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Through the Lens of the Carers: A Qualitative Study on Barriers, Resources, and Opportunities for Improvement in Suicide Prevention in (Psycho-)Oncology

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ABSTRACT

Objective: Cancer patients are at increased risk for suicidal crises, making suicide prevention a pertinent issue for clinical practice. However, international research suggests that healthcare providers are anxious and, for example, do not actively inquire about suicidality. Such avoidance does not follow expert recommendations and puts patients at risk. First international investigations have reported diverse barriers standing in the way of the recommended clinical care. The present study aimed to expand this investigation to the German context.

Methods: A preregistered qualitative study following a semi-structured interview guide was conducted with healthcare professionals (HCPs) ($N = 20$) working in the oncological setting. The interviews were transcribed and analyzed using qualitative content analysis, following an explorative theory-generating approach.

Results: The main result was a category system giving insight into both *barriers* and *resources* HCPs experienced concerning suicide prevention in their practice. *Barriers* comprised structural (e.g., scarcity of resources) and personal ones (e.g., lack of knowledge, difficult feelings). *Resources* were distinguished into work-related support, self-efficacy and skills, and private life/after work as an important equalizer. Along with the mentioned personal and structural dimensions, HCPs also highlighted possibilities for improvement.

Conclusions: The results provide an important basis for the development of needs-based solutions to strengthen suicide prevention in oncology. The study highlights that this can be achieved by both individual-level interventions (e.g., specific training) as well as organization-level changes (e.g., better implementation of standard operating procedures and shared responsibility). Addressing the reported shortcomings will support practitioners and improve clinical practice for patients.

HIGHLIGHTS

- In-depth qualitative interviews with oncology practitioners on suicide prevention
- Barriers to suicide prevention/exploration pertain on a structural/personal level
- Possibilities for improvement concern practical changes and strengthening resources

KEYWORDS
Cancer patients; healthcare professionals; oncology; qualitative; suicide prevention

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1. INTRODUCTION

Cancer and its treatment can implicate physical and psychosocial distress, including suicidal crises. The prevalence of suicidal ideation in cancer patients was as high as 71 % within a systematic review (Robson et al., 2010), underscoring the relevance of suicide prevention in oncology.

A central component of suicide prevention is the *recognition* of suicidality. Active exploration by healthcare professionals (HCPs) has been recommended (Knapp, 2022), including by expert organizations setting standards for psycho-oncological care, such as the German Cancer Society and the National Cancer Plan (Nationaler Krebsplan, Krebsplan, 2017). The national guideline "Psycho-oncological diagnosis, counselling and treatment of adult cancer patients" (Krebsgesellschaft & Krebshilfe, 2023) stresses the need for screening: "[HCPs] should be able to recognize the type and extent of psychosocial stress and, if necessary, initiate targeted diagnostic clarification by a specialist medical doctor or psychological psychotherapist"(p.51). This mirrors international calls to implement state-of-the-art suicide prevention across professional fields (Jobes & Barnett, 2025).

Suicidal thoughts are often not spontaneously disclosed, e.g., because of internalized stigma (Hom et al., 2017). However, talking about them with mental health professionals is experienced as helpful (Calear & Batterham, 2019), and a better relationship between patients and oncologists predicted less suicidal ideation (Trevino et al., 2014). Unfortunately, in the reality of routine care, suicidal ideation is rarely assessed: most of an older Americans sample (Miller et al., 2008), including cancer patients, visited HCPs a month before their suicide death, 25 % of them even a week before. To our knowledge, no recent literature exists on this topic, which underscores the importance of exploring HCPs' views to better understand the reasons behind this discrepancy. Patients' suicidal crises are highly stressful for providers who are often overstretched and have little specific training, leading to "dysregulated" (Smith et al., 2015) responses, including avoidance (Groth & Boccio, 2019; Quinnett, 2021). In a recent German study, 88 % of oncological HCPs reported feeling distressed facing suicidality (Senf et al., 2020). Previous qualitative studies, including semi-structured interviews (Granek, Nakash, Ben-David, et al., 2018; Granek et al., 2019a, 2019b) and questionnaires with case vignettes (Valente, 2010; Valente & Saunders, 2004) provide deeper insight: Oncological HCPs identified potential *barriers* to implementing suicide prevention recommendations. For example, they relied on ad-hoc strategies rather than following standard operating procedures (SOP), which promotes biases and misdiagnosis (Granek, Nakash, Ariad et al., 2018). HCPs also had trouble ascertaining the seriousness of suicidal intent (Valente, 2010). Although concentrating on suicidality, studies also included oncological HCPs in palliative care/with dying patients, and terminal diagnoses were seen as leading cause for suicidality (Granek, Nakash, Ben-David, et al., 2018) - often respected without further evaluation for underlying causes such as depression (Valente & Saunders, 2004). Moreover, considering suicide was viewed as understandable, even heroic, and as a legitimate desire to end suffering (Granek et al., 2019a). While these aspects are noteworthy, end-of-life decision-making is a complex topic in its own right distinct from suicide prevention.

As further barriers, HCPs reported lacking coping skills, knowledge, and awareness, uncomfortable feelings, religious and other values, the weight of responsibility, and previous personal experiences with suicidal crises (Granek, Nakash, Ben-David, et al., 2018; Granek et al., 2019a, 2019b; Valente, 2010; Valente & Saunders, 2004). Suicide myths (i.e., disproven preconceptions about suicide/suicidal individuals) were common as well (Granek et al., 2019a). HCPs also voiced fears of negative consequences, suggesting a work culture in which responsibility is not shared and HCPs are left alone with overwhelming tasks (Granek, Nakash, Ben-David, et al., 2018; Valente & Saunders, 2004).

Some of the barriers on the side of HCPs allude to more *structural issues* (Granek, Nakash, Ariad et al., 2018): For example, lack of time may indicate a too-high workload. Another structural issue is the lack of referrals, meaning that despite recognizing a potentially dire situation, no referral for in-depth diagnostic exploration/intervention was made - highlighting the absence of reliable procedures and protocols (Valente & Saunders, 2004). In addition, problems on the part of patients were unwillingness to seek treatment (Granek et al., 2019b) and not reporting when they were in crisis (Granek, Nakash, Ben-David, et al., 2018). Thus, although the phenomenon of help-negation is well-described (Deane et al., 2001), HCPs found it difficult to empathize with patients who are simultaneously desperate and struggling to disclose their need for support. In summary, research suggests diverse barriers to the recommended approach to suicide prevention located at different levels, both individual and structural.

As such, these barriers could differ between healthcare systems and settings, e.g., as the integration psycho-oncological care as part of psychosocial services diverges between countries (Grassi et al., 2017). Most studies focusing on oncological HCPs were conducted in the US or Israel, countries which could also vary in terms of cultural/religious assumptions regarding suicide, education or multidisciplinary cooperation. Previous (qualitative) research from Germany described experiences of (terminally ill) suicidal patients in nuanced ways (Ohnsorge et al., 2014a, 2014b; 2019) and analyzed palliative patients' death wishes (Elliesen et al., 2022). Senf et al. (2020, 2022) presented a more systematic investigation of HCPs' attitudes toward suicidal patients/suicide in the context of cancer. However, a thorough examination of oncological HCPs' perceived barriers and resources to adequate care for suicidal patients (particularly without terminal diagnoses) is still lacking.

1.1. Aims and Objectives

This work aims to investigate whether German oncological HCPs adequately investigate and explore suicidality in cancer patients - including identifying barriers and helpful resources. The findings shall inform needs-based solutions to support HCPs in their role as gatekeepers.

We aim to answer the following research questions:

1. Which *barriers* stand in the way of actively exploring and addressing suicidality in cancer patients?
2. What are the *facilitators/resources* supporting HCPs to actively explore and address suicidality in cancer patients?
3. Which possibilities for improvement do oncological HCPs identify?

2. MATERIALS AND METHODS

2.1. Study Design and Participants

This study follows a qualitative method using interviews to obtain a comprehensive picture of HCPs' professional stance, resources and challenges from their point of view, focusing on the complexity of the individual person's experience and emotional evaluations in the sense of an idiographic, bottom-up approach.

Its aims and procedure were preregistered as part of a larger, mixed-methods project and the materials are made available as well (https://osf.io/4c6jr). In the semi-structured interviews, experts were not provided with response categories/options but encouraged to reflect on their everyday working lives.

Participants included HCPs ($N = 20$) working at the oncology unit and associated departments (e.g., the psycho-oncology section of the Department of Psychosomatic Medicine and Psychotherapy) of a large University Medical Center certified as a Comprehensive Cancer Center. Participants were recruited via internal mailing lists, flyers, and through staff. Besides being actively engaged in cancer patients' care, the only inclusion criterion was sufficient knowledge of German. We aimed to include diverse professions. Participants were not paid. Before the interviews, they were informed about the study's aims, handling of personal data and anonymity of responses. All provided informed consent. The study contents and procedures were approved by the ethics committee of the Rhineland-Palatinate Chamber of Physicians (nr. 2023-16975).

2.2. Interview Procedure

The number of interviewees was determined following the theoretical sampling of qualitative studies to achieve representativeness and consistency (Corbin & Strauss, 1990). Recruitment and interviews were stopped after reaching saturation point, in line with common procedures in qualitative research. This is the point which no new information/categories concerning the research question emerge from the data; our sample size aligns with common observations of saturation (Guest et al., 2006). The semi-structured guideline was designed based on empirical literature, piloted with a psychotherapist in training/psycho-oncologist and refined with the help of experienced scientist-practitioners. Congruent with an exploratory, theory-generating approach it was further adapted during data collection. It started by exploring participants' working area within (psycho-)oncology, then moved on to experiences with suicidality. Most of the time was allocated to asking whether they actively explored suicidal ideation, problems and barriers, optimization possibilities and resources, needs for support, and the preferred design, contents and implementation of potential further training.

The anticipated 45-minute interviews (range: 21.83 – 52.02 minutes; $M(SD) = 39.47(8.35)$ minutes) were conducted by one of two project members (both psychologists and psychotherapists in advanced training, one certified as a psycho-oncologist). They were audio-recorded and transcribed according to established rules (Kuckartz, 2010).

2.3. Analysis

A qualitative content analysis (Kuckartz & Rädiker, 2022) using MAXQDA 2022 R22.7 V5 was performed. This method aims to inductively and deductively develop a category system in the interrelation between theory and material and line-by-line coding. After constructing the first version of the category system, a coding guide (containing coding and conflict rules) was used for training the intercoder, so that $\geq$ 30 % of transcripts were checked for conformity with coding adapting the category system constantly throughout. Disagreements were discussed until consensus. In the case of larger categories directly relevant to the research questions, coded quotes were revisited and subcategories were created.

3. RESULTS

3.1. Participant Characteristics and Overview

The 20 interviewed HCPs' characteristics are presented in Table 1. The majority were women (70 %), their ages ranged from 28 – 60 years with a large variation in the years of experience working in oncology ($<$ 1 to $\geq$ 20 years) with the majority having at least 10 years of experience, and nursing staff having the most.

TABLE 1. Sample characteristics.

Sociodemographic characteristics	
Gender *N* (%)	
Male	6 (30)
Female	14 (70)
Age *M* (SD)	41.45 (9.70)
Age range [in years]	28–60
Highest degree/level of education *N* (%)	
Certificate of Secondary Education	2 (10)
High school (degree/graduation), polytechnic degree	1 (5)
Vocational/professional training, apprenticeship	5 (25)
Master's Degree, state examination	8 (40)
Doctorate (e.g., PhD, EdD), license	4 (20)
Professional group *N* (%)	
Physician	5 (25)
Psychologist (psycho-oncologist/in training to psychotherapist/palliative psychologist)	5 (25)
Nursing staff	4 (20)
Specialist nursing staff (Study Nurse/oncological, medical assistant)	4 (20)
Pastoral care	2 (10)
Time in oncological practice *N* (%)	
5 months–2 years	1 (5)
3 years–9 years	5 (25)
10 years–14 years	4 (20)
14 years–19 years	2 (10)
$\geq$ 20 years	5 (25)
not applicable (HCPs worked across sectors)	3 (15)
Time in oncological practice per professional group *M* (*SD*)	
Physician	13.67 (11.02)
Psychologist (psycho-oncologist/in training to psychotherapist/palliative psychologist)	9.6 (7.87)
Nursing staff	17.5 (9.88)
Specialist nursing staff (Study Nurse/oncological, medical assistant)	12 (5.89)
Pastoral care	13.5 (4.95)

Note. The professional group shows their highest or most relevant position for the study.

3.2. Barriers

Interviewees' identified *personal* and *structural* barriers (Figure 1 for category system; Table 2 for direct quotes).

Personal barriers comprised four themes, three concerning HCPs and one patients from the HCPs' point of view. As part of the theme *Avoidance*, HCPs minimized the risk of suicidal crises, arguing that they affected only few patients ("It's more like one or two [patients] a year [who die by suicide]. There are some, but not the masses."(EI3).) They also tried "giv[ing] the patient something positive"(EI10) (instead of engaging with "having suicidal thoughts [as] something negative"(EI10)). They perceived a stigma related to the topic of suicide ("it [suicidal ideation] is such a taboo subject, that I don't really want to have anything to do with it."(EI2), and did not address it due to "helplessness"(EI18) and "fear"(EI14), so that "[nursing staff] would leave it in the hands of the doctor"(EI7). *Gaps in knowledge* comprised a lack of competency as well as specific "skills or tools"(EI2) in engaging with suicidal patients. *Difficult feelings* included the fear of making mistakes or offending the patient ("I'm always afraid that I might get it wrong."(EI20)), own distress ("[A patient being suicidal is] a very enormous burden and responsibility."(EI7), and difficulties in setting boundaries. Lastly, *Barriers on the part of patients* comprised self-stigma, patient characteristics making it difficult to breach the topic, and the complexity of difficulties as well as the potentially rapid changes of their condition. HCPs reported suicide myths and in some cases were unable to detach themselves emotionally from them, even if they knew that asking about suicidality does not trigger it ("I am worried that asking about suicidality will give a patient this idea."(EI8)).

FIGURE 1. Summary of personal and structural barriers to suicide prevention as identified by healthcare professionals working in (psycho-)oncology.
Figure legend: Barriers could be distinguished into more personal and more structural issues, with the first category comprising four themes and the second category comprising two.

TABLE 2. Illustration of the themes and subthemes of structural and personal barriers identified by healthcare professionals.

Category	Theme	Subtheme	Interview quotes
Structural Barriers 88	Scarcity of resources 41	Lack of time 21	"You never have enough time (laughs). There can always, could always be more time." (EI15)
			"Maybe [I am afraid] that I miss something? So, if I ask someone about suicidal tendencies, that I might forget to follow up with them among the stress. That I just do it to protect myself legally: Okay, I asked them, the patient explicitly denied suicidal tendencies and then it's ticked off. Maybe I then think at home, or on the way home—maybe I should have had a more in-depth conversation after all? Where there simply wasn't enough time. You have to say that in general: Such conversations during consultation hours are difficult. Time is very short. We always must tick off certain things, like an ultrasound, we have to discuss things, I have to document things on the side. Sometimes the patients can't hear well, they're old, and that can be very time-consuming." (EI4)
			"So, the first requirement would be that there is time. If you ask the question and then you say 'Okay, (laughs) I don't have time now', then it's extremely bad. Or you would have to offer a second time slot, on the same day or a short, short time later. (…) That is certainly a limiting factor." (EI5)
		Lack of staff 8	"It's the pressure on staff, and that doesn't just affect me, it affects everyone and it's just—someone like that is more time-consuming. So, if you recognize a problem, then there's often no one there [to follow up/take over]. For the care sector, I would say that it is often a problem that there is actually no one there or the person who is there is not qualified to recognize something like that. Or that they have such a big language barrier that they might miss certain undertones or all three of these things at the same time. That's actually the everyday life I see at the moment." (EI11)
			"It's also a bit more work to be more attentive. That's another thing, lack of staff, lack of time. It's something that requires more attention, more resources." (EI14)
			"Because then it's simply an overload. In the case of suicidal tendencies, if it is somehow known on the ward, there is pressure. Or someone is there in that case. Of course, you know, it can happen. (…) The psycho-oncologists, they were also poorly staffed at times because there were always personnel changes. I noticed that. Then I think they also hit the skids." (EI19)
		Lack of privacy 12	"(…) or the circumstances here in the room, for example, there are passage doors everywhere, you don't have enough peace and quiet to really know: Okay, I've got the patient alone here for an hour. Then people run in and out, the consultation room is occupied and that's not really the ambience you might want for such a conversation." (EI6)
			"I'm in the patient rooms. So that's difficult in a twin room. Much more difficult than on the bone marrow transplant ward, which I was thinking about. But as I said, I've also experienced hematology. If the need was somehow very, very great—whether they were suicidal, I don't know explicitly - but they said: 'Yes, you can also go to this room or that room and talk to them in private.' It's not always ideal, I have to say. Such great distress needs a safe space where it can be discussed. And, of course, peace and quiet and time.." (EI19)
			"Sometimes it's not that easy, especially in three- or four-bed rooms. Sometimes it's even impossible, to be honest. Some of the wards here, maybe even all of them, I don't know, have small lounges, which is sometimes quite good. But not all patients are mobile." (EI20)
	Organizational structure 47	Hierarchy and regulations 12	"Prior to this working position, I only worked in the [clinic] and there I was more on my own and had to rely on the relevant doctors reacting correctly and that I put it forward with enough emphasis. Now it's the case that I can also hand it in and, if in doubt, the director will intervene." (EI18)
			"I can say: 'Should I talk to the doctor? He'll make an appointment with youú, because I can't even make the appointment, because you always need a medical doctor to do that." (EI3)

(*continued*)

TABLE 2. Continued.

Category	Theme	Subtheme	Interview quotes
			"I wouldn't know that directly. As already mentioned, we always have an early meeting on Wednesdays, where one of the psycho-oncologists is always present. Of course I could tell him that. He will listen to it, but he would still need a doctor's registration, because without a doctor's registration there is no therapeutic contact or no talk with the patient. As far as we're concerned, I wouldn't feel that I am in a position to say: 'I think they're suicidal, go and see them.' I would really always go to my doctors. 'That is what's going on, please listen again, meet them again and then you decide.' (…) So that's really where my inhibition threshold would be. I really never learned it. And before I assume or overlook something: off to the doctor." (EI3)
		Guidelines 17	"I don't even know if there is an SOP [standard operating procedure]. I mean, they [the oncology unit] are certified as a center - I don't know if they need it. I suspect not. It's more about psycho-oncology, if they address that. But I don't think there's an SOP for suicidal thoughts. I can't imagine that now, but I don't know. I'd have to actively look it up." (EI8)
			"Yes, I think we definitely have that on the ward, and probably here in the outpatient clinic too. We also have SOPs [standard operating procedures]. I have to say, as I haven't had such a case yet, I haven't looked into them specifically. But (…) we actually have instructions for everything." (EI6)
			"I just know about it from my training. (…) Is it officially written down somewhere? I could imagine, but I don't know." (EI17)
		Work routines 18	"Sometimes I worry that people are so busy with their tasks and so focused on what they have to do that a lot of things are not seen and heard. Unless it's loud and clear enough. If someone said: 'I don't want to live anymoré, nobody can overhear that anymore. I just don't know whether we are then told very much from the staff members here. But all this pressure in everyday working life could be an obstacle to us getting involved." (EI12)
			"Yes, structurally it is like that. Maybe the patients only come in that day to have their blood taken, then their blood is taken, then they're not looked at at all. It also happens that they just come to the appointment and this and that is done and then nobody pays any attention to them. Only the lab is done or only the CT [computed tomography] is done and then they're sent home again. Nobody looks at how the patients are doing that day." (EI8)
			"Every day is different too. My every day is also different. How explicitly I want to or can go into it [when a patient is in crisis]." (EI9)
Personal Barriers 205	Avoidance 66	Minimization 21	"They [patients] say 'I just can't do it anymore. And I don't want any more therapy. We're not doing anything anymore. I'm going now, I'm going home now' and then the medical staff says 'That's it, there's nothing more we can dó. But that's not suicidal ideation, it's simply coming to terms with the illness and simply accepting that nothing more can be done." (EI5)
			"[I don't ask about suicidal tendencies], because it's never really a central topic. And I think it would also be difficult to find the right time (laughs)." (EI15)
			"[I know of] a female patient who couldn't cope psychologically and took her own life. It's more like one or two [patients] a year. There are some, but not the masses." (EI3)
		Positive focus 13	"[In the case of a patient reporting suicidal ideation] I would try to comfort them a little or somehow reassure them that I am there and that I want to help them, and that we will get through this together, so to speak. So, then I express my confidence in them." (EI7)
			"So, I think that's why I haven't done it [asked about suicidal ideation] yet, because I'm more of a positive person and always try to see the best in everything. And yes, suicide or death is, of course,

		somewhat normal. But having suicidal thoughts is not - well, in my opinion, it's something negative - and I actually only ever want to give the patient something positive, and not somehow inspire negative thoughts in them." (EI10)
		"I tried to reassure him that he should see the positive aspects, that he still has his family supporting him, (…) and that yes, his illness is horrible and it sucks, but we are trying to support him as much as possible so that he can carry on living a bit, with hospital stays and outpatient visits, but that life actually isn't that bad. And I encouraged him a bit not to have such thoughts, but to look into the future in a more positive way." (EI10)
	Stigmatization 11	"Of course, it starts with the fact that it [suicidal ideation] is such a taboo subject, that I don't really want to have anything to do with it." (EI2)
		"So clearly, I think many people have a problem with it [talking about suicidality]—so, an inhibition, a threshold. (…) There are a few colleagues [saying] 'Why are you coming up with this nonsensé [regarding palliative care]."(EI16)
		"Um, I think that, as I said, for many people it's a taboo to address it at all, to talk about it at all. I think that even when a patient dies by suicide, it's often something that leaves people very speechless or leaves them behind and, and often it's not really possible to talk about it, as well as about other things (…) even like grief, or things that are more familiar to us." (EI13)
	Diffusion of responsibility 21	"I think that there is a great deal of reluctance to address the issue of suicidality at all, i.e., the point that if it is there, then you also have to discuss it - and then comes helplessness: How do I deal with it? Or to know that there might be a lot of work involved, which I then must do. And then I prefer to think that it's not my job." (EI18)
		"Well, I think that it [exploration of suicidality] would have to be done by the person treating the patient, i.e., the medical doctor. And for the nursing staff, it's just kind of difficult. (…)Because the nursing staff who work here don't have any special training. I don't know whether you could or should expect them to do that. That's why I think I would leave it in the hands of the doctor." (EI7)
		"[To ask for suicidal tendencies] simply triggers a great fear [in practitioners], perhaps also a fear of responsibility." (EI14)
Gaps in knowledge 57	Lack of competence, methods and coping 32	"I simply don't know what questions to ask the patient. (…) And how I react to such a report. I mean, if someone were to tell me that they want to take their own life—I don't think I would know what to say at first. I think I would be shocked. Like: Shit, they're really doing it now. And how, how do I react now? How do I tell them that this is a really, really stupid idea? That's why I try to somehow get away from such thoughts." (EI10)
		"When you bring it up, you don't really know how to continue the conversation if someone actually says: 'Yes, I've already thought about it'. Yes, then I would sit there thinking: 'And now?' I think that's how many people feel and just contact psycho-oncology for further conversations, because what am I supposed to say or do? I can hold their hand, I can say it will work out and to keep fighting or… I don't want to say standard sayings, but yes (…)." (EI3)
		"But I think it's because you can't deal with it very well in some cases, or because we perhaps don't have the skills or tools to deal with it in the correct way, that we are perhaps sometimes a little withdrawn." (EI2)
	Suicide myths 25	"If the patient suddenly died and then it came out that they had done it [died by suicide], I think I would blame myself somewhat because I might have triggered the thought a bit." (EI10)
		"Yes, actually, I think I would be afraid if I asked them specifically. For example, that I would give them the idea in the first place by actively asking and they would then think 'Mh, *should* I think about it?'" (EI6)

(*continued*)

TABLE 2. Continued.

Category	Theme	Subtheme	Interview quotes
			"Sometimes I have patients where you really notice that they say something like that [expressing suicidal ideation] to get a bit of attention." (EI4)
	Difficult feelings 82	Difficulties setting boundaries 8	"It's also something that attacks your own mental health, depending on how much contact you have with it and how close you get to your patients. The more intense the contact is, the more it affects you, I think, and distancing yourself is certainly more difficult. So, I think it makes a difference who is in the same boat as the patient as a practitioner. I could imagine that nursing staff, for example, report significantly higher stress levels than psychologists." (EI14)
			"I think [a former colleague of mine] also jumped in at the deep end back. She was also an emergency counselor. However, she had at least thought it through theoretically, but I think it [supporting relatives of someone who dies by suicide] also kept her busy for weeks. Yes, I think it's always that. That's one of the most dramatic ways." (EI20)
			"I'd say it has become easier over the years to decide what to take with you or not. But of course, there are cases that sometimes make you sleepless. Well, that doesn't happen often, but yes, you do think about it in the evening." (EI9)
		Fear of crossing boundaries 23	"When I ask them, it's almost overbearing. If I say 'Are you suicidal?', that I take someone completely by surprise. And they might think: 'How can she ask me that? Of course I'm not suicidal. I'm in an absolutely extreme situation in my life and I'm suffering, but I'm not suicidal.' So that's perhaps sometimes a barrier for me, that I think: 'Oh, I don't want to offend them completely and ask them that', then perhaps their loved one is sitting next to me and thinks: 'What is she asking us? Would [my partner] kill themselves?'" (EI4)
			"[I would be afraid] that they close themselves off. Because then I've missed the opportunity to help them. Then, hopefully, another staff member will have to try. Yes, so, the most important thing is always to stay in contact. How can I keep in touch and still confront or move closer or distance myself from time to time? But the important thing is how do I stay in contact; if a person closes themselves off then?" (EI19)
			"If I sense that it's about overcoming this crisis, then I don't think it's at all appropriate [to ask about suicidal ideation]. In this case, asking would rather snub the patients and not even unsettle them. I think they might not feel taken seriously if the topic of suicidality was brought up. If they are patients with small children or who have relatives or things, plans in their lives that are very important to them—and you put that in the foreground? [They have a sense of] I want to get back to my life … In this case, I don't actually ask about it, because I don't see that it's an issue at all." (EI18)
		Fear of making mistakes 19	"I always try to have a sense of when it's time to talk about a topic, or when the patients pass me the ball, so to speak. I always find it much easier to pick up on it than to address it proactively, if you will. And I think I do that very, very carefully, because I'm always afraid that I might get it wrong." (EI20)
			"[There's this anxiety] that you might somehow completely misinterpret something and that this error will damage the relationship you have with the patient." (EI15)
			"[When asking for suicidal tendencies I have thoughts like] 'What should I have done? Did I do something wrong? ' Anything that goes in the direction of being afraid of contact." (EI14)

	Concerns and distress 32	"[If a patient was suicidal] would really get to me, I have to say, yes. But I think that oncology in general is a field that really gets to you, because you must deal with so much death and such dire prognoses. Especially with younger patients, I find that you don't often forget that so quickly. But we also had psycho-oncologists we could talk to, especially on the ward, when we were looking after patients for a very long time." (EI6)
		"Yes, of course, it would also be bad for me if the patient said 'yes' [to a question about suicidality], of course that takes a personal toll on you, especially if you know them well. Um, yes, you're probably—subconsciously—afraid that it will affect you or that you don't want to hear this negative answer." (EI6)
		"I just think that my colleagues' mood would really suffer [from a patient being suicidal], yes, because I think that's a very enormous burden and responsibility too." (EI7)
Barriers on the part of patients 52	Uncontrollability and fluctuation of patients' condition 5	"If the patient said positively that they wouldn't hurt themselves, you would assume that to be true. But whether that's *really* the case, you don't know—the patient could be in a worse mood tomorrow, they could have completely different thoughts again. Or an hour later, when we [the staff] are at home. Then you don't see them, they can change their mind again. You might not even notice that." (EI8)
		"When so many factors come to play at the same time: I mean, I don't know, difficulties in the social sphere, and with the illness, and if the situation around the illness situation is also very dynamic (…) or strongly fluctuating [that makes risk assessment difficult]." (EI18)
		"You can smile and have fun and still kill yourself the next day. I don't think it's about symptoms, I don't think you could really go from there." (EI8)
	Self-stigmatization 19	"First of all, I would say it's a taboo subject for a lot of patients it's associated with a lot of fear, for example, fear that they're going crazy, that they're somehow weak, ungrateful, whatever. I think people associate a lot of negative words about it." (EI13)
		"I've heard that often [that it's stigmatized]. Or just received responses like: 'Hm, nopé. I sometimes find that older men, in particular, block the support out and say: 'Nah, I don't need all that psycho-oncology nonsense, I can handle it'." (EI6)
		"Maybe a patient is extremely ashamed that I'm asking them something like that [asking about suicidal thoughts], and they might be worried like this. They might think; 'If I have thoughts like this, then people will think I'm crazy or something, or that I'm weak, or something dire is wrong with me. ' So [the fear would be] that this then perhaps expresses itself more through feelings such as anger, and the patient then somehow tries to protect themselves by simply breaking off the relationship, that would be a shame." (EI13)
	Challenging patient profiles 28	"If I were to ask them about suicidal ideation, many patients would probably dismiss it completely." (EI4)
		"You see some patients, they also let you feel this as a doctor, something along the lines of (…) 'You have to help me now' and (…) 'otherwise I don't need you'. Yes, that's super, super, super professional [instead of more emotionally involved], the relationship that develops then." (EI5)
		"I don't think it depends on the group of people [meaning gender, age or cancer entity], but more on the patient's appearance or character. Whether they're a very brash person who gives you the impression that they're coming here, but they're above it all. So, in these cases, you would certainly be more reserved." (EI9)

Note. The quotes have been translated (German to English) shortened. Numbers next to each theme and subtheme indicate the number of times they were coded. Additions in square brackets were made by the research team to add context and clarity.

One of the two major *Structural barriers was Scarcity of resources*: Pressures regarding time, overstretched staff, and lack of rooms/accommodations allowing for confidential conversations ("[Asking for suicidality is] something that requires more resources."(EI13)). It was not an exception that these factors hindered HCPs from providing the recommended clinical care in the reality of everyday practice. The other theme related to the *Organizational structure*, more specifically the lack of (knowledge about) SOP ("I don't even know if there is an SOP"(EI8)) and thus uncertainty about the correct course of action, as well as strict hierarchies/rigid routines (e.g., "I can't even make the appointment, [only] a medical doctor"(EI3)).

3.3. Resources

Reports of resources (Table 3; Supplementary Table 1 for full category system) focused on three themes: *Work-related* factors, *Private life/after work*, and *Self-efficacy and skills*. As part of the first, HCPs highlighted their "functioning team"(EI18), its characteristics ("a good team atmosphere"(EI7)), and the help it afforded them. Colleagues or "personable"(EI14) supervisors they could rely on were important as well, including psycho-oncologists ("how quickly they respond and that there's always someone to talk to"(EI3)). Supervision, patients' and their relatives' feedback "with close and trusting contacts"(EI2), and their own work experience reduced "fear of addressing this topic"(EI12). Second, HCPs referred to free/family time as crucial for mental health and balance. The ability to "switch off"(EI11) and detach from work was perceived as helpful, as were rituals and more active processing of difficult experiences. Lastly, HCPs drew strength from their professional knowledge/competency, the stance that they knew addressing suicidal thoughts "as something protective, preventative"(EI14), and the evidence for positive effects of psycho-oncological interventions more generally.

3.4. Possibilities for Improvement

HCPs saw several optimization possibilities (Table 4), again located at both the personal and structural level. There seemed to be greater hesitancy to voice the latter, as structural aspects were perceived as harder to change or as inevitable, general characteristics of the healthcare system, such as tight resources. Additional suggestions for improvement included clearer procedures ("[Instruction] is what there should be, […] including for nursing staff"(EI14)), more interdisciplinary collaboration (e.g., "work[ing] more with the general practitioners"(EI4), "supporting each other"(EI19)), and the implementation of screening across settings/clinics "in a standardized way"(EI9). Opportunities at the personal level included professional support such as supervision ("once a month would make sense"(EI8)), open communication "to spread […] the knowledge that you don't trigger suicidality by asking about it"(EI17), making it "a little less taboo"(EI16) and more specific education/training as "it's not given enough attention [in the HCPs training]"(EI2).

Regarding this last aspect, Figure 2 summarizes the pertinent aims, methods, contents, and formats. Generally, interviewees were interested in receiving suicide prevention training, with some noting it should be mandatory for each HCP in cancer care.

TABLE 3. Resources relating to suicide prevention and challenging situations more generally mentioned by the HCPs.

Theme	Subtheme	Contents
Work-related	Team (EI18)	• Interdisciplinary work (EI19) • Being supported by people from different professions (EI19) • Discussions with colleagues (EI19, EI17) (in confidence) (EI1), team meetings and exchanges (EI17) • Good team structure (EI14), good team climate, good group dynamics (EI7) • Intervision (EI14) • Talking in a large team (including medical directors), exchanging ideas and thus automatically processing them (EI6) • Trusting each other (EI6) • Talking to colleagues (EI16) • Talking to colleagues about previous challenging experiences (EI16); retrospective talks (EI3) • Speaking very openly (EI4) • A Functioning team (EI18) • Responsibility distributed across different shoulders (EI18)
	Contact persons	• Psycho-oncology as a "good link" of different professionals (EI16) • Hospice team and pastoral care team (EI20) • Psycho-oncology; quick responses, contact person, easier registration (which has recently been improved) (EI3) • Physicians who listen to nursing staff; low hierarchy (EI7) • Calling superiors/unit directors (EI14, EI12, EI18) • Working group psychosomatics as the guiding directors of psycho-oncology (EI18)
	Supervision (EI19, EI8, EI12)	• Individual (EI20) • Team (EI20) • Emergency supervision (EI20) • Spiritual care and supervision (EI19)
	Feedback from patients/ relatives	• Gratitude from patients/relatives with positive feedback (EI8); gestures such as a bouquet of flowers (EI8) • Positive and close contacts with patients/other visitors (EI20) • Intense and emotional exchange with patients and gratitude; making the job feel meaningful (EI1)
	Experience (EI1, EI19)	• Experience leads to fewer feelings of anxiety (EI14) • Experience brings routine (EI12)
Private life/ After work	Free time and family	• Doing things at home that are different from work (EI7, EI14) • Hiking with colleagues (EI7) • Good contacts, people you can talk to and relieve yourself after a stressful conversation (both privately and professionally) (EI18) • Family (EI4) • Good environment at home (EI7)
	Boundaries	• Mentally saying "stop" and going for a walk (EI3) • Boundaries through "clocking off" (EI3) • Using the way home to review the day (EI4) • Walking to the station, mentally and paving the way with thoughts and leaving them there (EI7) • Not taking the thoughts home with you (EI15) • Being able to switch off well, certain resilience (EI11) • The work coat stays at work and at home, other clothes are worn (EI11) • Leaving the worries there (at work) and not taking them home with you (EI3) • Setting boundaries by writing a documentation (EI3)

(*continued*)

TABLE 3. Continued.

Theme	Subtheme	Contents
		• Mental hygiene (EI11)
	Rituals	• Lighting a candle and sitting down to let everything go (EI20) • Labeling pieces of wood when a patient dies and burning them together as a ritual every once in a while (EI11)
	Processing	• Taking a few days to process (EI16) • Talking to others (EI16) • Allowing sadness (in conversation or thoughts); noticing how it makes you aware of life (EI16) • Taking a deep breath, coming back to the here and now and then finding focus again (EI12)
Self-efficacy and skills	Knowledge	• Knowledge that crises are a "normal" (even if serious) stress reaction, positive aspects like being able to provide relief (EI13) • Seminars (EI14, EI16), further training (EI16) • Psychotherapy training (EI12, EI14) • Getting informed about how to deal with challenging topics, read up on them (EI6) • Training: communication, understanding people (EI12)
	Effective means	• Knowledge that psycho-oncology helps patients (EI2) • Good professional relationship with psycho-oncology (EI15) • Conviction that the help system works and support services can avert loneliness and helplessness (EI18)
	Addressing suicidality as an important strategy	• Knowledge about positive consequence if suicidality is addressed adequately and patients can be helped (EI5) • It is important and meaningful and feels good to discuss difficult topics in order to help patients (EI16) • Addressing the topic and not making it taboo is a crucial professional task (EI18) • Professional attitude: Asking and informing patients can have protective, preventative effects; thus, there should be no fear, but it is a "normal" task and part of the job (EI14)

Topics HCPs wished to know more about included the management of patient distress, actionable recommendations for how to broach the topic and broader strategies for helpful interviews/exploration. They would also appreciate receiving more facts and empirical information. In their view, there was a need to raise awareness and to more actively and openly engage with patients at risk.

4. DISCUSSION

This study aimed to identify barriers to suicide prevention, existing resources and (tangible, needs-based) possibilities for improvement from the perspective of (psycho-) oncological HCPs.

The first guiding question was which barriers hinder an adequate approach to suicidality in cancer patients. The present bottom-up approach identified a range of *structural* and *personal* factors. They were congruent with barriers previously reported in other studies, suggesting that, despite differences, certain difficulties transcend regions and healthcare systems. Our results may also be transferable to other fields that manage

TABLE 4. Expert recommendations on how to strengthen suicide prevention in (psycho-)oncology.

Level of the respective optimization for improvement	Specific ideas/interventions
Structural	
Structural resources and visibility	• Expand resources (time, personnel) (EI14, EI8) • Create spaces for quiet conversations (EI6) • Promoting psycho-oncology with flyers, brochures and posters (EI16, EI12) • Make (anonymized) contact points for patients visible (e.g., self-help groups (EI8, EI4), hotlines for acute emergencies or general shame-inducing questions (EI14)) • Make the help network more accessible (EI18) • Make Standard Operating Procedures and instructions for action more salient and accessible (EI7)
Instructions	• Standard operating procedures, instructions for action (EI8, EI9) regarding appropriate referrals (EI3) • Concrete instructions (simply formulated, e.g., in a step-by-step model, uniform heuristic) (EI13) • Guidelines based on communication training (EI16)
Interdisciplinarity	• Physicians must take concerns of other professions more seriously (EI1) • Asking about suicidality as standard (EI1) • Improve interdisciplinary work (EI4) (shared responsibility (EI6), more support of each other with exchange of methods and approaches (EI19, EI20)) • Get to know responsible colleagues (EI18) • Introducing pastoral care as a resource for other professions (EI19) • Simplifying access to psycho-oncology (e. g., fixed consultation hour) (EI5)
Routine screening	• Including suicidality questionnaires as standardized in general medical history questionnaires (EI9) • Screening for suicidality and depression (as a reference point for more detailed questions) (EI4)
Personal	
Integrating the topic into education	• Include information on conducting conversations and exploring (EI1) • Integrate case examples (EI3) • Hospitate with psycho-oncologists (EI3)
Strengthening the team and supervision	• Exchange about experiences to strength understanding (EI1) • Team building and balancing (EI7) • Strengthening interdisciplinary teams (EI7) • Discussion group led by psycho-oncologists (EI16) • Supervision to support Healthcare Professionals (EI1) • Supervision (voluntarily, 1-2 times/a month (EI8), 1-2 times/a year (EI7))
Open communication	• Removing taboos through more open communication (EI16, EI4) • Destigmatizing suicidality though more frequent communication (EI14, EI3)
Supporting Healthcare Professionals	• More support for Healthcare Professionals (EI18) • Direct contact with psycho-oncologists as a standard (as contact person for other professions) (EI1) • Psychological support in all areas (EI15) • Active patient approach by psycho-oncologists (EI9) • Delegate dealing with suicide to psycho-oncologists/physicians (no additional burden on other professions) (EI16) • Annual discussion about well-being (like an annual check-up) (EI4)

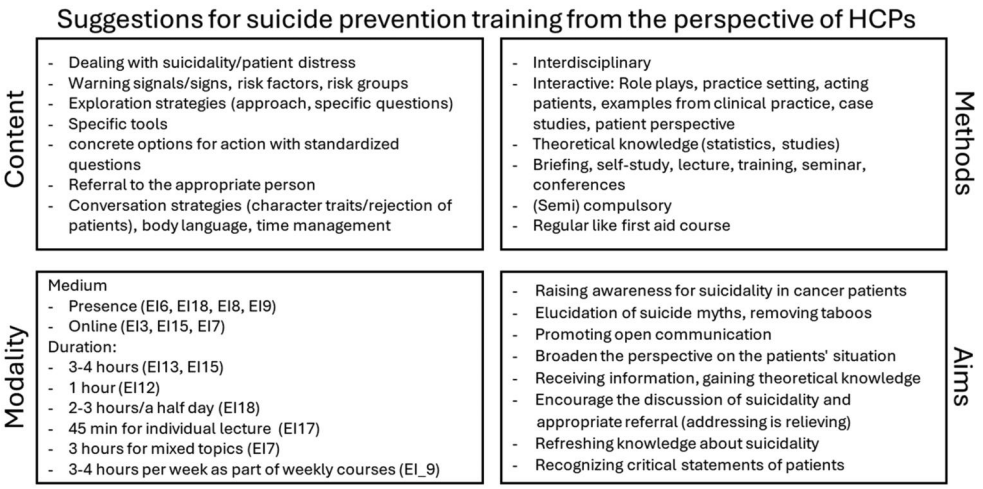

FIGURE 2. Suggestions for suicide prevention training from the perspective of the healthcare professionals.
Figure legend: This figure shows content, methods, modality and aims that were suggested by (psycho-)oncological healthcare professionals (HCPs) for their own suicide prevention training,

chronic illness associated with an elevated risk of suicide, such as diabetes (Fan et al., 2024) or heart disease (Petersen et al., 2020).

For instance, on a *personal* level, one barrier was knowledge gaps. As in a previous qualitative study (Granek et al., 2019a), participants' responses mapped onto disproven myths, ranging from concerns of iatrogenic harm: "I would give them the idea in the first place by actively asking"(EI6) to the devaluating view that those who express suicidality might not actually require help. HCPs were aware of knowledge gaps and reported not knowing how to respond in clinical practice. This underscores the importance of suicide prevention training, including theoretical knowledge/facts.

Another aspect hindering exploration is a perceived threat to the positive relationship/working alliance: "[I would be afraid] that they close themselves off. Because then I've missed the opportunity to help them."(EI19). This relates to previous reports of both HCPs and patients experiencing suicidality as taboo subject (Granek et al., 2019a; Öztürk & Hiçdurmaz, 2023; Valente, 2010; Valente & Saunders, 2004). However, other qualitative studies showed therapists' empathic, sensitive responses to patients voicing suicidality strengthened trust and intimacy (Love & Morgan, 2021), suggesting that HCPs' fears may unwarranted. Aligning with previous findings (Granek, Nakash, Ariad et al., 2018) so-called patient-related barriers in fact reflected HCPs' challenges in fully grasping the patients' situation and dealing with uncertainty. This is especially understandable if HCPs have not received training to engage with suicidal patients, which has been related to avoidance of/fear of engaging with suicidal patients (Jahn et al., 2016). Training should therefore critically address prevailing narratives around suicide, to uncover their influence and to actively challenge them. This could improve prevention efforts by reducing knowledge gaps and

correcting harmful misconceptions, in line with research underlining that knowing about evidence-based suicide prevention strategies strengthens professional self-confidence and sense of agency (Jobes & Barnett, 2025).

Some HCPs talked about knowing some of the myths to be wrong, however, they found it hard to emotionally detach themselves from them and behave in a different way. This arises the concern that only training including knowledge gaps/myths might not be enough for actual prevention behavior in each case. Along these lines, there were three parts of avoidance found in HCPs.

One strategy to avoid talking intensively about suicidality by the HCPs was to reinforce hope and fighting spirit. However, if such responses leave no space for patients to share distress, they run the risk of enforcing "toxic positivity" (including emotional suppression, unrealistic optimism and disingenuous happiness), with adverse consequences for the burdened person who expected to experience relief and understanding (Shipp & Hall, 2024). In one interview (EI10), the intention of forcing a positive outlook was to end a conversation about suicidality. In our category system, such ways of coping were rather motivated by difficult feelings than by spiritual/religious values (Granek et al., 2019a; Valente & Saunders, 2004).

The second part of avoidance was minimization of the relevance of suicidality in cancer patients, although HCPs gave many examples (including of patients who died by suicide), described in more depth in Schwinn et al. (2025). The discrepancy might indicate a somewhat inconsistent approach to the topic and not (yet) a well-grounded, reflexive personal stance. It may also reflect underlying misconceptions or self-protective mechanisms which serve to avoid reckoning with a lack of knowledge, lack of professional security, and difficult feelings. One could even question whether misconceptions themselves arise with a self-protection function. Overall, many barriers are hindrances to both addressing patients' suicidality as well as consciously engaging with the topic, highlighting the importance of training that fosters personal reflection instead of only enhancing theoretical knowledge. The third kind of avoidance behavior became visible with the weight of professional responsibility (Valente & Saunders, 2004), as *diffusion of responsibility*. The fact that many "nursing staff […] don't have any special training"(EI7) reinforced the perception that solely psychological HCPs were responsible for addressing suicidality. However, in line with expert recommendations (Krebsgesellschaft & Krebshilfe, 2023), this study highlights that each profession is crucial. In particular nursing staff working closely and intensively with patients are important gatekeepers, also through referrals to integrated psycho-oncological service. Psycho-oncology, as a rather new and not internationally represented discipline, is an important pillar in the care system, promoting the destigmatization of cancer and mental illness with a focus on quality of life (Lang-Rollin & Berberich, 2018). Thus, it is essential to strengthen and clarify all professionals' roles in the larger system of care, and to enable them to recognize and support patients in need (Christensen, 2019).

Furthermore, HCPs identified limiting *structural* barriers such as rigid hierarchies (e.g., that patients' registration to the psycho-oncology service could not be made by all professional groups). At the same time, hierarchies exacerbated worries about

consequences. While opportunities for referrals to experts in case of suspected suicidality proved to be an important strength, contrasting a previous investigation (Valente & Saunders, 2004), (local) challenges included the lack of space for confidential conversations (which were also experienced in the interviews).

The second research question aimed to identify facilitators, which again, were located at both the individual/personal and the structural level. This resource-oriented approach expands on previous studies and supports the assumption that HCPS' reluctance to address suicidality may be driven especially by personal misconception and not (only) lack of resources: First, rather than mutually exclusive, barriers and resources often coexist in daily practice and personal/interpersonal resources (e.g., team cohesion, individual experience, coping strategies) help manage or buffer systemic challenges. Second, many HCPs value resources like supervision, training, and interdisciplinarity, but these are not consistently implemented across all settings, so that what one person sees as a valuable resource may be lacking for another and thus perceived as a barrier. Some describe supportive colleagues as a resource, while in other areas, hierarchical structures hinder co-operation. Third, certain resources - such as clear referral or registration pathways to psycho-oncology or pastoral care - are viewed as independently helpful and generally well implemented. Fourth, the fact that some HCPs recognize the importance of addressing suicidality without acting accordingly reveals contradictions and a simultaneity of chances and challenges.

In the scope of the third research question, we investigated ways to overcome the barriers, strengthen the resources, and improve suicide prevention in (psycho-)oncology. Some of these factors, mainly of the structural kind, need to be addressed at the political/societal level, as they constitute the result of underfunded and overburdened healthcare systems. However, others could be addressed by individual- or working group-/clinic-level interventions. For instance, training on risk/protective factors and suicide prevention is an often-suggested intervention(Granek, Nakash, Ben-David, et al., 2018; Valente, 2010) and was also endorsed by the interviewees, but has not yet sufficiently been implemented in practice (Jobes & Barnett, 2025). In addition, when providing training, it also needs to be adapted to the circumstances of the workplace and existing needs, e.g., for guidance regarding risk assessment and intervention strategies (Granek, Nakash, Ariad et al., 2018). Moreover, careful consideration is needed in designing training programs to reduce barriers while also strengthening existing resources that are not yet applied to suicide prevention efforts (also through more/regular supervision, interdisciplinary cooperation/teamwork, designated contact persons). Key factors include the use of appropriate formats, duration, and (semi-)compulsory participation to ensure that HCPs can attend despite limited time, staffing, and financial resources - and to engage those who have not yet recognized suicide prevention as part of their role. Equally important is the content: training should address topics relevant to oncology HCPs and use active, practice-based methods (e.g., real case examples, role plays, on-the-job/practical training). Learning appropriate interventions, such as crisis response plans, is crucial (Jobes & Barnett, 2025). In addition, it would be essential to integrate self-awareness and reflection elements, strategies in setting boundaries, and fostering open communication, as well as a supportive team culture of shared responsibility.

5. LIMITATIONS

This is a qualitative study with a small sample which aimed to generate new information. Future investigations need to validate and enrich the present findings. In addition, while we recruited a diverse sample concerning age, gender, experience and professional group at a large, Comprehensive Cancer Center, not all professional groups involved in the care of cancer patients and survivors were represented (e.g., social workers, nutritional counselling, phycical therapists). Moreover, the sample was not gender-balanced, representing the overrepresentation of women among HCPs. To build on the present work, we plan a quantitatively oriented nationwide survey validating the present findings and exploring, e.g., gender-based differences. Moreover, participant self-selection biases and social desirability must be considered. We assume that those who are interested in the topic and intrinsically motivated are more likely to participate, whereas practitioners more wary of/opposed to the study topic might not have taken part. Consequently, the range and severity of difficulties HCPs encounter in clinical practice could have been underestimated.

6. CONCLUSION

Since cancer patients are a vulnerable group, it is important to find out which factors stand in the way of successful suicide prevention. This study fills a research gap in the context of the German care situation and expands previous considerations of death wishes and suicidality in cancer patients beyond palliative medicine. Combining a theory- and data-driven approach, this investigation shows current personal and structural barriers to the exploration of and adequate intervention on suicidality by oncological HCPs. At the same time, it highlights existing resources and tangible suggestions to rectify existing pitfalls, e.g., on the personal level, which kind of further training HCPs would be interested in receiving, and on the structural level, which aspects of their work pose challenges to providing state-of-the-art care to patients. The fact that those insights come from HCPs themselves underscores their practical relevance. The study shows the importance of increasing awareness and fostering knowledge of this topic among (psycho-)oncological HCPs and experts in charge of prioritizing and managing clinical care. Further investigations should focus on misconceptions, self-protecting mechanisms, as well as specific training characteristics and content for oncological HCPs.

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DISCLOSURE STATEMENT

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DATA AVAILABILITY STATEMENT

We cannot make our full interview transcripts available as they contain sensitive information about healthcare professionals and their patients. However, excerpts are provided to provide as much in-depth information as possible. The study aims and procedure were preregistered as part of a larger, mixed-methods project via the Open Science Framework where the materials (e.g., interview guideline) are made available as well (https://osf.io/4c6jr).

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