THIS IS YOUR LIFE: LET'S TALK ABOUT IT

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Suicide and non-fatal suicidal behaviour are major public health problems across the world. Data from the WHO indicate that 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 (Agerbo 2007), including the healthcare professions – and most recently, 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 (Halliwell and Hoskin 2005), and four times the rate in the general population (Bartram and Baldwin 2008).

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 feeling overwhelmed, depressed, and 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. Of those who had seriously thought about it (n = 135), 49% still felt they were at risk to repeat. The risk is real. The numbers are compelling.

As Halliwell and Hoskin (2005) forward, "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 (Platt et al 2012), more of us than ever before are pushing for dialogue in the hope that with increased awareness we can reduce the numbers. It's time we talk about it.

Separating The Myths From The Facts

It's important to know the facts. They can help you recognize the warning signs, respond appropriately, and even save the life of a friend, family member, or colleague.

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

Myth #8: Pet ownership reduces the risk of suicide.
Anecdotally it may seem that pet ownership is protective, but research to-date has not demonstrated a material association between pet ownership and suicide. In fact, the loss of a beloved pet can be a risk factor *for* suicide.

Risk And Protective Factors

Personality factors, depression (and other forms of mental illness), alcohol and drug abuse, inherited factors, and environmental factors (including chronic major difficulties and undesirable life events) are widely known to be the key risk factors for suicide (Goldney 2005). The factors of risk specific to the veterinary profession, contributing to the high rate of suicide, have not yet been studied (Platt et al. 2012), but thanks to the inaugural work of Bartram and Baldwin (2008), we have a starting point in better understanding the issue of suicide in our profession. Bartram and Baldwin have designed a comprehensive hypothetical model to exemplify the risk, pointing to a confluence of interrelated and potentially compounding factors. According to Bartram and Baldwin (2008, 2010), the following factors may contribute to the risk of suicide in veterinarians: personality factors, undergraduate training, professional isolation, work-related stressors, attitudes to death and euthanasia, psychiatric conditions, access to and knowledge of means, stigma around mental illness, and suicide contagion.

Personality factors. Those who are drawn to a career in veterinary medicine may have a preference for working with animals rather than people, and may, therefore, be at greater risk of social isolation and consequent depression. Veterinarians also tend to be high achievers. High achievers have tendencies to perfectionism, conscientiousness, and neuroticism, all of which can be risk factors for mental illness.

Undergraduate training. Halliwell and Hoskin (2005) suggested that the very high academic entry requirements into veterinary schools may be linked with increased vulnerability to suicide. Others (Gunnel et al. 2005), however, have reported a negative association between intelligence and suicide, making the association unclear, but worthy of consideration. It's also been suggested that the highly demanding veterinary curricula and pressures to succeed in school may preclude the growth of social skills and emotional intelligence which enhance coping, limiting the development of resilience.

Professional isolation. Many veterinarians in private practice work in relative isolation where there is often very 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 (Mellanby and Herrtage 2004).

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 increases 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 involvement in ending animal life may alter views on death and the sanctity of human life, and in the face of ongoing troubles, enable self-justification and reduce inhibitions towards suicide, making suicide seem a rational solution.

Psychiatric conditions. Just as mental illnesses such as depression and substance misuse and dependence are associated with suicide in doctors (Hawton et al. 2004), 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.

Access to and knowledge of means. Although alcohol is the most commonly misused substance, veterinarians have access to and knowledge of prescription medications (including drugs for anaesthesia 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 (Hawton 2007).

Stigma around mental illness. The stigma surrounding mental illness is known to influence the accessing of mental health care. Such stigma may be particularly problematic for those working in professions where 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 of career implications. Stigma is problematic, as it reduces help-seeking behaviour, and in this way, enables suicide planning.

Suicide contagion. The increased vulnerability to suicide as a result of direct or indirect exposure to the suicidal behaviour of others, known as suicide contagion (Maris et al. 2000), may contribute to the risk in veterinarians. Awareness of a death by suicide can travel readily between members of a relatively small profession. This, along with the awareness of the risk in the profession as a whole, may reduce inhibitions.

Just as there are factors that contribute to the risk of suicide, there are factors known to be protective (Centre for Suicide Prevention 2014). Not surprisingly, these include a strong social network of family and friends, pregnancy, motherhood, 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 what is generally known, the sense of responsibility to family and the belief in the necessity to cope with suicidal thoughts was identified as protective in a recent study investigating the protective factors against suicide in the veterinary profession (Bourdet-Loubere 2006).

The Warning Signs

The rate of suicide for those with clinical depression is about 20 times greater than in the general population (Pope and Vasquez 2011). 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 behaviour, especially if they seem 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 two key behavioural 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 oneself. 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 is "be there and care." As uncomfortable as the situation may be for you, just imagine how it is for your colleague if they're feeling like

they're reaching the end of their rope. Remember, suicide is a permanent solution to a temporary problem. The situation can and will change. And remember too, that suicide is not an individual, but a community issue. We are our fellow's keeper. It is within community that we survive and thrive. 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 help, call a crisis hotline yourself for guidance on how to proceed.
7. Assure them that things can and will change.
8. Stay with them. Do something together. Recruit the company of trusted others as warranted.
9. When the situation 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. Help them seek the help they need. Professional assistance can make all the difference.

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