professionals have a very nice attitude and listen, while others do not. Most indicated that they had a feeling of safety, empathy, and trust, while others indicated disobedience of health workers. However, all of them were of the opinion that the need for individualised treatment and the need for a psychooncologist at the beginning of the treatment would be unavoidable.

Throughout the participants' statements, there was a constant need for a supportive environment, an environment that listens and hears you, especially when physical changes start to manifest themselves due to the healing process itself, which is usually long. Some problems only appear after the treatment has been completed.

Oncology patients are not always cared for in our society in a way that includes holistic care. Participants also mentioned that once treatment is over, you are no longer as fit for work. For people who are unable to participate in the work process, it is also a financial burden. The impact of the illness can leave a person completely unable to work, which adds to the emotional toll.

It is necessary to establish mechanisms that allow a sense of understanding, to create an environment based on mutual trust, the expression of feelings, the possibility of cooperation, and only then can we talk about the quality of life of patients undergoing cancer treatment.

Cancer is a disease that, most of the time, unexpectedly interferes in the life of the individual and his/her family. However, organised self-help is available within patients' associations and societies, both individually and in the form of self-help groups. In cases of severe psychological distress, help with medication/psychopharmacotherapy is also available. Bulotiene and Pociute [20] conducted a study in the field of suicidal ideation in oncology patients and found that pharmacotherapy is particularly effective in preventing suicidality. Psychotherapeutic approaches, on the other hand, are considered as supportive measures in solving problems in the patient's life. This results in a reduced likelihood of suicidal acts or, in a preliminary stage, in the prevention or reduction of the onset of depression. This principle is followed by health-care staff in the case of severe forms of depressive disorders in oncology patients, who opt for antidepressants and psychosocial forms of support, while, in milder cases, psychosocial interventions and education in the field of the psyche (psychoeducation) are used. The importance of recreation and physical activity is also highlighted, as this improves the physical functioning of the patient. Physical exercises in oncology patients have a positive impact on quality of life and further reduce psychological problems. Music therapy and yoga, art (art), and support groups (for expressing, sharing, and problem solving) are also available to support patients and contribute significantly to overall positive well-being and are proving to be an important part of the treatment of such patients. For patients facing terminal illness, it is necessary to plan a course of further treatment, where palliative care plays an important role [1].

Data from America indicate that nurses, especially in the outpatient setting, have found themselves without the right tools to assess risk factors in oncology patients [21]. Such outpatient clinics have often partnered with psychiatric departments and, in collaboration with them, are contributing to the successful development of the health-care system. The educational strategy followed in the aforementioned study included raising awareness among health professionals about oncological diseases, in which suicidality was more common [21].

Granek *et al.* [22] state that strategies to address distress include emotional accessibility, providing support, treating physical symptoms, and counselling. However, to address suicidality, useful strategies are as follows: situation assessment, palliative care, treatment of physical symptoms, and referral for professional assessment. Barriers to addressing distress are most commonly lack of training, stigma, workload/lack of time, and limited availability of resources for mental health support. A German study of health professionals (doctors, psychologists, nurses, and psychotherapists) investigated their exposure to cancer patients showing signs of suicidality. They reported that 83.3% of the employees had at least one encounter with a suicidal

oncology patient in the past year. A higher proportion of nurses (71.2%) felt anxious about an oncology patient expressing a desire to commit suicide. 88.1% of employees felt anxious about an oncology patient expressing a desire to commit suicide. About 81.1% of the employees would choose to acquire further knowledge, and 73.2% of the health-care professionals had acquired previous basic knowledge [18]. It is important to have a good knowledge of the field and then to manage oncology patients with a proper multidisciplinary approach.

Conclusion

Cancer treatment is very complex. The psychological distress of patients and their families is often overlooked due to the long treatment and recovery pathways [10]. A proposed strategy is to identify subgroups at highest risk of suicide [23]. It makes sense to work on strengthening preventive screening programs and to provide adequate psychological support to patients. Identifying psychological distress in oncology patients is a problem, as patients often do not express it and health professionals do not have the appropriate tools to objectively assess the level of risk for suicidality. Research indicates the usefulness of various questionnaires that can be helpful in identifying suicidality. However, a conversation and relationship with the patient are necessary to provide insight into whether the patient is stable and their condition corresponds to the answers given. It is important to offer support and help to the patient at the time of diagnosis. The most effective methods for treating psychiatric disorders, according to studies, are pharmacotherapy, physical activity, psychosocial interventions and psychosocial education, support groups, etc., which have a positive impact on the patient's mental health, reducing the presence of anxiety and depressive disorders. Suicidality among oncology patients in Slovenia is still a relatively unexplored topic. It would be necessary to examine what methods would prove to be most effective in identifying such patients and what approach would be most appropriate in Slovenia. When patients feel a positive and supportive atmosphere, coping with such a disease can be more bearable.

Limitations of the research

We included a small sample of participants ($n = 5$), but we were able to obtain in-depth information about the problem under study. A qualitative study could have been done on a larger number of participants or patients undergoing treatment in hospital. This would have provided important data that would have helped to improve the quality of care for oncology patients and

to detect and reduce the emotional distress that they experience during their treatment. Furthermore, we had limitations due to the familiarity of one participant; this may have influenced the responses to not answer as openly as they would have otherwise. We suggest a larger sample to obtain more information on the identification of suicidal ideation.

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