

Veterinary Wellness Bien-être vétérinaire

Suicide in veterinary medicine: Let's talk about it

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Suicide and non-fatal suicidal behavior are major public health problems across the world: approximately 1 million people worldwide die by suicide each year. In fact, the number of lives lost through suicide exceeds the number of deaths due to homicide and war combined. Beyond the tragedy of life lost, there is the devastating human cost to family, friends, and colleagues, a cost carried forward with lasting impacts and lifelong repercussions. Suicide is injurious, both deeply and widely.

Several studies have identified a link between suicide and occupation (1), including the healthcare professions and our own profession. The rate of suicide in the veterinary profession has been pegged as close to twice that of the dental profession, more than twice that of the medical profession (2), and 4 times the rate in the general population (3).

No matter where we live, what we do, and what our state of the world, we share the common experiences of joy and sadness, face strife and hardship, and struggle to meet life's challenges. Sometimes "the stuff of life" can pile up, leaving us overwhelmed, depressed, and feeling alone. It can even push us over the edge to thoughts of suicide. The 2012 CVMA National Survey Results on the Wellness of Veterinarians ($n = 769$) found that 19% of respondents had seriously thought about suicide and 9% previously attempted suicide (4). Of those who had seriously thought about it ($n = 135$), 49% felt they were still at risk to repeat. The risk is real. The numbers are compelling.

As Halliwell and Hoskin (2) indicate, "We must develop a greater awareness within the veterinary profession of the issue of suicide, and of the predisposing signs and of the warning signs. There is ample evidence that bringing these issues out into the open, rather than bottling them up, is of great assistance in preventing suicides." Although the stigma associated with suicide has been an important barrier to discussing the issue (5), we need to open the dialogue in the hope that with increased awareness we can reduce the numbers — and stem the tragedy. It's time we talk about it.

Separating the myths from the facts

Know the facts! They will help you recognize the warning signs, respond appropriately, and even save a life.

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Myth #1: Talking about suicide may give someone the idea.

Talking about suicide does *not* create or increase risk. The best way to identify the intention of suicide is to ask directly. When someone is given the opportunity to talk, the threat to carry through with suicide diminishes.

Myth #2: People who talk about suicide should not be taken seriously.

Suicidal talk is a major warning sign for suicidal risk and should *always* be taken seriously. The myth suggests that suicidal talk is just attention-seeking behavior, while in truth it is an invitation to help the person to live. If help isn't forthcoming, especially after they've made themselves vulnerable by having disclosed sensitive thoughts and feelings, they may feel it will never come. Without appropriate response, suicidal talk — which begins with suicidal thoughts — can escalate to suicidal acts.

Myth #3: Once someone has attempted suicide, they will not attempt again.

People who have attempted suicide are the most at-risk for future attempts. The rate of suicide is 40 times higher for those who have already attempted. The foremost predictor of a future suicide is a past attempt.

Myth #4: Most suicides are caused by one sudden traumatic event.

A sudden traumatic event may trigger the decision to take one's life, but suicide is most often a result of events and feelings that have added up over a long period of time.

Myth #5: A suicidal person clearly wants to die.

What a suicidal person most often wants is *not* to actually carry through with suicide, but to avoid life in its present form and find a way to handle the circumstances that are difficult and impossible to bear.

Myth #6: Suicide is generally carried out without warning.

A person planning suicide usually gives clues about their intentions, although in some cases, intent may be carefully concealed.

Myth #7: Males have the highest rate of suicidal behavior in North America.

Males die by suicide approximately 4 times more often than females, yet females attempt suicide approximately 4 times more often than males. Females, therefore, have the highest *rate* of suicidal behavior.

Myth #8: The risk of suicide is highest around Christmas.

The rate of suicide is actually fairly constant throughout the year, with a slight rise in January, *after* the holidays, and peak in early spring. The holiday season can be a protective factor for those at risk. The “time of togetherness” can increase feelings of connectedness and the obligation to make it through the holidays in the interest of harmony.

Myth #9: Pet ownership reduces the risk of suicide.

Anecdotally it may seem that pet ownership is protective, but research has not demonstrated an association between pet ownership and suicide. In fact, the loss of a beloved pet can be a risk factor *for* suicide.

Myth #10: Animals die by suicide.

Although folklore includes tales of suicide among animals, modern naturalistic studies of thousands of animal species in field situations have not identified suicide in nonhuman species. Death by suicide is strictly a human phenomenon.

The risk factors

The widely acknowledged risk factors for suicide in the general population include personality factors, depression (as well as other forms of mental illness), alcohol and drug abuse, inherited factors, and environmental factors (including chronic major difficulties and undesirable life events) (6). Although the specific factors contributing to the increased rate of suicide in the veterinary profession have not yet been determined (5), thanks to the recent work of Bartram and Baldwin (3), we have a starting point in better understanding the issue. Bartram and Baldwin (3) designed a comprehensive hypothetical model to exemplify the risk, pointing to a confluence of interrelated and potentially compounding factors. According to Bartram and Baldwin (3,7), the following factors may contribute to the increased risk of suicide in our profession: personality factors, undergraduate training, professional isolation, work-related stressors, attitudes to death and euthanasia, access to and knowledge of means, psychiatric conditions, stigma around mental illness, and suicide contagion.

Personality factors

Veterinarians tend to be high achievers, and high achievers have tendencies to perfectionism, conscientiousness, and neuroticism, all of which can be risk factors for mental illness. Similarly, veterinarians with a preference for working with animals rather than people, may have a higher risk of depression as a result of relative social isolation.

Undergraduate training

Halliwell and Hoskin (2) suggest that the very high academic entry requirements into veterinary schools may be linked with increased vulnerability to suicide. However, others report a negative association between intelligence and suicide (8), making the association unclear, but worthy of consideration. It's also been suggested that the highly demanding curriculum and pressures to succeed in veterinary school may preclude the expected growth of emotional intelligence and social skills in

that critical juncture of life, limiting the development of coping skills and resilience.

Professional isolation

Many veterinarians in private practice work in relative isolation where there is often little supervision and access to assistance from veterinary colleagues, an environment ripe with the potential for professional mistakes. The considerable emotional impact of such mistakes may contribute to the development of suicidal thoughts (9).

Work-related stressors

Inadequate professional support and professional mistakes, along with other work-related stressors such as long working hours; after hours on-call duties; conflictual relationships with peers, managers, and clients; high client expectations; unexpected clinical outcomes; emotional exhaustion (compassion fatigue); lack of resources; limited personal finances; concerns about maintaining skills; and the possibility of client complaints and litigation can all contribute to anxiety and depression, which increase vulnerability. Long-term exhaustion (burnout), characterized by disillusionment and demoralization, may also increase vulnerability.

Attitudes to death and euthanasia

Veterinarians in private practice are commonly required to engage in the active ending of life, with strong beliefs in quality of life and humane euthanasia to alleviate suffering. Likewise, those in food production are required to end the lives of animals via the slaughter of livestock. Active participation in the ending of animal life may alter views on death and the sanctity of human life, and in the face of life's challenges, enable self-justification and reduce inhibitions towards suicide, making suicide seem a rational solution.

Access to and knowledge of means

Veterinarians have access to and knowledge of prescription medications (including drugs for anesthesia and euthanasia), increasing the potential for misuse. With ready access and knowledge, such substances could be used not only as a (maladaptive) means of coping, but also as a means to suicide, potentially being a key factor in the high rate of suicide in the profession (10).

Psychiatric conditions

Just as mental illnesses such as depression and substance misuse and dependence are associated with suicide in doctors (11), by extension, they may also be a factor in suicide by veterinarians. Two-thirds of people who die by suicide suffer from a depressive illness.

Stigma around mental illness

The stigma around mental illness is known to influence the accessing of mental health services. Such stigma may be particularly problematic for those working in professions in which their identity is firmly entrenched as “the helper.” The need for “helpers” to seek rather than offer help, especially as it relates to mental health, may be perceived as a sign of weakness,

engendering feelings of guilt and shame as well as worry about career implications. Stigma is problematic, as it reduces help-seeking behavior, thereby enabling suicide planning.

Suicide contagion

The increased vulnerability to suicide as a result of direct or indirect exposure to the suicidal behavior of others, known as suicide contagion (12), may contribute to the increased risk in veterinarians. Awareness of a death by suicide can travel readily among members of a relatively small profession. This, along with the awareness of the risk in the profession as a whole, may increase risk.

Protective factors

Just as there are factors that contribute to the risk of suicide, there are factors that reduce the risk (13,14). Factors known to reduce the risk include having a caring family and good friends (i.e., a strong social network), pregnancy and motherhood (i.e., the maternal bond), and a stable home environment. The willingness to seek help is also protective, giving those who recognize the need for and value of assistance the edge to build resilience. Likewise, proper interventions (diagnosis and treatment) are protective. In addition to these factors, a recent study investigating the protective factors against suicide in the veterinary profession identified the sense of responsibility to family and the belief in the necessity to cope with suicidal thoughts as protective (15).

Warning signs

Be aware of the warning signs! With awareness you can better know when to step forward to lend a hand — to support the health and wellbeing of a colleague, friend, or family member, and even save a life. The 3 cardinal warning signs are clinical depression, changes in behavior, and talk about suicide.

The rate of suicide for those with clinical depression is about 20 times greater than in the general population (16). Clinical depression is not just feeling a little sad or “down-and-out” or having an “off” day or two. It is much more pervasive and manifests as a combination of symptoms so potent and wide-ranging that they can interfere with the ability to work, study, sleep, eat, and enjoy once pleasurable activities. Symptoms include feelings of sadness, helplessness, hopelessness, and worthlessness; low energy; difficulty concentrating; irritability, anger, and hostility; loss of interest in usual activities; changes in appetite and sleep patterns; and thoughts of dying. The aspect of depression that appears to be most closely associated with suicide is the sense of hopelessness.

Changes in behavior, especially if out of character or questionable, are strongly associated with the risk of suicide. Recklessness, such as over-drinking, speeding, and promiscuity, and withdrawal from usual enjoyed activities are 2 key behavioral changes to be aware of. Other changes include visiting or calling people (to say goodbye), giving away prized possessions, acquiring lethal means (e.g., purchasing a gun), and increasing the use of alcohol or drugs. Even a positive change, such as a sudden turnaround in someone who has been depressed, can be a warning sign. Rather than signifying improvement, it can indicate acceptance of suicide as the answer and the plan to do the things they care about “one last time.”

The risk is overt if there is talk about suicide — of having no reason to live, being a burden to others, being in unbearable pain, and wanting to hurt or kill one’s self. The presence of a plan is especially of concern. The more specific, detailed, lethal, and feasible the plan, the greater the risk.

How to respond: Be there and care

What can you do to help a depressed or suicidal colleague? The motto to follow: *be there and care*. As uncomfortable as the situation may be for you, just imagine how it is for your colleague if they’re reaching the end of their rope. Remember, suicide is a permanent “solution” to a temporary problem. Suicidal impulses are often brief, at the point when the person feels hopeless. The situation can and will change. Remember too that suicide is not an individual, but a community issue. Humans are social beings who thrive — and survive — within community. Here’s how you can *be there and care*:

1. Approach the person.
2. Ask how they are feeling.
3. Listen with care and concern.
4. Ask if they have suicidal thoughts.
5. If they do, find a crisis hotline and stay by their side as they make the call.
6. If they do but refuse to call, call a crisis hotline yourself for guidance. It is imperative to access professional support, direction, and services as needed.
7. Assure them that things can and will change.
8. Stay with them, and recruit the company of trusted others (as warranted), until you know the person is safe with the necessary supports in place.
9. When it is safe to leave, make specific plans to see them the next day so they have a reason to hang on for one more day.

The first step may be the hardest, but it’s the right thing to do. Despite your every effort, however, remember that you cannot take responsibility for someone else’s life — the decision is ultimately their own. You may, however, be able to help them find hope and see other ways of dealing with their problems and pain, and help them seek the support they need. Professional assistance can make all the difference.

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Answers to Quiz Corner

Les réponses du test éclair

1. c) Doxycycline is the drug of choice for empirical treatment of tick-borne rickettsial diseases as well as for borreliosis.
c) La doxycycline est le médicament de choix comme traitement empirique des rickettsioses transmises par les tiques ainsi que pour la borréliose.
2. c) Like all NSAIDs, carprofen can induce gastrointestinal (GI) ulcers. Carprofen has been associated with idiosyncratic reactions, but they target the liver.
c) Comme tous les anti-inflammatoires non stéroïdiens, le carprofène peut provoquer des ulcères gastro-intestinaux. Le carprofène a été associé aux réactions idiosyncrasiques, mais a pour cible le foie.
3. a) *Dicentra* can cause neurological signs, philodendrons can cause oral and gastrointestinal irritation (GI), rhododendrons can cause GI and neurological problems, and kalanchoes are potentially cardiotoxic. Lilies are the only plants listed that can cause renal disease.
a) *Dicentra* peut causer des signes neurologiques, les philodendrons des irritations orales et gastro-intestinales, les rhododendrons peuvent causer des problèmes gastro-intestinaux et neurologiques et les kalanchoés sont potentiellement cardiotoxiques. Les lys sont les seules plantes énumérées qui peuvent causer une maladie rénale.
4. d) Aversion therapy is usually effective at treating cribbing.
d) La thérapie par aversion est habituellement efficace contre le tic à l'appui.
5. d) Injection lesions can be trimmed out from the carcass' neck without detracting from the value of the cut. This is not true of hindquarter cuts. The neck is often less safe and convenient to inject than the hindquarters because of the difficulty in restraining the head and neck. All intramuscular injections are painful. Commonly used injection sites have equal lymphatic drainage.
d) On peut réaliser le parage des lésions dues aux injections dans le cou sans affecter la valeur monétaire de la coupe. Ceci n'est pas vrai pour les coupes provenant des quartiers postérieurs. Le cou est souvent moins sécuritaire et commode à utiliser pour les injections que les quartiers postérieurs à cause de la difficulté de contention de la tête et du cou. Toutes les injections intramusculaires sont douloureuses. Les sites d'injections communément utilisés possèdent le même drainage lymphatique.