

Strategies and Barriers in Addressing Mental Health and Suicidality in Patients With Cancer

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PURPOSE: To identify how oncology nurses address mental health distress and suicidality in patients, what strategies they employ in treating this distress, and the barriers they face in addressing distress and suicidality in patients with cancer.

PARTICIPANTS & SETTING: 20 oncology nurses at two cancer centers in Israel were interviewed.

METHODOLOGIC APPROACH: The grounded theory method of data collection and analysis was employed.

FINDINGS: Strategies used in addressing patients' mental health distress were being emotionally available, providing practical support, treating physical symptoms, and referring to counseling. Strategies in addressing suicidality were assessing the situation, offering end-of-life or palliative care, treating physical symptoms, and referring for assessment. Barriers to addressing distress were lack of training, stigma, workload or lack of time, and limited availability and accessibility of mental health resources. Barriers in addressing suicidality were lack of knowledge and training, patient reluctance to receive care, and lack of protocol.

IMPLICATIONS FOR NURSING: Developing guidelines for addressing and responding to mental health distress and suicidality is essential to improving patients' quality of life and reducing disease-related morbidity and mortality. Reducing mental healthcare stigma for patients is critical.

KEYWORDS mental health distress; suicide; mental health care; stigma; grounded theory

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The oncology literature recognizes that a cancer diagnosis can result in mental health distress (most commonly depression and anxiety) and suicidal ideation (i.e., thinking about or having an unusual preoccupation with suicide) in patients (Nakash, Shemesh, Nagar, & Levav, 2012; Singer, Das-Munshi, & Brähler, 2010). While being treated for cancer, patients often experience physical and emotional distress (Kaul et al., 2017; Zebrack et al., 2015), with nearly 30% of people developing an anxiety or mood disorder as a result of their diagnosis (Nakash, Liphshitz, Keinan-Boker, & Levav, 2013). In addition, those who have cancer are at increased risk for suicidal ideation (Walker et al., 2011), suicidal attempts (Henry et al., 2018; Henson et al., 2018), and suicidal acts (Hem, Loge, Haldorsen, & Ekeberg, 2004).

Treatment of mental health distress in people with cancer can potentially affect the course of the disease (Carlson & Bultz, 2004), the length of hospital stay (Prieto et al., 2002), treatment adherence and efficacy (Kennard et al., 2004), satisfaction with treatment (Bui, Ostir, Kuo, Freeman, & Goodwin, 2005), and quality of life (Adler & Page, 2008). Once mental health concerns are identified, psychosocial interventions may ease suffering in people with cancer and improve quality of life, no matter the prognosis (Li, Fitzgerald, & Rodin, 2012; Spiegel, 2011). For example, Li et al. (2012) noted that psychosocial (e.g., cognitive behavioral therapy, mindfulness-based therapy, psychoeducation) and pharmacologic interventions (e.g., selective serotonin reuptake inhibitors) can treat and reduce depression and anxiety in those who have cancer.

Although screening for and treating mental health distress in people with cancer has been widely recognized as the gold standard in oncology care and although the research indicates that psychological

interventions for people with cancer are effective, many do not receive any treatment for their mental health distress (Holland & Alici, 2010; Nakash et al., 2014). The number of patients with a mental health disorder for which they do not receive treatment is close to 40% (Nakash et al., 2014).

One explanation for this gap between how much support patients need versus how much support they receive is that healthcare workers frequently fail to identify mental health distress or suicidality in their patients (Jacobsen & Wagner, 2012; Söllner et al., 2001). A study by Söllner et al. (2001) found that one in three people were identified by their oncologists as experiencing mental health distress when they showed clear signs of needing help. An even lower number of the participants (ranging from 15%–50%) who required mental health support were referred to psychosocial care (Söllner et al., 2001). Another study by Strömgen et al. (2001) that included 102 patients with advanced cancer found that more than half reported symptoms of depression, but less than

one-third of these patients had any mention of these difficulties in their medical records.

The literature is consistent in documenting the importance of identifying mental health distress in patients and the difficulties that healthcare providers (HCPs) face in this task, but few studies have explored how HCPs address this distress when it is identified. As a result, the objective of this study was to explore how oncology nurses address mental health distress and suicidality in patients with cancer. In particular, the authors were interested in the specific strategies oncology nurses use and the barriers they face in addressing these emotional situations with their patients.

Methods

Design and Participants

This study was part of a larger project that explored how HCPs, including oncologists, nurses, and social workers, identify suicidality in their patients (Granek et al., 2017; Granek, Nakash, Ariad, Shapira, & Ben-David, 2018; Granek, Nakash, Ben-David, Shapira, & Ariad, 2018a). The grounded theory method of data collection and analysis was employed (Charmaz, 2006; Glaser & Strauss, 1967). The conceptual theoretical model created from this project was published in a previous article (Granek et al., 2017) in which the authors presented a model of suicidality in the cancer context with an active will to live on one end of the spectrum and an active will to die on the other end of the spectrum; the latter includes patients who desired euthanasia and/or who took their own lives. The middle of this spectrum encompassed patients with a decreasing will to live moving toward a readiness to die. Patients appeared to fluctuate along different points on this spectrum depending on a host of factors, including the degree of their mental and physical suffering (Granek et al., 2017). This spectrum suggests that suicidality in the cancer context may be more dimensional than categorical. Additional research conducted by the current authors asked nurses to share how they define and identify mental health distress and suicidality in their patients (Granek, Nakash, Ariad, Shapira, & Ben-David, 2019).

In the current study, 20 oncology nurses were interviewed about the strategies they use to address their patients' mental health distress and suicidal indications and what barriers they face in these tasks. Most participants were women, and participants had a mean age of 51.2 years (SD = 9). Additional participant demographics are presented in Table 1. The

TABLE 1. Sample Characteristics (N = 20)

| Characteristic | n |
|--|----|
| Gender | |
| Female | 19 |
| Male | 1 |
| Marital status | |
| Married | 14 |
| Divorced or separated | 4 |
| Single | 2 |
| Patients seen weekly across locations | |
| 5–15 | 2 |
| 16–25 | 3 |
| 26–40 | 5 |
| Greater than 40 | 10 |
| Practice location^a | |
| Ward or hospice | 10 |
| Day hospital | 9 |
| Clinic | 6 |
| Radiation department | 5 |
| Palliative care | 3 |
| Oncology emergency department | 2 |
| Time in practice (years) | |
| 5–15 | 9 |
| Greater than 15 | 11 |
| ^a Participants could select more than one option. | |

study took place at two academic oncology centers in central and southern Israel.

Procedure

After obtaining institutional review board approvals at participating institutions, nurses identified as potential participants were emailed information about the research and asked to respond if they wished to hear more about the study. Participants were eligible if they worked exclusively with patients with cancer and had the language proficiency to participate in the interview. Twenty nurses responded, and all agreed to be interviewed. All participants signed a consent form, and an interview guide was used. All interviews were recorded and later transcribed. All identifiable information was removed from the transcripts.

The interview guide was developed by the research team and was based on their clinical and research expertise and on a literature review. The first five interviews were conducted by the principal investigator (Granek), who has extensive experience with qualitative research, and a research assistant, who is a mental health clinician. The rest of the interviews were conducted by the research assistant who was trained by the principal investigator in qualitative interviewing. Interviews took place at the hospital where each nurse worked, at a time and a location of his or her choosing. Interview questions pertained to how nurses respond to mental health distress and suicidal indications in patients. Questions also focused on barriers that nurses face in these tasks. The interview guide is presented in Figure 1. Demographic data were collected using a demographics survey.

Data Analysis

Data collection and analysis took place at the same time. Line-by-line coding of the transcripts was used. Analysis was inductive so that the emerging codes and categories were based in participants' stories and not on codes or categories that were preconceived. The study's principal investigator and the research assistant coded the first five transcripts independently and met often to discuss the coding process and to reach consensus in the event of discrepancies about the codes. This ensured that both coders were in agreement about the definition of the codes emerging in the coding scheme. The remainder of the interviews were coded by the research assistant who met frequently with the study's principal investigator and the study team to discuss the emerging themes and the analytic process. Constant comparison was used to look at the relationships across codes and categories.

The approach was constructivist and focused on the data and the possibilities for meaning that can be constructed from them. The researchers doing the analysis wrote memos about their thoughts and reflections throughout the process of data collection and analysis that were later used to inform the coding scheme. Data collection stopped when data saturation was reached. NVivo, version 10.0, was used to store and organize the data. To ensure validity and consistency in the emerging coding scheme, the study team met often to discuss developing findings.

Findings

Strategies in Addressing Mental Health Distress

Being emotionally available: The primary strategy in addressing mental health distress in patients involved being emotionally present and available. Nurses reported showing their support by talking at

FIGURE 1. Selected Questions From Semistructured Interview Guide Concerning How Nurses Assess Mental Health Distress in Patients With Cancer

- Can you tell me a little bit about your role here as a nurse?
 - When did you start working here?
 - How did you choose to work in oncology?
- How many patients do you see each week?
- Can you tell me a little about how you address mental health distress and suicidality in your patients?
- Can you give me an example of one patient where this may have happened? Please describe this in detail.
 - How did you address these concerns with your patient?
- What happens when you identify mental health distress or suicidality in patients with cancer (e.g., refer out, treat, ask more questions)?
 - How do you address or respond to these concerns?
- Is there any official or formal protocol on how to address mental distress and/or suicidality in your patients? Please describe.
- Can you tell me about some of the challenges you face in responding to patients with mental health distress and/or suicidal indications?
- Have you ever gotten any education in school or in your training on how to address mental health distress in your patients? Please describe.
- Is there anything else that I have not asked you about that you think is important for me to know about this topic, or is there anything else that we have already talked about that you want to expand on?

length to patients about their well-being, listening to them discuss their troubles pertaining to the disease, and being emotionally supportive overall. One nurse explained, “When they see there’s acknowledgment and someone is listening to them, someone has a sympathetic ear, then they can open up. Many times they can’t talk with their family in the same way they can talk with us” (Nurse 13).

Providing practical support: In addition to providing emotional support, nurses reported that providing practical information was critical to addressing mental health distress. For example, one nurse explained, “I see how I can help. Sometimes it’s just by giving answers—where do you go, and what do you do, and how do you treat, and giving them some timelines for when things will get better” (Nurse 12).

Treating physical symptoms: Nurses noted that mental health distress was often caused or triggered by physical pain. Consequently, one strategy in addressing mental health distress was to deal with the physical symptoms first in an attempt to cure the distress. On this, one nurse noted the following:

Many times physical pain causes mental health distress. But when we manage to treat it, and decrease the level of pain, then you see once again the smile and the interest in life coming back. The pain is treatable. Once it is treated, I feel there’s hope, like a ray of light coming through. (Nurse 4)

Referring to counseling: Another strategy in addressing mental health distress involves referring to other HCPs on the team. These include psychologists, psychiatrists, social workers, spiritual consultants, palliative care team members, and, at times, the treating physician. As one nurse explained,

We have a multidisciplinary team. We make efforts to involve more than one professional in the case of mental health distress in a patient. Not just a nurse or a doctor but also a psychologist, a social worker, and a spiritual care consultant, so that someone else can be involved. They can talk to the patient from a different perspective. (Nurse 20)

Strategies in Addressing Suicidality in Patients

Assessing the situation: Nurses reported that when patients expressed suicidal ideation, they responded first by talking with the patients about their feelings to assess their emotional state and what is bothering them. As one nurse explained,

If someone expresses anger and frustration and one of the expressions is “I want to die,” it could be that I would try to contain it and solve it together with the patient, inside the relationship we have. If it will be something more significant, I will call a social worker, the psychologist, and the treating physician. (Nurse 6)

Offering end-of-life or palliative care: Nurses equated suicidal ideation most often with patients who were nearing the end of life. As such, one strategy in addressing suicidal ideation was to focus on offering good end-of-life care that could relieve physical and emotional suffering. One nurse explained further:

When people say, “Finish me off—I can’t anymore,” I tell them that I can’t do this, but that I can help them be less conscious during difficult times so that they won’t experience it and won’t remember it and won’t be miserable. (Nurse 8)

Another nurse had a similar response:

I’ll usually ask myself and ask them how we can relieve their symptoms and make their life significant enough to live. To talk about essence—what gives you meaning at this time? What do you think will help you get through or give you strength during this period? (Nurse 8)

Treating physical symptoms: As with treating mental health distress, nurses responded to their patients’ suicidal ideation by focusing on how to relieve the physical suffering of their patients. However, unlike with treating mental health distress, this theme also included offering palliative sedation to eliminate physical pain. One nurse noted, “For patients who ask for euthanasia—there’s hospice and palliative sedation and there are ways to ease the suffering” (Nurse 10). Other nurses inquired with their patients directly whether their suicidal ideation was related to their physical pain. For example, one nurse explained her process: “I inquire what is meant by ‘I’m sick of living.’ I ask them, ‘If I help you with the pain, will it be better?’ and they often say, ‘Yes’” (Nurse 17).

Referring for assessment: Nurses reported that when they suspected suicidal ideation in a patient, they immediately sent the patient for further assessment, usually by a hospital psychiatrist, social worker, or psychologist. In other cases, patients could be escorted to the emergency department to seek

assessment there. One nurse reported, “If a patient tells me they want to commit suicide, I won’t discharge them. I will consult with the psychiatrist. If she’s not here, I’ll send the patient to the emergency room. I will never send them home” (Nurse 17).

In other cases, some nurses preferred to consult first with the patient’s treating physician, who then normally referred the patient to a psychiatrist. One nurse told a story about a patient she had recently counseled with suicidal ideation.

She said, “I don’t want to live.” I asked her if she was saying this out of pain or suffering or if she really meant it. She said she really means it. I called the manager of the breast radiation service and asked her to come over urgently. She came and talked with the woman and had the same impression. She told a psychiatrist to come see her and then the doctor took the woman to the [emergency department]. (Nurse 12)

Barriers in Addressing Mental Health Distress

Lack of training: Nurses reported that although they wished they had better training and instruction on how to address their patients’ mental health distress, they lacked the tools and education to do this. One nurse remarked, “It’s too bad that we don’t have something that tells us when we identify a specific mental state in the patient [to] do this or that. We don’t have that here” (Nurse 16). Another nurse similarly explained, “We don’t receive enough tools for identification or for response, and also for coping. I say this with great sorrow because we need these tools” (Nurse 1).

Stigma around mental health care: Another barrier facing nurses involved the patient’s reluctance to receive mental health care from a social worker or a psychologist due to stigma. On this, a nurse explained further:

There is a very negative stigma with social workers. I don’t know why, but nobody wants to go to them. When I tell patients it’s for psychological support, they tell me they are fine. When I say there are services they are entitled to which can ease their distress, then it’s OK because it’s not for “psychological support,” which sounds like they have a problem. (Nurse 18)

Workload or lack of time: Another important barrier to addressing mental health distress related to having a lack of time to attend to patients’ needs,

often because of an intense workload. One nurse remarked that every indicator for mental health distress in patients requires a serious response.

The question is whether I can provide such a response or whether I have the resources to provide it. We are in a service-oriented unit that is designed to give chemotherapy to the patient. They come to me over a period of time; we meet them every week and make connections with them. But our service is a moving assembly line for giving treatment and blood transfusions. During the provision of this service, other things like mental health distress come up, but it’s not our bread and butter. (Nurse 7)

Regarding the relationship between time to respond to mental health distress and workload, another nurse explained further:

I sometimes identify mental health distress in patients who are having trouble coping with their situation. I don’t have many tools or time to deal with it. It’s terribly sad when I have four patients waiting impatiently behind the door for my explanation about the treatment. So sitting with a patient for a deeper conversation is a problem. (Nurse 18)

Limited availability and accessibility of mental health resources: The final barrier to addressing mental health distress pertains to a lack of resources, including social workers, psychologists, and psychiatrists who could attend to patients’ needs. One nurse stated that social workers aren’t always available.

We are . . . the ones who are at the front, and we are available all the time. A social worker may not work every day. That is, I don’t always have an immediate solution for the patient. In this respect, we are under a lot of stress. The entire oncology department, including pediatrics, has one psychologist on a half-time position. Now you can understand to what degree the psychologist is “available.” (Nurse 1)

In another hospital, the resources were even less available. A nurse provided additional detail:

Unfortunately, we don’t even have a position of a psychologist here at the ward. Recently, they brought a psychologist for more hours, but this is

new. Until recently, the day hospital psychologists used to come here. Here in the ward, there is not enough response to the emotional aspects of the disease. I don't see the willingness on the side of the system to take care of it. (Nurse 16)

Barriers in Addressing Suicidality

Lack of knowledge and training: Nurses were consistent in reporting that they do not have the skills, training, or knowledge to address patient suicidality. As a result, the primary response to any indication of suicidality was to report it to a physician or a mental health professional. On the difficulty of addressing patient suicidality, one nurse remarked, "I don't have any difficulty in identifying suicidality. I identify it well. My difficulty is more in how to deal with it, what to give them. I lack the tools, how, what to say to them" (Nurse 13).

Patient reluctance to receive care: Another barrier to addressing patient suicidality had to do with patients' reluctance to receive care for their suicidal ideation. One nurse recalled a story about a patient who had died by suicide despite the healthcare team identifying this risk and trying to help him: "We sent him to the emergency room, and a psychiatrist saw him and ruled out suicidality. And a week later he did what he did" (Nurse 17). Another nurse described a situation where the patient's family expressed concern about suicidality but where the patient also denied having any such thoughts:

I have a patient whose family keeps calling me saying he is threatening to commit suicide. I told them [that] all I can do is refer him out. But I can't talk to him because it doesn't matter what I say. He's fixed on a certain pattern of thought. I can't do anything with this matter. Not because I don't want to, but because he won't listen to me. When I meet him, he's completely different. His wife said he's a different person at home. (Nurse 3)

Lack of protocol: The last barrier to addressing patient suicidality was a lack of protocol about what to do when patients expressed suicidal ideation. Nurses explained that although there were many protocols for other situations, none existed about what to do in the case of a suicidal patient. A nurse explained further: "I think a protocol about suicidality must be issued, and it must list who do you turn to, what you fill out, and maybe list what important questions we shouldn't ask the patients" (Nurse 10).

Discussion

The oncology literature is consistent in documenting the adverse psychosocial consequences of undergoing treatment for cancer (Kaul et al., 2017; Zebrack et al., 2015). In addition, several studies have indicated that oncology personnel, including nurses, frequently fail to identify these mental health needs (Granek et al., 2018a; Kaneko et al., 2013; Miyajima et al., 2014). What has been studied less frequently is how oncology nurses address their patients' mental health distress and suicidality once they identify concerning symptoms.

Findings by the current authors show that some of the effective strategies that nurses use in addressing mental health distress include making themselves emotionally available and providing practical support to their patients. Participants in this study emphasized that in addressing patients' mental health distress, they offer listening and acknowledgment alongside practical support and clear information about each patient's status and care options. These findings correspond with studies conducted within mental health settings documenting that patients seek mental health care primarily to feel understood and supported by their providers (Nakash, Nagar, & Levav, 2014). Patients often also ask for practical suggestions to help them navigate their care, as well as work and interpersonal difficulties associated with the illness (Nakash, Cohen, & Nagar, 2018).

Participants in the current study noted that they address mental health distress among their patients by treating physical symptoms and by referring these patients to counseling. They highlighted the fact that they work as part of an interprofessional team and acknowledged their role as gatekeepers, particularly when referring patients to specialized mental health care. Although these strategies are effective, other research has documented that in many settings there are no readily available psychosocial resources to refer out (Fagerlind, Kettis, Glimelius, & Ring, 2013; Granek, Nakash, Ben-David, Shapira, & Ariad, 2018b).

Participants also mentioned effective strategies in addressing suicidality that primarily included assessing the situation and/or referring for professional psychiatric assessment. Conducting a thorough risk assessment is a critical first step in addressing suicide risk (Anguiano, Mayer, Piven, & Rosenstein, 2012). Although participants in this study acknowledged the importance of a thorough risk assessment, they also stressed that they lack knowledge and training in how to conduct it. A previous study of 454 nurses (Valente, 2007, 2010; Valente & Saunders,

2004) included a survey that described a hypothetical patient experiencing suicidal ideation. Few of the nurses were able to identify the risk factors of suicide in this patient. In addition, many incorrectly assumed that normal symptoms of having cancer, such as crying and worrying, indicated suicidal risk (Valente, 2010). Although the nurses expressed concern about the patient showing suicidal ideation, many chose not to intervene because they lacked the skills and knowledge to act. Some also noted that their personal values around suicide and discomfort about this topic were barriers to helping the patient (Valente, 2007; Valente & Saunders, 2004). It is critical that nurses who work in oncology settings know how to identify risk of suicide in people with cancer (Cooke, Gotto, Mayorga, Grant, & Lynn, 2013). Using validated and reliable suicide assessment measures as part of regular care can facilitate the implementation of a standardized assessment process and ease the burden off the already overburdened staff (Batterham et al., 2015). Although there are no measures that have been validated for individuals with cancer, there are instruments such as the Suicidal Behaviors Questionnaire–Revised and the Suicidal Ideation Attributes Scale that have been validated across populations and that can be used. Alternately, short validated measures to monitor emotional distress, such as the Distress Thermometer, can also be employed (Holland & Bultz, 2007).

Participants in the current study also noted that they often offer palliative care for suicidal patients who are nearing the end of life. They emphasized their intention to help patients find meaning during this difficult stage of the illness. Indeed, some studies have shown that loss of a sense of meaning in life can contribute to a feeling of demoralization and is highly predictive of suicidality (Fang et al., 2014). Coping strategies that focus on meaning making can help people with cancer adapt to their situation (Lee, 2008).

Barriers to addressing mental health distress and suicidality included a lack of knowledge and training, a lack of time, and limited availability and accessibility of mental health resources. Additional barriers also included the patient's refusal to receive care and no formal protocol on what to do when a patient indicates suicidal intentions. Some of these findings around barriers to addressing patient needs have been corroborated by other research in the field. For example, HCPs from many different regions of the world have noted that time constraints in responding to patients' distress is a barrier (Biddle et al., 2016;

KNOWLEDGE TRANSLATION

- Nurses report significant barriers in responding to patients' mental health needs.
 - The development of guidelines to address mental health distress and suicidality in patients with cancer is crucial to patient well-being.
 - Mental healthcare stigma is pervasive and serves as a primary barrier to accessing care.
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Fagerlind et al., 2013; Wein, Sulkes, & Stemmer, 2010). Other studies among oncologists found that barriers to addressing patients' mental health distress included patient reluctance to receive care and a lack of institutional resources, such as lack of time and psychosocial services (Granek et al., 2018b).

Limitations

The current study included a self-selected sample of oncology nurses. It is, therefore, possible that these findings cannot be generalized. However, it is likely that nurses who chose to participate in the study reflect those who are more comfortable with and willing to discuss issues pertaining to suicidality and mental health distress. These nurses may be better able to deal with these issues in caring for patients with cancer. As such, the challenge of dealing with and responding to mental health distress and suicidality among patients with cancer may be an even more significant challenge in the general oncology nursing community. In addition, quantitative research on this topic can potentially shed light on how prevalent this problem is across larger samples of nurses. The current authors did not collect information on each nurse's level of education. This variable may affect the way that nurses respond to patients' mental health distress and suicidality. Future research should include education as a potentially important variable mediating the ability to address these types of concerns in patients with cancer.

Implications for Nursing

Findings from the current study highlight the need to implement standardized assessment tools into regular practice. Developing clear guidelines for responding to mental health distress and suicidality in patients with cancer is essential to ensuring that they are receiving the highest possible quality of care. In addition, this approach can improve quality

of life for patients and reduce morbidity and mortality related to the disease. Training nurses to provide interventions that are evidence based, such as low-intensity cognitive behavioral therapy, has the potential to ameliorate the mental health treatment gap among patients with cancer and to reduce healthcare costs. Within such a model, nurses can be trained to deliver the primary care for emotional distress (Araya et al., 2003; Cuijpers, Donker, van Straten, Li, & Andersson, 2010). In addition, in cases where elevated risk is identified, referral to specialized care (such as mental health professionals, including psychologists and social workers) that can offer evidence-based treatments should be made available.

Stigma related to the use of mental health services can serve as a significant barrier to accessing care. Stigma refers to personal attributes that are socially disapproved, resulting in social rejection of the individuals who hold them (Hinshaw & Stier, 2008). Research has documented that stigma serves as a barrier to mental health care (Corrigan, 2004; Corrigan, Druss, & Perlick, 2014). Stigma delays service seeking, may cause early termination of treatment, and may undermine social inclusion and rehabilitation (Corrigan et al., 2014; Mosher, Winger, Given, Helft, & O'Neil, 2016). The World Health Organization (2001) identified care stigma as the hidden burden of mental health disorders.

Mental healthcare stigma is associated with the perception that an individual who seeks mental health services is discredited and/or deviant (Vogel, Wade, & Haake, 2006). Stigma is pervasive. In a telephone survey conducted among 1,006 randomly selected adults in the United States, the American Psychological Association (2019) documented that although more Americans positively consider seeking mental health care when needed, stigma is persistent. Specifically, 33% respondents agreed with the statement "People with mental health disorders scare me," and 39% said they would view someone differently if they knew that person had a mental health disorder.

Stigma as a cultural concept is highly context-specific. The current study was conducted in Israel, a multicultural society. As in other developed countries, in Israeli society, mental health stigma is prevalent, hindering the process of social inclusion of those who have mental disorders (Nakash & Levav, 2012). The Hebrew term for a mental disorder is *mahalat nefesh* (disease of the soul), which contributes to its negative social perception (Levav et al., 2005). Using the term *soul* (*nefesh*) assumes a spiritual essentialism and stands in contrast to biopsychosocial models of

psychiatric disorders. Indeed, a study examining the acceptance of this term among Israeli adults found that although most mental health service-users rejected the current Hebrew term for mental disorder, HCPs reported higher acceptance of this term (Levav et al., 2005).

Despite the importance of reducing care stigma, therapeutic interventions rarely include attention to reducing care stigma with the exception of psychosocial rehabilitation programs. Findings from the current study point to the need to refute the effects of mental healthcare stigma throughout the course of treatment. Such efforts should include raising awareness of the pervasiveness of the problem and its consequences, as well as facilitating service user education and empowerment. Public campaigns to increase knowledge and acceptance of mental health problems can also be effective in reducing stigma.

Conclusion

Oncology nurses in this study provided support and listened with empathy to their patients who experienced mental health distress and suicidality. At the same time, they highlighted limitations regarding accessibility and practical interventions and support for their patients. These are essential factors in a good nurse-patient alliance, which is central to providing effective mental health interventions and prevention of suicide in people with cancer. Developing clear guidelines to responding to mental health distress and suicidality in individuals with cancer is critical to improving the quality of care for the patient. In addition, adopting these guidelines can reduce poor quality of life and potential disease-related morbidity and mortality in patients with cancer. Reducing stigma among those seeking mental health care is critical. The current study points to the importance of effective and ongoing training of oncology nurses to reduce barriers in addressing patients' mental health needs.

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QUESTION GUIDE FOR A JOURNAL CLUB

Journal clubs can help to increase and translate findings to clinical practice, education, administration, and research. Use the following questions to start discussion at your next journal club meeting. Then, take time to recap the discussion and make plans to proceed with suggested strategies.

1. What are the most common ways in which mental distress is assessed in your clinical practice?
2. How comfortable are you in assessing mental distress, and how do you respond to the presence of this distress?
3. What do you do when a patient expresses suicidal ideation?
4. Some of the nurses in this study reported that they do not have sufficient resources in their institution(s) to address mental distress or suicidal ideation. What can be done to address this beyond hiring more mental healthcare providers?
5. What is your experience with patients who have taken their own lives?

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