

## Original Research Reports

# Thoughts of Death and Suicide Reported by Cancer Patients Who Endorsed the “Suicidal Thoughts” Item of the PHQ-9 During Routine Screening for Depression

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**Background:** *Patients with serious medical illnesses, such as cancer, are at increased risk of suicide but are also often facing death. The Patient Health Questionnaire-9 (PHQ-9) is widely used to screen patients for depression. It includes an item that asks about thoughts of death and hurting yourself (Item-9). Objective:* To describe the nature of thoughts of death and suicide reported in clinical interviews carried out to further assess suicidal ideation of cancer outpatients who had endorsed the “suicidal thoughts item” (Item-9) of the PHQ-9 during routine depression screening. **Method:** Secondary analysis of anonymized service data (with ethical approval) derived from the routine clinical administration of self-report questionnaires and telephone interviews to outpatients attending a Cancer Centre in the UK. **Results:** Complete data were

available on 330/463 (71%) of patients who had endorsed Item-9. In a subsequent structured telephone interview, approximately one-third of these patients denied any thoughts that they would be better off dead, another third acknowledged having thoughts that they would be better off dead, but not of suicide, and the remaining third reported clear thoughts of committing suicide. **Conclusion:** Only one-third of cancer outpatients who endorse the “suicidal thoughts item” of the PHQ-9 report suicidal thoughts at a subsequent interview. Services planning to set up depression screening with the PHQ-9 need to carefully consider the relative benefits and burden to their service and patients of including Item-9 and interviewing all those who endorse it.

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Patients with severe medical illnesses such as cancer are at increased risk of suicide.<sup>1</sup> The Patient Health Questionnaire-9 (PHQ-9) is widely used to screen medical patients for depression and includes an item (Item-9) that asks how frequently the respondent has been bothered by “thoughts that you would be better off dead, or of hurting yourself in some way” over the preceding 2 weeks, scored from 0, ‘not at all’ to 3, ‘nearly every day’.<sup>2</sup>

We have previously reported that 8% of a large sample of cancer outpatients endorsed this item (scored more than 0) on routine screening with the PHQ-9.<sup>3</sup> However, interpreting these results is complicated by the fact that patients who have a life-threatening illness such as cancer may be preoccupied with thoughts of death rather than

suicide. Two questions, therefore, arose from this initial study: First, can we use patients’ scores on Item-9 to predict who actually does have suicidal thoughts, rather than simply thoughts of death and dying? Second, what do cancer outpatients really mean when they endorse Item-9;

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that is, what kinds of thoughts do they have about death and suicide? We addressed the first of these questions in a previous study of the current sample.<sup>4</sup> We found that patients with higher scores on Item-9 were more likely to have suicidal thoughts. However, we were unable to provide a cut-off score above which patients require further clinical assessment because nearly a quarter of patients who had a low score (score of one) reported suicidal thoughts at interview. This paper addresses the second of these questions by describing in detail the nature of thoughts of death and suicide reported at interview by cancer outpatients who had endorsed Item-9 of the PHQ-9 during routine depression screening at the cancer clinic.

## METHODS

We analyzed data collected by a routine clinical service from patients who had attended clinics at the Cancer Centre (colorectal, gynaecological, genitourinary, sarcoma, melanoma, breast, and miscellaneous cancers) between July 2003 and December 2004. Permission was granted by the Local Research Ethics Committee to report the accumulated anonymized data without individual patient consent. The data were provided by a depression screening service operating in selected outpatient clinics of the Edinburgh National Health Service Cancer Centre. This Cancer Centre serves approximately 1.5 million people in Scotland, UK. All outpatients were asked to complete depression screening questionnaires except those attending for their initial assessment and those with cognitive impairment or communication difficulties. Clinic staff helped patients to complete the questionnaires, which were administered using touch-screen computers while they waited for their consultation. During the period on which the data reported on here were collected, the questionnaires administered included the PHQ-9.

The results of each patient's questionnaire were given to their oncologist or cancer nurse before their consultation. If the clinician had immediate concerns about the patient's mental state, they were able to contact the hospital's consultation-liaison psychiatry or psychology services for further advice. A number of these patients were also routinely interviewed over the telephone by trained staff soon after their clinic visit for further assessment. One of the reasons for such an interview was endorsement of Item-9 of the PHQ-9 (thoughts that you would be better off dead, or of hurting yourself in some way). The telephone interviews were structured and intended to assess any thoughts of death or suicide the patient had experi-

enced over the preceding four weeks: Patients were first asked whether they had been thinking about dying and, if so, were asked to describe their thoughts. Those who reported that they would be better off dead were asked about thoughts of ending their life, and any methods or plans they had considered as well as whether they had actually attempted to end their life.

Because of the large numbers of patients attending the Cancer Centre, it was not feasible for all the telephone interviews to be carried out by a psychiatrist. Instead, trained psychology graduates and nurses were employed. These staff were selected for their communication skills and received at least 1 month of intensive training in administering the telephone interviews. With patients' permission, the interviews were digitally audio-recorded to facilitate regular clinical supervision and quality control of the assessments. Training and supervision of staff were led by a senior consultation-liaison psychiatrist. All patients who reported suicidal thoughts at the telephone interview were discussed with a psychiatrist and an appropriate treatment plan made, involving the patient's primary care doctor when necessary.

We extracted all the records of patients who had endorsed Item-9 and associated recordings of the telephone interviews. In cases where there was no audio-recording (due to technical problems at the time of the interview), we used the written notes taken by the interviewer for analysis. When a patient had received more than one clinical interview in the time period of data collection (i.e., if they had attended the clinic more than once or had received more than one telephone call to clarify their symptoms), we used their first completed interview.

Two psychiatrists (MS, JW) agreed on six clinically meaningful categories of suicidality before the interviews were analyzed (see Table 1). Three raters experienced in conducting suicide risk assessments placed each patient into one of these categories. Allocation was made by consensus. We then calculated the number and proportion of patients in each of the categories.

## RESULTS

During the time period covered by the dataset, 11,444 PHQ-9 questionnaires had been completed by 4639 patients (many of the patients had attended the clinic more than once during the time period).

Three hundred sixty of the 463 patients who had endorsed Item-9 had been interviewed. The majority of patients who did not receive an interview had been

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