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Public Stigma Toward Persons with Suicidal Thoughts—Do Age, Sex, and Medical Condition of Affected Persons Matter?

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Objective: Suicidal persons often face public stigmatization which affects help-seeking behavior and may lead to an additional suicide risk. There is not much known about differences in stigmatizing attitudes concerning characteristics of affected persons. The present study investigates public stigma toward suicidal persons in Germany by focussing on differences concerning sex, age, and medical condition of the affected person.
Method: A national telephone survey (N = 2,002) was conducted using case vignettes presenting a person with suicidal thoughts. Vignettes systematically varied in sex, age, and medical condition (depressive symptoms vs. cancer). Several components of stigma were assessed ("weakness of will" as a cause, separation, negative emotional reactions, and desire for social distance).
Results: About 44% of the respondents agreed that a cause of suicidal thoughts is "weakness of will," and two thirds disagreed that they would feel and think the same as the described person. In terms of emotional reactions, fear was more pronounced than anger. Stigmatizing attitudes were particularly pronounced when the described person was female and depressive symptoms were presented.
Conclusions: Magnitude of public suicide stigma varies depending on the characteristics of the described person. Groups that are at special risk of being stigmatized should be considered in antistigma programs.

BACKGROUND

Although rates of suicide declined steadily in the past 30 years in Germany (TU Dresden, 2019), every year approximately 10,000 people die by suicide which refers to an age-standardized rate of 9.1 deaths per 100,000 inhabitants (Federal Office of Statistics, 2018a; World Health Organization, 2018). Public stigma is a major issue for persons affected by suicidality since stigmatization can be seen as a stressor that again may lead to an increased suicide risk (Carpiniello & Pinna, 2017; Link & Phelan, 2006; Rüsch, Zlati, Black, & Thornicroft, 2014). Moreover, fear of condemnation and shame frequently lead to social withdrawal,

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nondisclosure and ultimately diminished search for help (Calear, Batterham, & Christensen, 2014; Fulginiti, Pahwa, Frey, Rice, & Brekke, 2016; Hanschmidt, Lehnig, Riedel-Heller, & Kersting, 2016).

With reference to Goffman (1963), Link and Phelan (2001) have conceptualized public stigma as a process including the interrelated components labeling, stereotyping, separation, status loss, and discrimination. In recent years, this stigma concept was primarily applied in the field of mental illness stigma (Corrigan & Kosyluk, 2014; Rüsch, Zlati, Black, & Thornicroft, 2014). In the context of suicide stigma, this would mean, a person has a characteristic that distinguishes her or him from the general public (e.g., having suicidal thoughts). This label is linked to undesirable characteristics known as stereotypes ("Persons with suicidal thoughts have a weak will") resulting in negative emotional reactions toward this group ("I am annoyed by suicidal persons"). This process is the basis for the separation between "us" and "them" (Corrigan & Kosyluk, 2014; Link & Phelan, 2001; Rüsch, Angermeyer, & Corrigan, 2005). Further, the stigmatization process depends on the social, political, and economic power of the stigmatized group and can lead to status loss and discrimination which implies, for example, withholding help (Link & Phelan, 2001; Rüsch, Angermeyer, & Corrigan, 2005).

It is well documented that public stigma is associated with decreased help-seeking behavior among persons having a mental illness and/or suicidal thoughts (Calear, Batterham, & Christensen, 2014; Henderson, Evans-Lacko, & Thornicroft, 2013). Since the identification of specific stigmatizing attitudes in the public may provide the basis for developing prevention and awareness campaigns (Calear, Batterham, & Christensen, 2014; Gould, Velting, Kleinman, Lucas, Thomas et al., 2004), public stigma toward suicidal persons gained increased attention in the past years (Batterham, Calear, & Christensen, 2013; Corrigan, Sheehan, & Al-Khouja, 2017; Rudd, Goulding, & Carlisle, 2013).

A review on suicidality and stigma from 2017 found that there are negative perceptions about individuals who have attempted suicide. They were labeled as weak, selfish, or unable to cope with their problems resulting in "social distancing" which in turn leads to secrecy, shame, embarrassment, and self-stigma (Carpiniello & Pinna, 2017). More recent results from the United States underline these findings: Sheehan, Dubke, and Corrigan (2017) found in their vignette-based online survey, that persons who attempted suicide or died by suicide were stereotyped as "weak" and "crazy" and evoked feelings of fear and anger. Similar results were found in a qualitative stakeholder analysis (Sheehan, Corrigan, & Al-Khouja, 2017).

In research on public mental illness stigma, case vignettes are often used as a stimulus (Angermeyer & Dietrich, 2006; Angermeyer & Schomerus, 2016). Advantage of this procedure is that symptoms and other attributes of the described person (e.g., sociodemographic characteristics) can be varied and examined with regard to the magnitude of stigmatization (Steiner, Atzmüller, & Su, 2016).

There is a lack of vignette-based studies that address the question how specific characteristics of suicidal persons impact public attitudes and which groups are at special risk of being stigmatized. Against this background, this explorative study investigates public stigmatizing attitudes toward suicidal persons in Germany by focussing on variations in attitudes according to sex, age, and medical condition of the affected person. To cover different components of stigma according to Link and Phelan (2001), separation between "us" and "them", negative emotional reactions, the causal attribution "weakness of will" representing a stereotype, and desire for social distance will be assessed.

METHODS

Telephone Survey

Analyses are based on a cross-sectional telephone survey (CATI—computer-assisted telephone interview), which was conducted in

April and May 2018 in Germany by the social research institute USUMA. The survey was part of a project whose main aim is the development and evaluation of an e-mental health intervention to reduce self- and perceived stigma of persons afflicted by suicidality (Dreier et al., 2019). The whole project (including the telephone survey) was approved by the Ethics Commission of the Medical Association in Hamburg (process number: PV3707).

A case vignette describing a person with suicidal thoughts was presented to the participants (see Appendix 1). The vignettes were developed within the project team and discussed with physicians, psycho-oncologists, psychotherapists, and afflicted persons. They were audio-recorded with a trained speaker to counteract possible interviewer effects and thus to increase objectivity. The vignettes systematically varied in sex (female vs. male), age (32 years old vs. 73 years old), and medical condition (mental disorder: depression vs. somatic disorder: cancer) resulting in eight versions which were randomly assigned to the respondents. The varying sociodemographic characteristics of the person in the vignettes are expected to have an impact on the magnitude of public stigmatizing attitudes (Angermeyer & Dietrich, 2006; Holzinger, Floris, Schomerus, Carta, & Angermeyer, 2012). Both depression and a severe somatic disease like cancer are known to be related to suicidal tendencies, but it is unclear whether there are differences in attitudes according to medical condition.

Sample

The sample consisted of $N = 2{,}002$ adults aged 18 and older, living in private households with a conventional telephone connection or cell phone in Germany. Telephone numbers were drawn from all registered telephone numbers at random. Ex-directory households and cell phone numbers were included via computer-generated numbers. Potential participants were informed about the purpose of the survey and that they could withdraw the interview at any time without having any disadvantages. All participants gave verbal informed consent. Based on the net sample without units that were not eligible, response rate was 47.3%.

Table 1 summarizes the sociodemographic composition of our sample, compared to official German statistics. The sample can be considered representative of the German population concerning the described characteristics.

Measures

Stigmatizing attitudes toward persons with suicidal thoughts were operationalized by a question measuring the separation between "us" and "them," by agreement to the possible cause "weakness of will," by negative emotional reactions, and by a modified version of the Bogardus Social Distance Scale (Bogardus, 1925). All above-mentioned assessment tools are related to the case vignettes. Other tools also measuring stigma that are not related to the case vignettes are not considered in current analyses.

TABLE 1
Sociodemographic Characteristics of the Study Sample Compared to Official Figures from Germany

	Sample[a] $N = 2{,}002$	Population in Germany	p*
Sex (female, %)	51.1	50.7[b]	.45
Age (groups, %)			
18–24	9.2	9.2[c]	.19
25–39	23.0	22.5[c]	
40–59	35.2	35.6[c]	
60–64	7.2	7.6[c]	
>65	25.4	25.1[c]	
Level of education (%)			
≤9 years	35.7	34.2[d]	.08
10 years	31.2	32.0[d]	
≥12 years	33.1	33.5[d]	

[a]Weighted data.
[b]Federal Office of Statistics (2018b), p. 26.
[c]Federal Office of Statistics (2018b), p. 31.
[d]Federal Office of Statistics (2018b), p. 84.
*p-value of χ^2 test.

Separation between "Us" and "Them". In research on mental illness stigma, respondents' belief in a continuum of symptom experience is a tool to assess a distinction between "them" (persons with a particular mental illness) and "us" (persons who are mentally healthy). This includes the assumption that a belief in a continuum of symptoms from mental health to mental illness is associated with less stigmatizing attitudes (Makowski et al., 2016; Schomerus, Matschinger, & Angermeyer, 2013). In our study, respondents were asked to what extent they would feel and think similar in that situation as the suicidal person described in the vignette. Answers were given on a 4-point Likert scale ranging from 1 "completely disagree" to 4 "completely agree" (plus "don't know" category). For current analyses, the scale was inverted so that higher scores represent a stronger separation toward the described person.

Causal Attribution. In order to retrieve knowledge, respondents were asked about possible causes of the suicidal thoughts described in the vignette. These causes were based on a list developed by the World Health Organization (2014) and depict individual factors (e.g., suffering from a mental illness) and extrinsic factors (e.g., lack of social support through the environment in case of a crisis). For the present analyses, we chose an item representing a stigmatizing causal attribution that refers to personal responsibility (Angermeyer, Mnich, Daubmann, Herich, Wegscheider et al., 2013). Respondents were asked whether they consider "weakness of will" a possible cause. Response options ranged from 1 ("completely disagree") to 4 ("completely agree") plus "don´t know" category.

Emotional Reactions. In order to assess emotional reactions of the respondents, a list of nine items was used, which is related to different ways of responding to a person with suicidal thoughts (Makowski et al., 2016). The items were coded from 1 ("completely disagree") to 4 ("completely agree"). A principal component analysis (Varimax rotation) yielded the same three factors that have been found in previous studies concerning mental illnesses (Angermeyer & Matschinger, 1997; Makowski et al., 2016; Schomerus, Matschinger, & Angermeyer, 2013): anger (items: "...feel angry," "...feel annoyed," "...triggers incomprehension"), fear (items: "...triggers fear," "...feel uncomfortable," "...feel insecure"), and prosocial reactions ("...feel pity," "...feel sympathy," "...want to help"). In order to depict stigmatizing attitudes, the negative emotional reactions anger and fear are relevant for current analyses. Internal consistency (Cronbach's α) was 0.62 for the anger scale and 0.69 for the fear scale.

Desire for Social Distance. Respondents' desire for social distance was assessed by means of a scale developed by Link, Cullen, Frank, and Wozniak (1987), which is a modified version of the Bogardus Social Distance Scale (Bogardus, 1925). The scale contains seven items, each representing a social relationship: subtenant, coworker, neighbor, person one would recommend for a job, person of the same social circle, in-law, and child carer. Respondents could indicate to what extent they would accept the person described in the vignette using a 4-point Likert scale ranging from 1 "completely disagree" to 4 "completely agree" (plus "don't know" category). Principal component analysis (Varimax rotation) yielded a one-factor solution as in previous surveys on attitudes toward mental disorders (Makowski, Mnich, Ludwig, Daubmann, Bock et al., 2016). Thus, a sum score is used for current analyses. Internal consistency (Cronbach's α) of the scale amounted to 0.81. For current analyses, the scale was inverted so that higher scores represent a greater desire for social distance.

Statistical Analyses

Chi-square tests were performed to compare the demographic sample characteristics age, sex, and education with official statistics. Arithmetic means and standard deviations of the stigmatizing attitudes were calculated for the whole sample. To test for differences according to medical condition, age, and sex in the vignettes, analyses of

covariance (ANCOVA) were applied controlling for age, sex, and education of the respondents. Previous studies have shown that these sociodemographics affect stigmatizing attitudes (Angermeyer & Dietrich, 2006). Further, we controlled for own affliction ("Are you or have you been affected by suicidal thoughts yourself," yes/no) and contact to persons afflicted (yes/no). Estimated marginal means (EMM) display mean responses adjusted for the covariates. To counteract multiple testing, Bonferroni adjustment was applied. Thus, the significance level was set at $p \leq .01$. Finally, partial Eta^2 indicates the effect size. Thereby, partial Eta^2 of 0.01 represents a small effect, .06 a medium effect and from .14 on, one speaks of a strong effect (Cohen, 1988). All analyses were performed with the statistics software IBM SPSS 25.

RESULTS

Magnitude of Public Stigma toward Persons with Suicidal Thoughts

About 44% of the respondents rather or strongly agreed to the item "weakness of will" as a possible cause for suicidal thoughts (Table 2). Concerning emotional reactions, respondents agreed slightly less to reactions that are related to the dimension of anger (M = 1.50, SD = 0.60), compared to fear-related reactions (M = 1.90, SD = 0.73). About two thirds of respondents rather or strongly disagreed to the statement that they would feel and think similar in that situation. Concerning desire for social distance, respondents would accept a person with suicidal thoughts more in relationships such as neighbor or coworker and less in relationships such as subtenant or child carer.

Magnitude of Public Stigma toward Persons with Suicidal Thoughts—Comparison of Vignette Characteristics

Table 3 shows the estimated marginal means (EMM) of the stigma-related items and scores for the characteristics varied in the vignettes. Analyses are controlled for age, sex, and education of the respondents as well as personal experience with suicidal thoughts and contact to affected persons. Higher EMMs indicate more pronounced stigmatizing attitudes.

Possible Cause: "Weakness of Will"

In terms of medical condition and age of the described person, no significant differences in the agreement to the possible cause "weakness of will" were found. Respondents who heard the female vignettes expressed significantly more agreement to this cause than those who heard the male vignettes ($p = <.001$, partial $Eta^2 = 0.01$).

Separation between "Us" and "Them"

Disagreement with the statement "I would feel and think similar in that situation" was stronger when a person with depressive symptoms was depicted ($p < .001$, partial $Eta^2 = 0.06$). Separation between "us" and "them" was more pronounced in case of younger age ($p = <.001$, partial $Eta^2 = 0.01$) and female sex ($p = .008$, partial $Eta^2 = < 0.01$).

Desire for Social Distance

Desire for social distance was significantly more pronounced in case of the vignettes depicting depressive symptoms ($p = <.001$, partial $Eta^2 = 0.04$) and male sex ($p = .002$, partial $Eta^2 = 0.01$).

Emotional Reactions

Female suicidal persons evoked slightly more fear than male suicidal persons did ($p = .001$, partial $Eta^2 = 0.01$). Feelings of anger were more pronounced in case of the suicidal person with depressive symptoms ($p = .001$, partial $Eta^2 = 0.01$) and younger age ($p = .004$, partial $Eta^2 = <0.01$).

Effect sizes (partial Eta^2) of the different characteristics of the vignettes on the stigmatizing attitudes ranged from $Eta^2 = <0.01$ to 0.06. Thereby, medical condition of the

TABLE 2
*Means, Standard Deviations (SD), and Percentage (%) of Agreement/Disagreement for all Stigma-Related Items and Scores (*N *= 2,002)*

Items	Mean	SD	% rather/strongly agree
Cause of suicidal thoughts			
Possible cause for such thoughts is . . .weakness of will (1 = strongly disagree, 2 = rather disagree, 3 = rather agree, 4 = strongly agree)	2.34	0.98	44.1
Emotional reactions (1 = strongly disagree, 2 = rather disagree, 3 = rather agree, 4 = strongly agree)			
He/she scares me	1.83	0.95	23.6
I feel uncomfortable	2.11	0.96	37.2
I feel insecure	1.74	0.86	18.3
Score Fear	**1.90**	**0.73**	–
I react angrily	1.49	0.82	11.8
I react with incomprehension	1.56	0.80	11.4
I feel annoyed by this person	1.45	0.70	7.5
Score Anger	**1.50**	**0.60**	–

Items	Mean	SD	% rather/strongly disagree
Separation between "us" and "them"			
I would feel and think similar in that situation (1 = strongly agree, 2 = rather agree, 3 = rather disagree, 4 = strongly disagree)	2.98	1.01	65.4
Desire for social distance			
I would accept such a person as a. . . (1 = strongly agree, 2 = rather agree, 3 = rather disagree, 4 = strongly disagree)			
Subtenant	2.42	0.96	43.5
Coworker	1.59	0.68	7.8
Neighbor	1.94	0.82	19.8
Child carer	2.90	0.96	65.5
In-law	2.33	0.95	37.5
Person of the same social circle	2.17	0.90	30.2
Person one would recommend for a job	2.41	0.88	42.2
Score desire for social distance	**2.25**	**0.60**	–

Means and SD of the anger and fear scores (in bold).

suicidal person accounted for the largest effect.

DISCUSSION

The current study investigated public stigmatizing attitudes toward suicidal persons in Germany by focussing on differences concerning sex, age, and medical condition of the suicidal person. Data originated from a representative population survey by telephone conducted in 2018.

Possible Cause: "Weakness of Will"

About 44% of the respondents rather or strongly agreed that a possible cause of suicidal thoughts is "weakness of will." In this regard, it has to be kept in mind that

TABLE 3
Estimated Marginal Means of the Stigma-Related Items and Scores for the Different Vignettes

	Medical condition				Age				Sex			
Measure	Depressive symptoms (n = 888–910)[c]	Cancer diagnosis (n = 937-960)[c]	p*	Partial Eta^2	32 years old (n = 913–939)[c]	73 years old (n = 907–932)[c]	p*	Partial Eta^2	Female (n = 904 –923)[c]	Male (n = 917 –947)[c]	p*	Partial Eta^2
Possible cause: "weakness of will"[a]	2.33	2.36	.575	<0.01	2.34	2.35	.794	<0.01	2.43	2.26	**<.001**	0.01
"I would feel and think similar in that situation"[b]	3.20	2.75	**<.001**	0.06	3.07	2.86	**<.001**	0.01	3.03	2.91	**.008**	<0.01
Score desire for social distance[b]	2.37	2.13	**<.001**	0.04	2.22	2.27	.040	<0.01	2.20	2.29	**.002**	0.01
Score Fear[a]	1.87	1.92	.162	<0.01	1.89	1.89	.997	<0.01	1.95	1.84	**.001**	0.01
Score Anger[a]	1.54	1.45	**.001**	0.01	1.53	1.46	**.004**	<0.01	1.52	1.47	.089	<0.01

[a]1 = strongly disagree, 2 = rather disagree, 3 = rather agree, 4 = strongly agree.
[b]1 = strongly agree, 2 = rather agree, 3 = rather disagree, 4 = strongly disagree.
[c]Analyses are controlled for respondents´ age, sex, education and personal experience with suicidality (own affliction, contact to affected persons).
*Significant p-values (≤.01) are bold.

respondents also agreed to other possible causes which were not attributable to self-responsibility and thus not stigmatizing (e.g., lacking support through family and friends: 69.2%, difficulties in the access to help offers: 56.2%)."Weakness of will" was more often seen as a cause when the person in the vignette was a woman. Such negative assumptions about a group are often associated with attributions where the individual is primarily made responsible for their crisis (Barrowclough & Hooley, 2003). Following this, respondents may presumed self-responsibility more for female persons with suicidal ideation.

Separation between "Us" and "Them"

About two thirds of the respondents rather or strongly disagreed that they would feel and think the same as the person described in the vignette. This separation between "us" and "them" was more pronounced when the suicidal person in the vignette featured depressive symptoms. This characteristic accounted for the largest effect size ($Eta^2 = 0.06$). Empathy is associated with more positive attitudes toward a stigmatized group (Tarrant & Hadert, 2010), and our results indicate that respondents could empathize more with a suicidal person with somatic disease compared to one with mental disease.

Desire for Social Distance

Respondents would accept a person with suicidal thoughts in more distant relationships, such as neighbor or coworker and less in closer relationships (subtenant, child carer). Significant variations in the desire for social distance were found for medical condition and sex with medical condition accounting for the largest effect ($Eta^2 = 0.04$). Additional analyses comparing the single items of the desire for social distance scale due to medical conditions (not shown in detail) revealed that the rejection in all seven items of the scale was significantly higher for the vignette with depressive symptoms compared to the cancer vignette. Stronger desire for social distance toward those afflicted by a mental illness was also found in a study from New Zealand in which persons suffering either from schizophrenia, depression, or skin cancer were compared. Participants showed a greater willingness to interact with the person with skin cancer compared to the respective mental disorders (Breheny, 2007). However, when interpreting results concerning desire for social distance, it has to be kept in mind that the protagonists of the vignettes are in an acute crisis and respondents may not think that they are capable of being a child carer, at work, or searching for a job in that situation.

Emotional Reactions

In terms of negative emotional reactions, the described suicidal persons generally evoked more feelings of fear than of anger. Prosocial reactions to people with suicidal thoughts, that we also assessed, were most prevalent (not shown in detail). A recent online survey that compared negative emotional reactions toward depressed persons, suicide attempters, and persons that died by suicide found—opposite to our findings—that among all groups, feelings of anger were more often pronounced than feelings of fear (Sheehan, Dubke, & Corrigan, 2017). However, the description of a person that already attempted or even died by suicide probably yields reinforced and differential emotional reactions and are therefore not really comparable to our findings that focus on persons with suicidal thoughts.

In our survey, the female vignettes evoked slightly more fear than the male vignettes. This difference appears very small and studies in the field of mental illness stigma yielded inconsistent results (Braunholtz et al., 2007; Jorm & Griffiths, 2008; Schnittker, 2003).

Strengths and Limitations

Due to the telephone survey, a large national sample could be accessed in an efficient manner. Although a response rate of 47% can be considered sufficient, a selection

bias due to nonresponse cannot be precluded. Further, we cannot rule out that persons with experience concerning the topic or those who are more open toward it are more likely to participate and persons that reject to give a telephone interview about suicidality may also show more stigmatizing attitudes.

The use of case vignettes allows for consistency between conditions and minimizes social desirability bias since persons are responding to a fictitious situation. However, they have to be short and it remains unclear to what extent our results reflect attitudes as they would occur in real-life social situations with more complex circumstances. Brevity was also reason for not giving more details about the medical condition (e.g., causes). It is likely that such details would have modified stigmatizing attitudes.

For reliability analysis, Cronbach's α was calculated to assess the internal consistency of the scales. Internal consistencies of the two subscales of negative emotional reactions ranged between 0.62 (anger) and 0.69 (fear). These relatively low values can be attributable to the small number of items (3) used to measure the two subscales. A comparison with other studies using this scale in the context of mental illness stigma shows that this problem is common (Makowski et al., 2015; Makowski, Mnich, Ludwig, Daubmann, Bock et al., 2016). This points out that the low internal consistency is not a specific problem of the application in suicide stigma. Overall, results concerning emotional reactions should be interpreted with caution and future research should critically reflect the application of these scales that are frequently used in stigma research. Internal consistency of the desire for social distance scale (seven items, Cronbach's $\alpha = 0.81$) can be considered satisfying (Blanz, 2015).

Although we found differences according to the characteristics age, sex, and medical condition in the vignettes, it is debatable how meaningful these differences are because with an effect size of partial $Eta^2 = <0.01$ to 0.06, the explanatory power of the characteristics is rather limited. Nevertheless, our results indicate that variations in the magnitude of stigmatizing attitudes are mainly due to the medical condition of the suicidal person.

Implications

Public stigmatization can affect help-seeking behavior and may lead to an additional suicide risk. Public stigma can be reduced by awareness campaigns and contact-based interventions (Borschmann, Greenberg, Jones, & Henderson, 2014; Corrigan, Morris, Michaels, Rafacz, & Rüsch, 2012; Henderson, Evans-Lacko, & Thornicroft, 2013). Our results suggest that groups that are at special risk of being stigmatized should be subject of such antistigma programs (e.g., young and female suicidal persons that feature depressive symptoms). Campaign messages should focus on suicidality as a complex phenomenon with several internal and external causes (World Health Organization, 2014) and highlight attributions that absolve the individual of an exclusive responsibility (Barrowclough & Hooley, 2003). Contact-based interventions could also help to reduce negative assumptions about persons with suicidal ideation and reinforce empathy toward affected persons (Borschmann, Greenberg, Jones, & Henderson, 2014; Corrigan, Morris, Michaels, Rafacz, & Rüsch, 2012).

As this is one of the first studies analyzing variations in suicide stigma according to characteristics of affected persons, more research is needed to understand the patterns of variation in order to strengthen the present findings and to shape interventions that aim to reduce public suicide stigma.

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APPENDIX 1 VIGNETTES

MENTAL DISORDER (DEPRESSION)

The 32-/73-year-old Johanna D./ Johannes D. feels depressed and sad since a couple of months. Mrs./Mr. D. feels useless, has the impression to do everything wrong, and lost any interest in the things that brought joy to her/ him. She/He doubts that her/his life has any sense and with increasing frequency thinks about taking her/his own life.

SOMATIC DISORDER (CANCER)

The 32-/73-year-old Johanna D./ Johannes D. knows since a few months that she/he is suffering from cancer. Currently, Mrs./Mr. D. feels constantly exhausted and suffers from nausea and pain. She/He feels hopeless and is scared that the disease is further progressing. She/He doubts that her/his life has any sense and with increasing frequency thinks about taking her/his own life.