

Why do psychiatrists commit suicide? Denial or stigma?

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SUMMARY

Objective: Suicide is a complicated public health issue. Despite the expectation that psychiatrists have the most knowledge of suicide from a biopsychosocial perspective, there are few studies assessing the mental health and suicide rates of psychiatrists. This study aims to assess the suicide-related attitudes and behaviors of mental health professionals, as well as the stigma associated with suicide.

Method: This cross-sectional survey was conducted with psychiatrists (resident in psychiatry and specialist) in Turkey. An online survey was created via the Google Forms public web address. Online questionnaires were delivered through Google Forms by emailing and messaging on WhatsApp, Telegram, Google and Yahoo groups. The study was performed between November 23, 2022 and February 23, 2023. The Socio-demographic Information Form and the Stigma of Suicide Scale (SOSS) were used to evaluate the participants.

Results: 225 psychiatrists participated in the study. All participants reported low levels of stigmatization related to suicide. Assistant physicians had significantly higher scores in the elevation/norming subscale compared to specialist physicians ($p=0.018$). Participants who believe in a religion received significantly higher scores in the stigmatization and isolation/depression subscales compared to those who do not believe ($p=0.006$, $p=0.003$, respectively). Participants without a history of suicidal ideation received significantly higher scores in the stigmatization subscale compared to those who have had suicidal ideation ($p=0.004$).

Discussion: Although the stigma scores related to suicide reported by the participants were low, we know that the suicide rates among psychiatrists are high. Psychiatrists may hide, deny, and rationalize their feelings, thoughts, and beliefs about suicide

Key Words: Suicide, social stigma, denial, psychiatrists

INTRODUCTION

Suicide and suicide attempts, which can be seen in people of all ages around the world, are a complex public health problem. According to the World Health Organization, approximately 800,000 people die by suicide each year (1), and it is estimated that the number of people who attempt suicide is at least three times this figure. The devastating consequences of suicide become even more significant when considering the affected families, friends, and communities of each person who dies by suicide.

Studies have reported that physicians have higher suicide rates than the general population (2). A meta-analysis published in 2019 indicated that sui-

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cide rates among physicians are higher than in the general population, and the risk varies among countries. Female physicians are more at risk, and anesthesiologists and psychiatrists have higher suicide rates compared to other physician groups (3). Personality traits such as intense work conditions, perfectionism, and an excessive sense of responsibility, as well as difficulties in balancing personal and professional life, are associated with physician suicide (4).

There are a limited number of studies evaluating the mental health and suicide rates of psychiatrists, despite there being many studies on physician suicides in general (5-8). It is noteworthy that despite psychiatrists being expected to have the best know-

ledge of suicide from a biopsychosocial perspective, as well as approaches and prevention methods, there are few studies on this topic. Although it is well known that psychiatrists are at higher risk of suicide compared to other specialties, the reasons for the high suicide rates among them should be discussed and investigated. Factors leading to high suicide rates among psychiatrists, which are largely preventable and emphasized at every opportunity, need to be studied. Stigma associated with suicide, which can cause patients to avoid seeking medical help, ignore their illness, or self-treat, can be a significant factor in suicides among psychiatrists. This study aims to evaluate the attitudes and behaviors of mental health professionals that may be related to suicide, as well as the level of stigma associated with suicide.

METHODS

The population and sample

This study is a cross-sectional study. The population of the study consists of mental health professionals (psychiatry residents and specialists) working in Turkey. Doctors who graduate from medical school in Turkey are entitled to receive training in the field of mental health and illnesses by passing a specialization exam. After completing their 4 or 5-year education, they become specialists in mental health and illnesses. When planning the study, the minimum sample size was calculated to represent the population of psychiatrists. The sample size was calculated using the following formula: "Sample size $n = \frac{[DEFFNp(1-p)]}{[(d2/Z21-a/2(N-1)+p*(1-p)]}$." The total number of psychiatrists in Turkey is 3330 (n), and based on a 5% margin of error, an 80% confidence interval, and a 50% assumed frequency of results, the minimum sample size was calculated as 157 participants using the OpenEpi, Version 3, open-source calculator.

Data Collection

Snowball sampling method was used as the data collection method in the study. The Socio-demographic Information Form and the Stigma Toward Suicide Scale were used to evaluate the participants. For this purpose, a survey was created specif-

ically for the research using "Google Forms" web address. The link containing the research questions was shared on e-mails and social media platforms where psychiatrists were present. Those who agreed to participate in the research gave their consent to participate in the study.

Materials

Socio-demographic information form: The form was created by the researchers after reviewing relevant literature and examining similar studies. The form includes a total of 18 questions, including socio-demographic characteristics such as age, gender, and marital status. In addition to this information, there are also questions regarding alcohol and substance use, psychiatric consultation, self-medication, and suicidal ideation and attempts.

Stigma of Suicide Scale (SOSS): The scale contains a set of one or more word phrases that describe someone who has committed suicide (e.g., 'selfish', 'cowardly', 'brave'). It was developed by Batterham and colleagues (9) in 2013. The validity and reliability studies of the Turkish version of the scale were conducted by Öztürk, Akın, and Durna (10) in 2016. SOSS has a three-dimensional structure, with one of the dimensions evaluating stigmatization towards people who died by suicide, another dimension associating suicide with isolation or depression, and the last dimension including items related to the normalization or glorification of suicide (10). The Turkish version of the Stigma of Suicide Scale had an intraclass correlation coefficient value of 0.93. Cronbach's alpha values were found to be 0.90 for the total scale, 0.90 for the stigma sub-scale, 0.87 for the isolation/depression sub-scale, and 0.79 for the normalization/glorification sub-scale.

Ethical Approval

The study was approved by the Gazi University Ethics Committee on 22.11.2022 with Research Code No. 2022-1324

Statistics

The data on demographic characteristics of the sample and scores obtained from the scales were analyzed using the Kolmogorov-Smirnov test to assess normal distribution and descriptive statistics were used. Descriptive values are presented as number (n), percentage (%), mean, and standard deviation (SD). Cronbach's Alpha coefficient was used to evaluate the internal consistency reliability of each subscale score of SOSS. Independent T-Test was used to measure differences between groups divided according to parameters such as work experience, gender. Statistical analyses were conducted using the SPSS 22 program. $p < 0.05$ was considered statistically significant.

RESULTS

225 individuals working in the field of mental health and illness participated in the study. The mean age of the participants was 37.74 ± 9.05 years, and the mean length of service in the field was 11.73 ± 8.40 years. Other sociodemographic data of the participants are shown in Table 1.

Answers to questions prepared by the researchers regarding the individual's psychiatry application, self-medication, psychotropic drug abuse, family history, alcohol and substance use, presence or absence of suicidal ideation or attempts, and psychiatrists' attitudes towards suicide risk are presented in Table 2.

The participants were divided into groups based on gender, experience, religious beliefs, presence of suicidal ideation, and whether they practiced self-medication, and were compared in terms of SOSS subscales in Table 3. As a result, psychiatry residents had significantly higher scores in the elevation/norming subscale compared to specialist physicians ($p = 0.018$). Individuals who believe in a religion received significantly higher scores in the stigmatization and isolation/depression subscales compared to those who do not believe ($p = 0.006$, $p = 0.003$, respectively). Finally, individuals without a history of suicidal ideation received significantly higher scores in the stigmatization subscale compared to those who have had suicidal ideation

Table 1 Socio-demographic characteristics of the participants

	n	%
Gender		
Female	149	66.2
Male	76	33.8
Marital status		
Married	149	66.2
Single	59	26.2
Widow	1	0.4
Divorced	16	7.1
Childhood income level		
Low	38	16.9
Medium	145	64.4
High	42	18.7
Do you drink alcohol three or more times a week?		
Yes	13	5.8
No	212	94.2
Have you ever used a substance at least once in your life?		
Yes	65	28.9
No	160	71.1
Do you consider yourself a regular substance user?		
Yes	2	0.9
No	223	99.1
Does your family have a history of mental illness?		
Yes	136	60.4
No	89	39.6
Do you follow a religion?		
I have no faith in any religion.	115	51.1
I believe in a faith	110	50.9

($p = 0.004$). In our study, Cronbach's alpha values were 0.942 for the total scale, 0.943 for the stigmatization subscale, 0.890 for the isolation/depression subscale, and 0.838 for the elevation/norming subscale.

DISCUSSION

The aim of this study was to evaluate the suicidal thoughts, attempts, and factors related to suicide among physicians working in the field of mental health, as well as the level of stigma related to suicide. Suicide and/or suicide attempts are complex issues with no single cause or solution. Biological factors such as genetic predisposition, childhood psychological trauma, early loss, and psychiatric illness are the same in everyone as factors that increase the risk of suicide (11). The higher suicide rates among physicians and psychiatrists appear to require us to focus more on psychosocial factors rather than these biological factors.

A total of 225 physicians working in the field of psychiatry participated in our study. Looking at the socio-demographic data, the average age of the physicians participating in our study was 37.74, and their average duration of experience in psychiatry was 11.73 years. Suicide is reported as the second

Table 2. Questions asked to participants about suicide and related situations

	n	%
Have you ever visited a psychiatrist for mental distress?		
Yes	124	55.4
No	101	44.6
If you have any mental complaints		
I commence self-medication	99	44.0
I consult my psychiatrist friends.	18	8.0
I consult a senior I trust.	59	26.2
I refer to a psychiatrist I don't know personally.	49	21.8
Have you ever used psychotropic drugs for a short or long period of time without thinking you had a mental disorder?		
Yes	82	36.4
No	143	63.6
Have you ever had suicidal thoughts before?		
Yes	101	44.9
No	124	55.1
Have you ever attempted suicide?		
Yes	13	5.8
No	212	94.2
In the past week, have you considered death a good alternative?		
Yes	17	7.6
No	208	92.4
How does the risk of suicide among psychiatrists compare to other medical specialties, in your opinion?		
Lower	11	4.9
Equal	64	28.4
Higher	150	66.7

most common cause of death among individuals aged 15-29 worldwide (1). Despite the fact that the age average of our participants is outside of this range, 44.9% of the participants reported previous suicidal thoughts and 5.8% reported previous suicide attempts. Although they have an older age average, these reported rates raise questions about whether the rates are higher in younger physicians in their residency period.

In our study, although 55.4% of all participants reported having been examined by a psychiatrist before, 44% reported that they would start medication on their own if they had a mental complaint, while 34.2% reported that they would consult a psychiatrist friend or trusted mentor, and 21.8% reported that they would go to a psychiatrist whom they had never met. The rate of those who reported using psychotropic drugs, either short or long term, despite not considering themselves to have any mental disorders was 36.4%. We do not know when those who reported having been examined by a psychiatrist in the past were examined. However, nearly half of them reported that they would start medication on their own if they had a complaint. This finding is consistent with studies that report high

rates of self-treatment among psychiatrists (6). This can be explained in several ways: the cultural belief that knowledge about mental illnesses can protect those who treat them from becoming ill themselves, the belief that "I should not/ cannot have a mental problem," and the denial of mental distress experiences. On the other hand, the continuation of symptoms and their ease of access may have also led to self-treatment behavior. In our country and worldwide, pharmacotherapy is often recommended as the primary treatment for most mental disorders, but it is also known that medication alone is often not enough (6). A physician who believes more in biological psychiatry may also prefer to start treatment on themselves, like in other branches. While this behavior may be reasonable for mild-to-moderate depression or anxiety disorders, it may prevent appropriate and accurate treatment services for mental disorders such as alcohol-substance use disorders, bipolar affective disorders, and psychotic disorders where insight can be impaired, and reality assessment can be distorted. However, in our country, there are no restrictions on physicians prescribing medication to themselves for diagnosis or drug-related reasons. This situation may increase the risk of suicide both in relation to self-treating inadequately and in relation to

Table 3. Comparison of the participants, who were divided into groups based on a number of parameters, depending on their SOSS subscale scores.

	Mean-SD	Stigma			Isolation/depression				Glorification/normalization			
		f	t	p	Mean-SD	f	t	p	Mean-SD	f	t	p
Gender												
Female	1,82-0,48	1,947	-0,821	0,413	3,56- 0,55	0,282	0,205	0,838	2,25- 0,53	1,365	1,104	0,272
Male	1,89-0,58				3,54-0,55				2,16- 0,60			
Experience												
Residents (n=68)	1,89- 0,50	0,555	0,870	0,386	3,65-0,56	0,002	1,754	0,082	2,35-0,53	0,373	2,403	0,018
Specialists (n=157)	1,83-0,53				3,51-0,54				2,16-0,56			
Religious												
No (n=114)	1,76-0,49	0,040	-2,777	0,006	3,44-0,58	2,695	-3,053	0,003	2,17-0,55	0,050	-1,456	0,147
Yes (n=109)	1,95-0,52				3,66-0,50				2,28-0,55			
Suicidal ideation												
Yes (n=101)	1,77-0,51	1,352	-2,922	0,004	3,54-0,59	3,360	-2,242	0,809	2,24-0,64	9,341	0,563	0,547
No(n=124)	2,00-0,63				3,56-0,52				2,20-0,48			
Self-medication												
Yes (n=99)	1,85-0,54	0,788	0,175	0,861	3,57-0,57	0,054	0,488	0,626	2,18-0,58	1,385	-1,040	0,300
No (n=126)	1,84-0,50				3,53-0,53				2,26-0,53			

SD= Standard Deviation

increased suicide risk associated with the use of stimulating/sedative substances.

Mental disorders, burnout, and suicidal thoughts pose higher risks for psychiatrists than other healthcare professionals (12). Interacting with patients who may experience trauma, suicidal tendencies, homicidal tendencies, hostility, or lack of appreciation can cause psychiatrists to feel helpless and mentally exhausted (13). Burnout, combined with other risk factors for suicide, may seem like the only way out. Like all doctors in Turkey, psychiatrists also work under intense pressure. Dealing with around 1000 patients per month can lead to burnout, and encountering traumatic experiences may cause them to ignore their own problems. Failure to take note of symptoms or simply treating them symptomatically can lead to mental disorders and related suicides.

When looking at the personality traits of doctors, qualities such as ambitious, perseverative, hard-working, and perfectionism come to mind. Throughout medical education, doctors are seen as warriors who can overcome difficulties, gain practical skills, and discipline themselves. "They can stay awake, work without food or water, and stand for hours" because they are doctors; that's why they became doctors. This perspective actually leads to doctors internalizing chronic stress. Along with

physical exertion, the population served by psychiatrists, the pace of work, and the resulting decrease in social activities and events may also play a role in the increase of mental disorders and associated suicides.

Suicidal attempts are frequently seen in personality disorders as well as in serious mental illnesses (14-16). Personality disorders are more stigmatized than other psychiatric diagnoses (17) (18). Both society and physicians believe that individuals with personality disorders need to be controlled in terms of their behavior, and their symptoms and help-seeking are often perceived as manipulation. These individuals receive less sympathy and are less likely to be considered in need of professional help compared to those with other psychiatric disorders (19). Considering that physicians are also part of society, it is not unreasonable to assume that they carry similar stigmas towards individuals with personality disorders. Although it may be possible to control professional stigma, societal stigma and self-stigmatization may have become thought patterns that the individual is not even aware of. From this perspective, a psychiatrist who experiences ongoing symptoms despite self-treatment for their own mental health problems, including suicidal thoughts, may not seek treatment due to their internalized stigma, professional stigma, and societal stigma concerns.

5.8% of the psychiatrists who participated in our study reported a history of suicide attempt, 44.9% reported having had suicidal thoughts in the past, and 7.6% reported seeing death as a viable option within the last week. The levels of stigma related to suicide were generally low, but when evaluated based on sub-scales, it was found that the students in the early years of their psychiatric specialization had higher scores for glorification/normalization, and those who had previously had suicidal thoughts had lower scores for stigmatization related to suicide.

The low levels of stigma scores, despite a low history of suicide attempts, seem to contradict the high suicide rates among psychiatrists. Approximately 10% of the 2,500 psychiatrists invited to participate in the study agreed to participate, and during the study, two psychiatrists died by suicide. However, the low participation rate in the study can be explained by various factors such as fatigue, disinterest, lack of time, or burnout from online work.

As physicians, they may not consciously approach mental disorders and suicide with prejudice, but the lack of insight into their own mental state, influenced by denial and rationalization on the unconscious level, may be one of the underlying reasons for psychiatrist suicides.

It is necessary for psychiatrists who are receiving psychiatric training to also receive supervised psychotherapy training. Supervised psychotherapy training can contribute to the increase and enrichment of insight, as well as enabling the supervisor to observe and guide potential mental health problems of the assistant/ specialist whom they are training. As far as we know, there is no regulation on this issue in specialty training programs in Turkey or in the world. In some countries, it is mandatory to see patients under supervision during specialty training, ensuring that individuals are in constant communication with another mental health professional. However, there is no country that provides regular and controlled supervision after specialization. Making it mandatory for physicians working in the field of mental health to have such a requirement may contribute to early detection of possible mental disorders and consequently

to the reduction of suicide rates, as well as the development of insight. On the other hand, psychodynamic-oriented/insight-generating therapies are long-term and costly. Therefore, it may contribute similarly to have every psychiatric candidate have a mentor and mandatory regular meetings, even if there is no regular therapy process during the internship training.

In our study, 28.9% of psychiatrists reported using drugs at least once in their lives, and only 0.9% considered themselves regular drug users. Although 36.4% of physicians do not think they have any mental disorder, they stated that they use psychotropic drugs. Although the stigma scores related to suicide reported by the participating physicians were low, it is noteworthy that the suicide rates among psychiatrists are high. There have been 6 documented cases of suicide by psychiatrists in Turkey in the last 3 years. When these conflicting findings are considered together, it suggests that psychiatrists may hide, deny, and rationalize their feelings, thoughts, and beliefs about suicide.

In conclusion, it should be remembered that the vast majority of doctors do not commit suicide. However, every death is a tragedy that sends ripples through the system and carries the risk of contagion (11). Restricting doctors from self-prescribing may lead to them seeking help from another doctor, earlier detection and treatment of risky situations, and a decrease in suicide risk. Regulations on working conditions for doctors may also lead to a decrease in burnout and related suicides for all doctors. Furthermore, a doctor regularly exposed to chronic stress due to the nature of the patient population they work with could benefit from receiving regular supervision, which may lead to a decrease in burnout and related suicide risk. Initiatives to reduce stigma both at the societal level and among psychiatrists would undoubtedly be useful in reducing suicides related to mental illness. Ensuring that doctors have access to early intervention and confidential support services may also help reduce suicide behavior, even if stigmas cannot be eliminated (20).

There have been no studies on psychiatrist suicides in Turkey. This study may create an agenda and

stimulate broader, more representative research on the subject, initiating a discussion. The findings suggest that the stigma surrounding mental illness also exists within the profession, highlighting the importance of clinical training and post-graduate continuous education programs in this area.

However, there are limitations to this study. The number of participants and the online nature of the research are insufficient to draw generalizable conclusions. The variables studied are also not sufficient to determine the risk factors for suicide and psychiatrist/doctor suicides, which are complex

phenomena. By asking ourselves "what more could we have done?" after each psychiatrist suicide, and confronting our own denial, we can contribute to reducing suicide rates through more comprehensive and inclusive studies.

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REFERENCES

1. Organization WH. Every life matters: Understanding suicide and its impact. 2021.
2. Schernhammer ES, Colditz GA. Suicide rates among physicians: a quantitative and gender assessment (meta-analysis). *American Journal of Psychiatry*. 2004;161(12):2295-302.
3. Dutheil F, Aubert C, Pereira B, Dambrun M, Moustafa F, Mermillod M, Baker JS, Trousselard M, Lesage FX, Navel V. Suicide among physicians and health-care workers: A systematic review and meta-analysis. *PLoS One*. 2019 Dec 12;14(12):e0226361. doi: 10.1371/journal.pone.0226361. PMID: 31830138; PMCID: PMC6907772.
4. Myers MF, Gabbard GO. The physician as patient: a clinical handbook for mental health professionals: American Psychiatric Pub. Washington, DC, USA; 2008.
5. Kosulwit L. Mental health and quality of life among Thai psychiatrists. *J Med Assoc Thai*. 2015;98(2):S28-S37.
6. Balon R. Psychiatrist attitudes toward self-treatment of their own depression. *Psychotherapy and psychosomatics*. 2007;76(5):306-10.
7. Heinze G, Chapa GdC, Carmona-Huerta J. Specialty in psychiatry: Mexico 2016. *Salud mental*. 2016;39(2):69-76.
8. Tateno M, Jovanović N, Beezhold J, Uehara-Aoyama K, Umene-Nakano W, Nakamae T, Uchida N, Hashimoto N, Kikuchi S, Wake Y, Fujisawa D, Ikari K, Otsuka K, Takahashi K, Okugawa G, Watanabe N, Shirasaka T, Kato TA. Suicidal ideation and burnout among psychiatric trainees in Japan. *Early Interv Psychiatry*. 2018 Oct;12(5):935-937. doi: 10.1111/eip.12466. Epub 2017 Aug 8. PMID: 28786526.
9. Batterham PJ, Calear AL, Christensen H. The stigma of suicide scale. *Crisis*. 2013.
10. Öztürk A, Akin S, Durna Z. Testing the psychometric properties of the Turkish version of the stigma of suicide scale (SOSS) with a sample of university students. 2017.
11. Gerada C. Doctors, suicide and mental illness. *BJPsych bulletin*. 2018;42(4):165-8.
12. Snibbe JR, Radcliffe T, Weisberger C, Richards M, Kelly J. Burnout among primary care physicians and mental health professionals in a managed health care setting. *Psychological reports*. 1989;65(3):775-80.
13. Kumar S. Burnout in psychiatrists. *World Psychiatry*. 2007;6(3):186.
14. Boot K, Wiebenga JXM, Eikelenboom M, van Oppen P, Thomaes K, van Marle HJF, Heering HD. Associations between personality traits and suicidal ideation and suicide attempts in patients with personality disorders. *Compr Psychiatry*. 2022 Jan;112:152284. doi: 10.1016/j.comppsy.2021.152284. Epub 2021 Oct 26. PMID: 34763292.
15. Doyle M, While D, Mok PL, Windfuhr K, Ashcroft DM, Kontopantelis E, Chew-Graham CA, Appleby L, Shaw J, Webb RT. Suicide risk in primary care patients diagnosed with a personality disorder: a nested case control study. *BMC Fam Pract*. 2016 Aug 5;17:106. doi: 10.1186/s12875-016-0479-y. PMID: 27495284; PMCID: PMC4974738.
16. Su MH, Chen HC, Lu ML, Feng J, Chen IM, Wu CS, Chang SW, Kuo PH. Risk profiles of personality traits for suicidality among mood disorder patients and community controls. *Acta Psychiatr Scand*. 2018 Jan;137(1):30-38. doi: 10.1111/acps.12834. Epub 2017 Nov 15. PMID: 29141103.
17. Cattoor K, Feenstra DJ, Hutsebaut J, Schrijvers D, Sabbe B. Adolescents with personality disorders suffer from severe psychiatric stigma: evidence from a sample of 131 patients. *Adolescent health, medicine and therapeutics*. 2015:81-9.
18. Sheehan L, Niewegłowski K, Corrigan P. The stigma of personality disorders. *Current Psychiatry Reports*. 2016;18:1-7.
19. Adebowale L. Personality disorder: taking a person-centred approach. *Mental Health Review Journal*. 2010;15(4):6-9.
20. Brooks SK, Gerada C, Chalder T. Review of literature on the mental health of doctors: are specialist services needed? *Journal of Mental Health*. 2011;20(2):146-56.