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Invited Commentary for *PSYCHO-ONCOLOGY*

TITLE: **EDUCATION AND ASSESSMENT OF PSYCHO-EXISTENTIAL SYMPTOMS TO PREVENT SUICIDALITY IN CANCER CARE**

Running Head: SUICIDALITY IN CANCER CARE

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ABSTRACT

Clinicians acknowledge awkwardness and lack of skills in assessing suicidal symptoms. This requires increased education, screening for psycho-existential symptoms, and the therapeutic targeting of key symptoms. Assessment of hopelessness, pointlessness, low morale, entrapment, anhedonia, loss of control, loss of roles, and the wish to die prove extremely helpful in recognising a suicidal patient. Use of a screening tool for psycho-existential symptoms aids this recognition and empowers referral for treatment. Communication skills training increases each clinician's skill and provides a strategic sequence to explore symptoms that mediate suicidal thinking. Network analysis research to identify core symptoms suggests that hopelessness, pointlessness, and entrapment are key therapeutic targets to assuage suicidal thinking. Meaning-centered therapy helps to restore purpose and value to life, cognitive-behavioural therapy reframes pessimism and catastrophising, supportive therapy provides hope and accompaniment, while psychotropics treat clinical depression. There is both a clinical responsibility and an ethical imperative to treat suicidality effectively.

Key words: Suicidality, demoralization, depression, hopelessness, entrapment, screening, communication skills training, meaning-centered therapy, cancer, psycho-oncology

INTRODUCTION

"I cannot see the point anymore. Life has lost its value and purpose. There does not seem to be a reason to keep living." [De-identified patient]

Suicide is nearly twice as common in cancer care compared to the general population.[1, 2] Suicidal thoughts and the desire to hasten death can occur in 15% to 40% of oncology patients.[2] They often accompany existential distress and deserve to be listened to and responded to with sensitivity and skill.[3] Writing recently in Psycho-Oncology, Senf *et al.* from the University Hospital Frankfurt call for a dedicated educational curriculum about suicidality to address deficits and build expertise in health professionals caring for oncology patients who might develop a desire to hasten their deaths.[4]

Senf and colleagues obtained online survey responses from over 350 German physicians, nurses, psychologists, psychotherapists and other health professionals.[4] They identified that over 80% had at least one conversation with a patient about suicide in the past year, nearly half knew of an actual suicide, half considered their knowledge of suicide insufficient and over a quarter felt insecure in talking with patients about suicidal thoughts.[4] For instance, 53% of physicians and 73% of nurses wanted more expertise in responding to suicidal patients; 70% of nurses felt fearful and 44% were overwhelmed by these conversations. A strong call was issued for education to redress these deficits. Similar concerns have been reported in other studies.[5]

In another publication in Psycho-Oncology this year, Liu and colleagues examined the serial multiple mediation of demoralization and depression in the relationship between hopelessness and suicidal ideation.[6] Hopelessness had both direct and indirect effects on suicidal thinking.

Demoralization was either a sole mediator or a composite mediator with depression of the development from hopelessness to suicidality, whereas depression alone did not mediate this relationship. The symptoms of "feeling desperate" and being "disheartened" were the strongest therapeutic targets to counter the desire to hasten death.[6] These two studies invite discussion of this educational curriculum, the role of screening for psycho-existential wellness, and the therapeutic targets to assuage suicidal thoughts in cancer care.

Education about suicide risk factors

The presence of a psychiatric disorder is the most important factor placing a patient with cancer at risk of suicide, whether an adjustment disorder with demoralization or clinical depression, alongside the common factors of old age, being male, single, isolated and co-morbid substance abuse.[7] Anhedonia, as the dominant symptom of clinical depression, has been shown to have a robust association with suicidal thinking independently of depression.[8] Hopelessness has long been identified as an independent mediator of suicidality,[9, 10] and recent studies have shown that demoralization is three times more likely than depression to precipitate suicidal thinking.[11, 12, 13]

Demoralization is a state of poor coping in which low morale, hopeless-helplessness and growing pessimism can lead to a sense of pointlessness, life beginning to lose its value, meaning and purpose, with an associated risk of developing a sense of failure, low self-worth and even shame.[14] Meaning-based coping normally shores up a sense of accomplishment and fulfilment, which protects against any disheartenment and self-doubt, while generalised hope can exist as a robust trait to be drawn upon when loss experiences take away particular hopes.[15] Morale exists dimensionally across a spectrum of mental states, with the severe end of despair and demoralization leading to suicidality.

What is it that mediates this development of suicidal thinking? While there are a number of moderating or predisposing (such as poor symptom control and low social support) and protective factors (such as religion, supportive family and personal resilience), the mediating factors that precipitate a desire to hasten death are the loss of meaning, purpose, hope, self-worth, shame and perceived control over life.[10] These latter states coalesce into severe demoralization.

The development of a deeper intention to act and end one's life emerges with a sense of feeling trapped, becoming desperate, agitated and having poor impulse control. Entrapment is a noteworthy symptom when the prognosis is poor and options reduce for chemotherapeutic control of the disease.[16] The patient can feel stuck and defeated by a predicament they can no longer control, with some describing a sense of failure in not meeting one's needs or those of others.[17] Desperation with associated agitation is another set of symptoms that can lead to sudden, violent and urgent action to end one's life.[18, 19] These suicides can follow the breaking of news of disease progression where the patient is inadvertently left with a profound sense of demoralization about the future.

Screening for Psycho-Existential Symptoms

Patients with unrecognised depression, unaddressed demoralization and unabating anxiety constitute a very vulnerable group. Such unaddressed suffering leads to as many hospital admissions, extended lengths of stay and increasing health costs as do unmanaged physical symptoms.[20, 21] Much progress has been made through distress screening in cancer care.[22] In palliative care, use of the Edmonton Symptom Assessment Scale,[23] as a visual analogue rating scale for symptoms, originally included mental symptoms with good effect, but many services

dropped use of the latter through lack of confidence in such assessment. Recent validation of six key symptoms from the Demoralization Scale[24] (DS) allow for ready assessment of existential symptoms, the DS-6 having similar sensitivity and specificity as the original 24-item DS against the Demoralization Interview.[25] Patients can complete a scale with a Likert response set,[26, 27] or clinicians can ask patients to rate each symptom on a visual analogue scale. Key symptoms that can be assessed on a 0-10 scale for how much they bother, worry or distress a patient are: hopelessness, pointlessness, discouragement, entrapment, loss of control, and loss of roles. See how these can be set out as a tabulated screening tool in Table 1.

[Place Table 1 about here]

Confidence in clinicians being able to assess these psycho-existential symptoms can be acquired through communication skills training. Clinicians follow a sequence of strategies that include naming and empathising with the presence of any symptom whose score is elevated, exploring the symptom by understanding what has predisposed the patient to, precipitated, or perpetuated the symptom and what has been protective in turn. Often this conversation helps to debrief and ameliorate the patient's concern. Permission can be sought to refer for further specialist engagement when a psychiatric disorder is present.

Central Symptoms to Target in Suicidal Patients

Exploratory Graph Analysis makes use of Gaussian probability functions to lay out a network of symptoms by assessing the partial correlations between symptoms, whereby the strength of association between each pair of symptoms is assessed while controlling for all other associations in the network.[28] This network analysis assigns the probability of symptoms belonging to communities or clusters, displays the weight of associations between symptoms, and identifies the symptoms that are most central or important in any cluster. Two recent cancer studies (one by Liu *et al*. in this journal) have used the DS and Patient Health Questionnaire-9

(PHQ-9) for depressive symptoms to assess the relationship between these mental states.[6, 29] They show a clear separation of demoralization and depressive symptoms into distinct communities. Suicidal ideation is located in a cluster of symptoms associated with hopelessness, purposelessness and pointlessness while, close by, entrapment is associated with distress and discouragement.[25]

These network analyses suggest that clinicians focus on addressing symptoms of hopelessness, pointlessness, and entrapment as central symptoms to improve as one works to assuage suicidal thinking. Meaning-centered therapies offer pivotal strategies.[30, 31] Thus, hope could be focused on social interactions in the moment with loved ones, prayer or spiritually directed activities, and medical interventions that optimise physical symptom control. Entrapment and defeat are challenged by identifying aspects in a person's life that remain within their control and can deliver value in the here and now. Pointlessness is countered by re-establishing the coherent meaning and purpose found in relationships, creativity, interests and hobbies – activities that have always brought joy and fulfilment to the person. And of course, anhedonia can be addressed when appropriate by antidepressants. This novel emphasis on meaning-centered therapy does not dismiss the value of cognitively-oriented and supportive therapies to reframe negative thinking and structure creative activities. It points however to an expanding set of therapeutic models to address key symptom targets.

CONCLUSION

Oncology physicians and nurses seek education to increase their understanding of suicidal thinking, thus overcoming awkwardness in knowing how to respond to patients. Recognition of not only clinical depression but also demoralization as a form of poor coping or adjustment disorder is crucial to be able to respond to patients wishing to hasten their death. Screening for

psycho-existential symptoms is one pathway to better recognise those at risk. Communication skills training can focus on building comfort and confidence in assessing these symptoms. Targeting key symptoms of low morale, hopelessness, pointlessness, entrapment, and loss of purpose and worth are central to patient support alongside the traditional treatment of anhedonia.

Conflict of Interest:

The author declares that he has no conflicts of interest.

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Table 1: An illustrative screening tool to monitor Psycho-Existential Symptoms in distressed patients based on the shortened Demoralization Scale (DS-6).[23]

PSYCHO-EXISTENTIAL SYMPTOM ASSESSMENT SCALE

Choose a number between 0 to 10 to describe how bothered, worried or distressed you are by each symptom listed here.

Write the score under each date of assessment.

Date							
Discouraged							
Trapped by illness							
Hopelessness							
Pointlessness							
Loss of control							
Loss of roles							

REFERENCES

[1] Watson M, Grassi L. Recognising and Managing Suicidal Risk. In: Watson M, Kissane DW, editors. Management of Clinical Depression and Anxiety. New York, NY: Oxford University Press, 2017.
[2] Zaorsky NG, Zhang Y, Tuanquin L, Bluethmann SM, Park HS, Chinchilli VM. Suicide among cancer patients. Nature Communications 2019; 10(1): S207. Doi: 10.1038/s41467-018-08170-1
[3] Vehling S, Kissane DW. Existential distress in cancer: Alleviating suffering from fundamental loss and change. Psycho-Oncology 2018; 27(11): 2525-2530. Doi: 10.1002/pon.4872
[4] Senf B, Maiwurm P, Fettel J. Exposure to suicidality in professionals working with oncology patients: An online survey. Psycho-Oncology 2020; 29: Doi: …………………
[5] Granek L, Nakash O, Ben-David M, Shapira S, Ariad S. Oncologists', nurses' and social workers' strategies and barriers to identifying suicide risk in cancer patients. Psycho-Oncology 2018, 27: 148-154. Doi: 10.1002/pon.4481
[6] Liu ST, Wu X, Wang N, Zhao QQ, Xiao L, Fang CK, et al. Serial multiple mediation of demoralization and depression in the relationship between hopelessness and suicidal ideation. Psycho-Oncology 2020 Jun 15; Doi: 10.1002/pon.5439
[7] Spencer RJ, Ray A, Pirl WF, Prigerson HG. Clinical correlates of suicidal thoughts in patients with advanced cancer. Am J Geriatric Psychiatry 2012; 20(4): 327–336. Doi: 10.1097/JGP.0b013e318233171a
[8] Ducasse D, Loas G, Dassa D, Gramaglia C, Zeppegno P, Guillaume S, et al. Anhedonia is associated with suicidal ideation independently of depression: A meta-analysis. Depress Anxiety 2018; 35(5): 382-392. Doi: 10.1002/da.22709
[9] Chochinov HM, Wilson KG, Enns M, Lander S. Depression, hopelessness, and suicidal ideation in the terminally ill. Psychosomatics 1998; 39(4): 366–70.
[10] Breitbart W, Rosenfeld B, Pessin H, et al. Depression, hopelessness, and desire for hastened death in terminally ill patients with cancer. JAMA 2000; 284: 2907-2911.
[11] Fang CK, Chang MC, Chen PJ, et al. A correlational study of suicidal ideation with psychological distress, depression, and demoralization in patients with cancer. Support Care Cancer 2014; 22: 3165-3174.
[12] Robinson S, Kissane DW, Brooker J, Hempton C, Burney S. The relationship between poor quality of life and desire to hasten death: A multiple mediation model examining the contributions of depression, demoralization, loss of control, and low self-worth. Journal of Pain and Symptom Management 2017; 53(2): 243-249. Doi: 10.1016/j.jpainsymman.2016.08.013
[13] Vehling S, Kissane DW, Lo C, Glaesmer H, Hartung TJ, Rodin G, Mehnert A. The association of demoralization with mental disorders and suicidal ideation in patients with cancer. Cancer 2017; 123(17): 3394-3401. https://doi.org/10.1002/cncr.30749
[14] Kissane DW. Demoralization – A life-preserving diagnosis to make in the severely medically ill. Journal of Palliative Care 2014; 30(4): 255-258.
[15] Kissane DW. Diagnosis and Treatment of Demoralization. In: Watson M, Kissane DW, editors. Psycho-Oncology Care - Companion Guides for Clinicians I: The Management of Clinical Depression and Anxiety. New York, NY: Oxford University Press, 2017.
[16] Taylor PJ, Gooding P, Wood AM, Tarrier N. The role of defeat and entrapment in depression, anxiety, and suicide. Psychological Bulletin 2011; 137(3): 391–420.
[17] O'Connor RC, Nock MK. The psychology of suicidal behaviour. Lancet Psychiatry 2014; 1: 73–85.
[18] Busch KA, Fawcett J, Jacobs DG. Clinical correlates of inpatient suicide. J Clin Psychiatry 2003; 64: 14–19.
[19] Bostwick JM, Rackley SJ. Completed suicide in medical/surgical patients: who is at risk? Current Psychiatry Rep 2007; 9: 242–46.
[20] Okoronkwo, E. Estimation of costs-savings and improved patient outcomes of implementing a consultation-liaison service at Health Sciences North. Open Journal Psychiatry 2019; 9: 220-234. Doi: 10.4236/ojpsych.2019.93017
[21] Parsonage M, Fossey M. Economic evaluation of a liaison psychiatry service. Centre for Mental Health, London School of Economics and Political Science, London, 2011.
[22] Groff S, Holroyd-Leduc J, White D, Bultz BD. Examining the sustainability of Screening for Distress, the sixth vital sign, in two outpatient oncology clinics: A mixed-methods study. Psycho-Oncology 2018; 27(1):141-147. Doi: 10.1002/pon.4388

[23] Bruera E, Kuehn N, Miller MJ, Selmser P, Macmillan K. The Edmonton Symptom Assessment System (ESAS): A simple method for the assessment of palliative care patients. J Palliat Care 1991; 7(2): 6-9. https://doi.org/10.1177/082585979100700202
[24] Kissane DW, Wein S, Love A, Lee XQ, Kee PL, Clarke DM. The Demoralization Scale: a report of its development and preliminary validation. Journal of Palliative Care 2004; 20(4): 269-276.
[25] Belvederi Murri M, Zerbinatia L, Ounallia H, Kissane D, Casonia B , Leonia M, et al. Assessing demoralization in medically ill patients: Factor structure of the Italian version of the demoralization scale and development of short versions with the item response theory framework. J Psychosomatic Research 2020; 128: 109889 doi.org/10.1016/j.jpsychores.2019.109889
[26] Robinson S, Kissane DW, Brooker J, Michael N, Fischer J, Franco M, et al. Refinement and revalidation of the Demoralization Scale: The DS-II – Internal Validity. Cancer 2016; 122: 2251-2259. doi: 10.1002/cncr.30015
[27] Robinson S, Kissane DW, Brooker J, Hempton C, Michael N, Fischer J, et al. Refinement and revalidation of the Demoralization Scale: The DS-II – External Validity. Cancer 2016; 122: 2260-2267. doi: 10.1002/cncr.30012
[28] Golino HF, Epskamp S. Exploratory graph analysis: a new approach for estimating the number of dimensions in psychological research. PloS One. 2017; 12(6):e0174035
[29] Belvederi Murri M, Caruso R, Ounalli H, Zerbinati L, Berretti E, Costa S, et al. The relationship between demoralization and depressive symptoms among patients from the general hospital: network and exploratory graph analysis. Journal of Affective Disorders 2020; 276: 137-146.
[30] Rodin G, Lo C, Rydall A, Shnall J, Mal C, Chiu A, et al. Managing cancer and living meaningfully (CALM): a randomized controlled trial of a psychological intervention for patients with advanced cancer, Journal of Clinical Oncology 2018; 36: 2422–2432. https://doi.org/10.1200/JCO.2017.77.1097.
[31] Breitbart W, Pessin H, Rosenfeld B, Applebaum AJ, Lichtenthal WG, Li Y, et al. Individual meaning-centered psychotherapy for the treatment of psychological and existential distress: a randomized controlled trial in patients with advanced cancer. Cancer 2018; 124: 3231–3239, https://doi.org/10.1002/cncr.31539.