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Short communication

Barriers to suicide research are also barriers to suicide prevention:Insights from conducting a mixed-methods project in oncology

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ABSTRACT

Cancer patients are at risk for suicidal crises. There is a need for more research concerning specific risk/protective factors and knowledge about barriers and resources of prevention efforts in clinical practice. This contribution reports on difficulties during the realization of a research project that aimed to address these research gaps, among other approaches, via a patient survey and an interview study with healthcare professionals (HCPs). Throughout recruitment and implementation, we documented the barriers encountered and systematically analyzed them.

We identified three main categories of obstacles toward the research endeavor that also hold meaning for the efficacy of suicide prevention: First, *suicidal thoughts and behaviors are not (allowed to be) an issue in oncology*, subsuming the denial of their occurrence, the minimization of their relevance, the alleged appropriateness of the construct to oncology, and the rejection of responsibility; second, *prevailing suicide myths*, in particular of iatrogenic harm; and third, *strong, negative emotional reactions undermining dialogue*.

We interpret these experiences against previous considerations of dysregulated responses to suicidal patients in the healthcare setting and analyze their causes and functions. These findings highlight the urgent need for structured education on suicide prevention across medical disciplines, particularly in oncology. Addressing both knowledge gaps and emotional barriers among HCPs is crucial for fostering a proactive, evidence-based approach to suicide prevention. Future efforts should focus on integrating suicide risk assessment and intervention strategies into routine cancer care, alongside improved interdisciplinary collaboration and institutional support.

1. Introduction

Cancer patients and survivors have an elevated risk for suicidal thoughts and behaviors (STBs) (e.g., Heinrich et al., 2022) which makes suicide prevention an important concern for oncological clinical practice. However, international research has highlighted barriers to crisis intervention, for example, that healthcare professionals (HCPs) are hesitant to ask about suicidal thoughts and do not feel competent caring for suicidal patients (Granek et al., 2019a, 2019b; Jobes and Barnett, 2024). Additionally, there is a scarcity of empirical research on STBs from a psychological perspective, i.e., contextualising them within relevant theories, and focusing on modifiable factors shaping individual risk in addition to or in interaction with the illness (Ernst et al., 2024b).

To address these gaps in research and practice, we created the TASC project ("Together against suicidal ideation and behavior in cancer patients"), which pursues three goals within the German care context: First, to investigate prevalence rates of STBs in different cancer populations (Schwinn et al., 2024). Second, to expand the knowledge about psychological risk/protective factors for STBs in the cancer context. To this aim, we set up a patient survey including the constructs central to the field's most important theories, but under-researched against the background of physical illness (e.g., perceived burdensomeness (Rogers et al., 2021)). Third, acknowledging HCPs' important gatekeeper role, we wanted to find out how they approach suicide prevention in daily practice, which is why we conducted interviews. Psycho-oncology assumes a pivotal role within German comprehensive cancer centers,

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functioning as a critical adjunct to standard oncological care by attending to the psychosocial dimensions of the illness experience. According to the relevant guidelines, every cancer patient must be offered psycho-oncological care. But the gatekeeper role extends to those *not* tasked with psycho-oncological consultations. According to our interview results (Schwinn et al., 2025), most interviewees do not routinely explore suicidality and would feel unconfident managing it.

With backgrounds in psycho-oncology, psychotherapy and suicide research, our perspective is informed by the knowledge that patient suicides cannot always be predicted and/or prevented (Woodford et al., 2019) and (the prospect of) a patient suicide instils anxiety, guilt, and helplessness, no matter the level of expertise and experience (Newkirk and Galynker, 2023). Moreover, in the context of cancer, one must contend with a particular salience of death and dying, and acknowledge that specific concepts of death wishes exist that need to be distinguished from suicidality, e.g., to hasten death in the face of a terminal illness and declining quality of life. At the same time, suicidal crises *do* happen in individuals with cancer, also those with good prognoses (Kinslow et al., 2024) and long-term survivors (Lubas et al., 2020), and suicide prevention is an "ethical and professional imperative" (Jobes and Barnett, 2024). Holding these thoughts in mind as well as the goal to advance the international evidence base, the project's impetus was to explore the clinical reality and benefit both patients and HCPs. Against this background, the present commentary draws on empirical insights to reflect on systemic barriers to suicide prevention.

2. Methods

As described, the project includes new data collections. Here, we report on experiences made with the patient survey (which aims to inform goal 2) and HCP interview study (serving goal 3).

2.1. Data collections within the TASC project

For the patient survey, questionnaires were distributed at the clinics of the Cancer Center (UCT) of the University Medical Center Mainz, a certified comprehensive cancer center offering interdisciplinary, high-standard cancer care. Individual treatment plans are developed through tumor boards, with integrated support services including psycho-oncology, nutrition, and physical activity. Patients independently filled out the questionnaire that included symptom measures (e.g., the PHQ-9 (Kroenke et al., 2001) with the item " … thoughts that you would be better off dead or of hurting yourself in some way") and psychological constructs, comprising both risk and protective factors). For the HCP interview study conducted at the same clinic, we conducted 20 interviews with staff of diverse professions exploring their experiences working with individuals with cancer, including crises and suicidality, knowledge about and attitudes towards suicidal patients and suicide prevention more generally (e.g., the active exploration of suicidal ideation). Both in the case of the interview and patient study, potential participants were informed about the study's aims and contents, the voluntary nature of participation, anonymous data processing, and the right to revoke consent without suffering negative consequences. All participants provided written informed consent. All study contents and procedures were approved by the local ethics committee.

2.2. Data underlying the present report

When we contacted HCPs, either to interview them or to devise the survey implementation, we encountered difficulties that we had not anticipated. We recognized that we had underestimated the ways in which the barriers to suicide prevention that exist in clinical practice also constitute barriers to research on suicide prevention. Hence, the problems faced might hold meaning to advance suicide research in different settings. In any case, our experiences were neither homogeneous nor static, i.e., there were also instances where we observed shifts (in participants' attitudes and feelings) which could provide particularly important guidance if the goal is to change how HCPs and organizations put suicide prevention into action.

The basis of the present article comprises (1) the research team's field notes and internal discussions, primarily related to encounters with HCPs (both as study participants and also potential coordinators/multipliers) and (2) unsolicited feedback received through other channels (e.g., comments on questionnaires). This material was jointly reviewed by three members of the research team. Initial accounts were documented and supplemented with reflective memos capturing the subjective impressions of the respective team members. These records were subsequently reviewed by a team member not directly involved in the original encounters. For each data source, structured summaries were created, highlighting both explicit content (e.g., "refusal to implement the survey at the clinic") and implicit meanings (e.g., "worry about dangerous consequences"). Through iterative review and constant comparison, higher-level categories were constructed to capture recurring patterns across the material. The thematic structure was refined through team discussions. To ensure internal coherence and thematic relevance beyond singular accounts, only themes that recurred across multiple participants or data sources were retained.

2.3. Motivation and positionality

It is important to us that this work is not seen as a criticism of our colleagues but as an empathic examination of the complexities of clinical practice. While the categories were created inductively, we seek to locate our experiences within the international research landscape, to structure our insights and connect them with the available evidence base. To this aim, we draw on the description of patient distress and system anxiety by Smith et al. (2015) as a framework: The authors note that health settings are prone to react in maladaptive ways when faced with the challenge of caring for at-risk individuals and that the organizational level deserves attention to understand unhelpful responses.

3. Results

We identified three major categories of barriers to engaging with STBs in the oncological context more generally, and study participation and implementation more specifically that cut across modalities (i.e., feedback after presenting the project, opinions and experiences voiced in the interview, comments about questionnaire contents). They are summarized in Fig. 1.

3.1. Category 1 - STBs are not (allowed to be) an issue in oncology

When presenting our study to colleagues (both when trying to win them as collaborators in the dissemination of the patient survey and as participants in the HCP interviews), the occurrence of STBs in oncology was often minimized or denied. Alternatively, the *responsibility* for suicidal patients was denied, or HCPs stated that it was a taboo topic: Even the proposal of investigating STBs in cancer patients was devalued, for example by a colleague stating that it "made no sense" to inquire about suicidal thoughts in cancer patients: "That's nonsense, they are faced with death, they want to live and fight". A similar attitude expressed was that it was not ethically justifiable for suicide (prevention) to be discussed in the oncological context. The construct's fit with the psycho-oncological setting was brought into question, in the sense that the identification of STBs in people with cancer was said to constitute a misunderstanding: While passive death wishes were "to be expected", they were understood as "something different" from suicidal crises, and suicidal crises just did not happen in the context of cancer. Here, HCPs focused on terminally ill patients at the end of life, with HCPs expressing permissive attitudes ("It's okay if someone no longer wants to suffer").

Visiting a self-help group hoping to disseminate the patient survey, we heard echoes of these notions, and a troubling dialectic emerged:

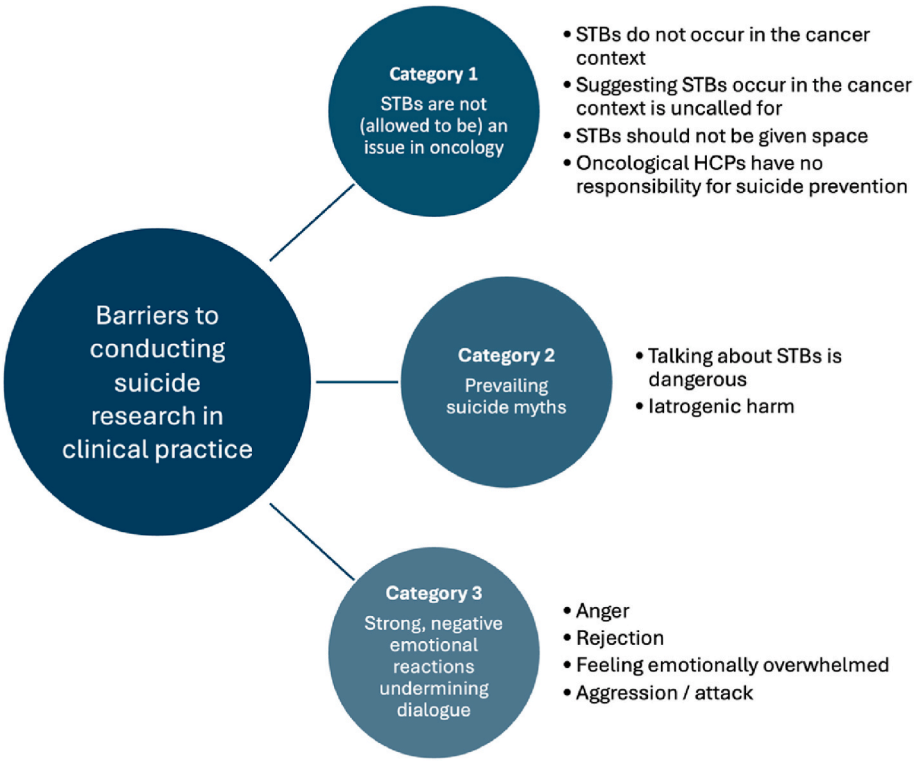

Fig. 1. Summary of the three main categories of barriers to suicide research identified in the present oncological research project.

Group participants stated that death wishes "affect almost everyone with this illness, everyone ponders whether they still want to live". At the same time, there was a consensus that mental distress (including STBs) was not to be discussed in the group. Instead, if a patient expressed negative emotions, the group's aim was understood as making them feel better as quickly as possible by offering hopeful affirmations. Giving space to negative feelings was explicitly not desired, for fear of worsening the affected person's distress or making other group members feel bad. This was mirrored in the interviews, with HCPs reporting "not going into" patients' negative thoughts and feelings but trying to communicate optimistic views.

At the start of the interview, HCPs often emphasized that they had had no exposure to STBs. Throughout, some maintained that suicide prevention was not relevant in day-to-day work and rejected responsibility ("That's not my role"). However, we also noticed a change from the rejective stance expressed at the beginning to more and deeper reflections (Schwinn et al., 2025): After being asked about concrete experiences, most interviewees relayed patients who reported suicidal ideation, made suicide attempts, or died by suicide (either their own experiences or those of colleagues). Upon ending the interview, many commented on having become more aware of the importance of suicide prevention in their work setting; and they voiced interest in the study results and more training.

3.2. Category 2 - prevailing suicide myths

We were often confronted with suicide myths, especially of iatrogenic harm: In the interviews, HCPs stated that they did not explore STBs for fear of exacerbating potential crises. This suicide myth also posed a particular challenge to the patient survey dissemination. Colleagues noted a need "to be careful", and that it was not possible "to give this questionnaire to just anyone". The focus of conversations about the project tended to shift in the direction of the assessment of STBs and risk factors, and whether exploring them was potentially dangerous as well (although the questionnaire also included resources). As a consequence, in response to HCPs' feedback, we made amendments to the study information and added more explanations, e.g., that not everyone affected by cancer endorses the subjective experiences the questionnaire enquires about. We were unsure whether such additions put even more emphasis on STBs than, for example, in routine surveys in other clinics that comprised similar constructs without such comments. In any case, these efforts did not help to dispel HCPs' worries, either. Some followed what they perceived as the best procedure and decided for whom the questionnaire was suitable and for whom it was not, i.e., anyone who might be distressed; citing compassion ("I don't want to burden them") and concerns about the questionnaire's effects ("I don't want them to think that their situation is so bad that they should consider suicide").

There were also positive experiences with HCPs who had been hesitant at first. For example, one team asked us for empirical evidence that asking about STBs poses no inherent risk. After reviewing it, they implemented the patient survey in their unit.

3.3. Category 3 - strong, negative emotional reactions undermining dialogue

The strongest emotional reactions were encountered when trying to cooperate with leaders of a self-help group. The researcher who had initiated the contact was confronted with rejection, heated discussions, and personal devaluation based on perceptions that she was "too young and healthy" to relate to the subjective experience of those affected. She felt helpless, guilty, and confused. In her previous research and clinical practice as a psychological psychotherapist (licensed in psycho-oncology), broaching the topic of STBs with patients had never made a situation worse, but instead provided relief and strengthened the therapeutic relationship.

However, after this unfortunate group session, constructive bilateral conversations followed: First, a more open exchange was possible with a group member who had initially reacted very emotionally. More composed, they explained their response had been led by "old feelings of helplessness" as they had lacked support to overcome their mental

crises. They talked about their own lived experience of suicidal thoughts and about another patient who died by suicide. Secondly, in later conversations, the group leaders commented on a sense of responsibility when handing out the questionnaire. They were concerned it might initiate conversations they felt not equipped to handle.

4. Discussion

This study aimed to summarize the challenges encountered during the implementation of a research project on suicidality in cancer patients and yield a deeper understanding of their relevance for suicide prevention efforts in clinical practice. The encountered difficulties were diverse, yet they could be best categorized into three overarching themes.

The experiences that fell under the first category inform us that suicide prevention is not at the forefront of HCPs' awareness. However, if the topic is brought to their attention, they recognize it as important - and express feeling unprepared (in the safe space of a confidential interview). One can argue that keeping the topic of suicide risk out of consciousness helps not to feel helpless and overwhelmed on an individual level. On an organizational level, it avoids the acknowledgement of the fact that the structures are inadequately designed to support patients in crisis. Negating the relevance of STBs and/or one's responsibility thus serves as a coping mechanism. Further, HCPs' reports demonstrate that a suicidal cancer patient does not conform to their role: according to Smith et al. (2015), an "ambiguous sick role" is a major factor contributing to dysregulated responses. Our colleague made it explicit: Cancer patients are assumed to be interested in living and to "fight" (for the problematization of these metaphors, see Ellis et al. (2015)). Patients expressing suicidal desire violate the expectations placed on them. This may lead to inconsistent behavior among HCPs. On the one hand, they may recognize the legitimacy of death wishes and seek to protect them from stigma. On the other hand, HCPs invest energy and effort to keep their patients alive and reduce their suffering. They may thus feel hurt by patients' desire to die, rendering their efforts futile. The incompatibility of suicide risk with the patient role is also demonstrated by the rejection of the construct of suicide/STBs. The level of distress patients are expected to feel further seems to depend on prognosis, with HCPs viewing terminally ill patients as the only ones with death wishes. This mirrors the empirical literature, in which death wishes are predominantly discussed in palliative care (Kolva et al., 2020). We were confronted with the unreadiness to accept that the wish to die might trump the wish to live in those with good prognoses as well, at least temporarily. Consequently, there is no plan for handling such cases, and having "no reliable method" to respond amplifies the risk for dysregulated responses (Smith et al., 2015).

This is a gap in care, especially given successes in early cancer detection and the rising survival times of people with cancer. HCPs need to know that suicidal crises can affect anyone irrespective of age, diagnosis or prognosis. They should also be made aware of their crucial role in prevention, highlighted by studies showing that most cancer patients who die by suicide had contact with HCPs shortly before (Aboumrad et al., 2018).

The acknowledgement of a wish to die and a wish to live as two separate motivational dimensions that are present in all of us at all times, with varying strengths and relations (Ernst et al., 2024a; Kovacs and Beck, 1977), could provide a starting point for conversations. Indeed, the self-help group members communicated their lived experience of the wish to die becoming more salient. Not being able to share such distressing thoughts can amplify shame, isolation and helplessness (Jobes and Michel, 2011).

Regarding the second category, the observations highlight both practitioners' concern about their patients and the sustained prevalence of suicide myths. These findings are in line with qualitative and quantitative findings from several countries (Granek and Nakash, 2020; Granek et al., 2019b; Lund et al., 2017). Although HCPs' worries came from a place of care, the selective questionnaire distribution undermines patients' agency, mirroring the common prototype of cancer patients being perceived as inactive and dependent (Tsiouris et al., 2021). Our attempts at revising the study information and contents in the hopes that they would eventually be accepted are in line with what Smith et al. (2015) termed a dysregulated response, as it was an ad-hoc effort not congruent with the actual need (i.e., education and discussion at colleague/team-leader level, not extensive documents for patients).

Furthermore, the observations summarized under category 2 could have several negative implications: First, regarding the present project, concerns about an inherent danger in asking about suicidal thoughts, one of the most common suicide myths (Nicholas et al., 2020), poses a threat to a) recruiting enough participants in the first place and b) achieving accurate estimates of the prevalence of STBs among cancer patients. Selective recruitment also limits the variance in the data and makes it more difficult to identify factors (positively or negatively) associated with STBs, diminishing the study's contributions. Second, it would be detrimental if the handling of the study survey was indicative of HCPs' general approach to distress in their patients, i.e., if HCPs clung to magical thinking along the lines of "If I don't ask, all is well". Such behavior might reassure HCPs but put patients at risk. For the future, these experiences taught us that cooperating partners should be involved earlier and receive more information. After all, there were instances in which evidence against suicide myths shifted attitudes. More generally, however, we deem it indispensable that HCPs receive accurate state-of-the-art education about suicide (prevention) as part of their training so that they feel more confident, and vulnerable patients receive support instead of being avoided. Notably, these findings emerged within a certified comprehensive cancer center with highly structured interdisciplinary care, highlighting that gaps in institutional frameworks for addressing suicidal thoughts and behaviors may persist even in professionalized, resource-rich settings. They must be integrated into the greater context, with suicide literacy and stigma in Germany being moderate in international comparison (Ludwig et al., 2022). This underscores the importance of embedding clinical suicide prevention strategies within broader implementation frameworks that take into account system-level barriers, public attitudes, and the translation of evidence-based practices into everyday clinical routines.

Regarding category 3, strong, negative emotions undermining dialogue, the encounter described showed us that we had not reflected our perspective and positionality enough. Although the researcher had highly relevant experience, the group session was different from her clinical work in the sense that it was not a confidential conversation within the protected space of the therapy room. Bringing suicide into focus within the group setting confronted group leaders and members with the mismatch between the potential extent of mental health crises in the context of cancer and the setting's limited options for action. We had not sufficiently considered the feelings of helplessness this might have caused. We assume that the emotional reaction was particularly strong because here, responsibilities were even more unclear and the sick role even more ambiguous; it might even overlap with the role of the group leader. Leaders of self-help groups often have no professional training but lived experience. This is a double-edged sword: Personal experience is a great strength when it comes to supporting others in recovery and survivorship, but it also blurs boundaries and might set group leaders up to be overwhelmed; made worse by limited options to safely intervene or refer, like in a clinic setting.

In the case of the group member who shared her lived experience, it was palpable that the confrontation with the topic reactivated emotional schemata that had not been sufficiently processed. As many (former) patients have had upsetting experiences in the healthcare context, the primarily shown emotion of anger could have been a secondary emotion replacing the primary emotions that feel too threatening (Greenberg and Watson, 2006). As suicidality is still stigmatized (Monteith et al., 2020), chances are high that patients have had upsetting experiences. As the group discussion reactivated feelings of threat and helplessness,

supposedly aggressive reactions become more understandable: Now, the researcher may have had to weather responses not really directed at *her*, but she was viewed as a representative of HCPs, including those the patient had encountered years before in a desperate situation.

While this report provides insights into the barriers to suicide prevention in oncology, several limitations should be considered. First, it was not conducted as a formal investigation led by a research question and instead deals with unplanned observations that we sought to understand after the fact. As such, its subjective nature must be highlighted. Conclusions remain influenced by our positionality, and others may have interpreted these experiences differently. Second, the study is oriented towards encounters with other professionals. While HCPs' reluctance to engage with suicidality may have implications for their interactions with patients, the present study does not directly include patient experiences. Third, the study is limited in scope and generalizability as findings are drawn from a single project conducted within a specific healthcare context. Openness to such projects and suicide prevention more generally may vary across institutional structures, healthcare systems, and cultural contexts. Fourth, the integration with the concept of "system anxiety" occurred post hoc and served as a heuristic device for interpretation. Future research aiming to systematically examine structural barriers or facilitators to suicide prevention efforts would benefit from applying established implementation science frameworks to guide data collection and analysis; for example, the Consolidated Framework for Implementation Research (CFIR) (Damschroder et al., 2022), which allows for mapping multi-level determinants across domains such as inner setting, outer setting, and individual characteristics.

5. Conclusions

This study underscores the need for enhanced education and training in suicide prevention across disciplines. Despite the evidence showing cancer patients' vulnerability to suicidal crises, HCPs seem ill-equipped to empathically attend to them. Suicidality contrasts with the goal of cancer treatment, which is survival - producing tension between conflicting priorities (Smith et al., 2015). The resulting difficulties in addressing STBs can manifest as a range of reactions, from denial and minimization, defence against responsibility, to anger. We interpret these as means of coping, as they serve to stabilize at times overwhelmed HCPs. Previous research has also pointed out negative reactions toward suicidal individuals, including rejection and avoidance (Groth and Boccio, 2019; Quinnett, 2021). To keep patients safe and to support HCPs caring for them, it is pertinent to identify barriers to suicide prevention on all levels. Suicidality is still surrounded by myths and a great fear of acting wrongly. Thus, training should not only communicate facts but also provide actionable advice, strengthen self-efficacy, and encompass the cultivation of reflective attitudes towards suicide and crisis intervention. HCPs need to be informed about their important gatekeeper role and empowered to make positive changes for their patients.

CRediT authorship contribution statement

Judith Hirschmiller: Writing – review & editing, Writing – original draft, Investigation, Data curation, Conceptualization. **Tamara Schwinn:** Writing – review & editing, Writing – original draft, Investigation, Data curation, Conceptualization. **Jörg Wiltink:** Writing – review & editing, Project administration, Funding acquisition. **Manfred E. Beutel:** Writing – review & editing, Supervision, Funding acquisition. **Rüdiger Zwerenz:** Writing – review & editing, Funding acquisition. **Elmar Brähler:** Writing – review & editing, Funding acquisition. **Mareike Ernst:** Writing – review & editing, Writing – original draft, Visualization, Investigation, Funding acquisition, Conceptualization.

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Declaration of competing interest

The authors have nothing to declare.

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