

# Suicide and Veterans

## What We Know, How We Can Help

---

BY DAVID A. LITTS, O.D.

**A**s a country, we have long admired the men and women who have worn our nation's military uniforms. Except for a short period during and after the Vietnam conflict, military members generally have been respected for their resourcefulness, strength, innovativeness and "can-do" spirit. They have shown us they can do just about anything in the name of national security. When the job is done, they slip back into the mainstream of society, taking up positions as leaders in large and small businesses or government, as rank-and-file members of the work force, and, yes, sometimes as members of the chronically unemployed and homeless underclass. Recently, news reports have turned our attention to what seems to be an emerging crisis of suicides among veterans. Most of that attention is focused on veterans of the recent wars in the Middle East.

For generations, those in uniform had rates of suicide roughly half that of the general population, even taking into account their age, race and gender. Those of us who study suicide were not surprised. Compared to the rest of the population, they were well-educated, healthy — mentally and physically — and drug abuse was rare. Consequently, we assumed that veterans of military service also had reduced rates of suicide, bringing their protected status with them as they reentered the civilian population. However, as recent studies indicate, suicide rates among veterans are definitely not less than those of non-veterans, and they probably are significantly higher. Why?

### WAR TODAY: THE DIFFERENCE

Society's experience of warfare is unique to each armed conflict. In World War II, for example, men enlisted or were drafted into the service and generally remained in their wartime assignment until tragedy struck or the war ended. Women enlisted into special units of the military and took over noncombat jobs that included nursing, gathering and interpreting intelligence and flying aircraft on noncombat missions.

Letters to and from home took weeks to

deliver, and for the folks back home, knowing, loving or waiting for news of someone involved in the war was a universal experience. After the war, veterans saw others like themselves everywhere. They were not alone.

During Vietnam, men enlisted or were drafted into service, and involvement in the war usually meant one tour of duty followed by a return home — no redeployment into combat. Women volunteered to serve in many critical roles, including as nurses. Among civilians, knowing someone who was serving or who had served in the war effort was a common experience, and war veterans were not alone in their communities — even if they were not welcomed back as heroes.

Quite different than in the past, the burden of the current generation's wars has been borne on the backs of less than 1 percent of the population — an all-volunteer force of men and women — and, of course, their families. In these most recent wars, military members have engaged in multiple combat tours interrupted by short periods at home with their families, followed quickly by a rigorous season of field training in reconstituted units, preparing for the next combat tour.

Thanks to the Internet, keeping in touch with



*This frozen war consciousness is the condition we call post-traumatic stress disorder.*

friends and family has never been so easy and immediate as it has been for many of the combatants serving in Iraq and Afghanistan. Sometimes the availability of instantaneous communication back home adds to the stress of combat, as stateside spouses share their day-to-day problems managing the family and household with

**Fact: relationship problems are one of the most frequent risk factors associated with suicides among military members.**

their soldier who spent the day dodging roadside bombs. For many, whether it is after one tour or five, eventually the stress and trauma of combat take their toll, and resilience wears thin. Family relationships begin to crumble, psychological health gives way to depression and alcohol abuse or to post-traumatic stress. These, left unaddressed, can cascade into hopelessness, despair and thoughts of suicide.

So, for the first time in our history, suicide rates among members of some military branches have reached or eclipsed the rates seen in the general population.

Increased military suicide rates are not limited to those in combat, though. Suicide rates are going up for noncombatant military members, too. It appears that the stresses brought about by the wars of this decade have taken a toll on nearly every component of today's military. Even military members who never leave American soil have endured longer work hours, six or seven days a week, for prolonged periods, under very high levels of stress, with the imperative of delivering high performance, day in and day out. Some have been exposed to combat as they observe the bloody details of battlefield action from the vantage point of a satellite overhead. Then, there are the demanding training requirements that compete with the operational requirements, compounding the daily, stressful grind.

In addition to the stresses of the military work environment, social and cultural factors have increased risk for suicide, as well. Because marriage confers to military members additional rights and privileges — for instance, off-base housing, additional pay and allowances and health insurance for partners — it's not unusual for young enlisted personnel to go ahead and

marry in order to “improve” their living conditions. As the ink is drying on the marriage certificate, many begin to discover it is not as easy as they thought, locked in a marriage with another teenager and unprepared for the new responsibilities. Fact: relationship problems are one of the most frequent risk factors associated with suicides among military members.<sup>1</sup>

How does this relate to veterans, those who wore the uniform in the past and have reentered civilian society? A report recently released by the Department of Veterans Affairs (VA) showed that based on data from 21 states, young veterans ages 18-34, both males and females, are dying by suicide at about twice the rate of their nonveteran peers.<sup>2</sup> For men, that ratio decreases to near parity by age 75, but for women, the ratio is highest in veteran women 75 and older — a puzzling statistic that requires more research.

**CUMULATIVE, LONG-TERM EFFECTS**

Veterans of recent wars are surviving severe injuries by the thousands, thanks to advancements in battlefield medicine, but many are left with serious disabilities, often including disabilities from brain injuries. We know that traumatic brain injuries (TBI) substantially increase risk for suicide, and that the increased risk can extend for decades after the injury, after rehabilitation has worked its course.<sup>3</sup>

In Iraq and Afghanistan, roadside bombs and other explosions are common perils for combatants, but, until recently, we did not appreciate their potential for causing TBI in spite of the protection afforded by modern body armor and heavily armored vehicles. Research is just beginning to reveal the long-term effects of multiple mild traumas to the brain, even when there is no evidence of a concussion. There appears to be a cumulative effect that can lead to delayed cognitive changes and depression — and, yes, increased risk for suicide, as well. What's more, the longer-term effects of multiple brain traumas may present symptoms remarkably similar to post-traumatic stress disorder (PTSD).<sup>4</sup>

It is estimated that some 10 percent to 20 percent of infantry veterans returning from warfare in Iraq and Afghanistan suffer from some degree of PTSD.<sup>5</sup> Having some of the symptoms — being constantly on alert (hypervigilance), wakefulness (difficulty sleeping), quick reactions to perceived threats (being on edge) and emotional distance



from others — serves individuals well while they're in the combat theater; however, what saves life and preserves mental health in combat can be destructive to normal functioning and family relationships back home.

What's more, if the individual's next combat deployment is scheduled in nine months or a year, it is imperative that these protective adaptations remain sharp until they are needed again in the field. At some point, though, the pain and distress associated with these symptoms leads to maladaptive behaviors. Alcohol takes the edge off and eases the pain of emotional isolation and the lost ability to connect with others, but only for a while. Hopelessness and despair can set in, a set-up, too, for suicide.

Of course in previous wars, combat cohorts experienced PTSD, though it was poorly understood and known by different names. Only recently have therapeutic techniques emerged that are effective in substantially reducing the symptoms, and we can assume there are still tens of thousands of veterans from previous eras who suffer from untreated PTSD. Recently, because of the VA's increased efforts to reach out to them, many are seeking treatment many decades later.

Traumatic experiences other than combat also can cause or exacerbate a veteran's PTSD. Among them, military sexual trauma (MST), experienced by both women and men in the military, is assumed to be a factor in veteran suicides, though there are research gaps pertaining to men.<sup>6,7</sup> Childhood traumatic experiences, especially childhood sexual abuse, also seem to amplify stress reactions after traumatic experiences in adulthood.

#### BARRIERS TO HEALTH CARE

It is true that while they are in the service, military members have access to unlimited, affordable (free) and high quality health services, including mental and behavioral health care — theoretically, at least. First, however, they must find the time to go. The demands on their time — including the tight scheduling of unit training — often makes scheduling appointments difficult, especially the kind of ongoing, regular appointments required to successfully treat PTSD or address family problems.

Then, consider the geographical barriers. Although behavioral health care is often available close to the operational unit's work or train-

ing location, other times it may be miles away, requiring arranging transportation if the military member does not have a car. For members of the National Guard and Reserve who live as civilians in their communities back home between deployments, distances to the nearest military or VA health care facility may be hundreds of miles, making it nearly impossible to make one appointment, let alone a dozen appointments necessary for treating PTSD.

Finally, there are persistent cultural and policy barriers. A mental health visit may result in a diagnosis that disqualifies the individual for military duty. In some sectors of military culture, mental health professionals are called "wizards." Go to the "wizard" and he'll make you disappear — from your military unit, that is — and leave you stereotyped as someone with a weak character. Out of such stereotypes come the prejudice and discrimination that are ubiquitous in some — though not all — segments of military culture. They become impediments to seeking behavioral health care for many who could benefit.

Research shows that those with symptoms of mental illness assess stigma to be a greater barrier than those without symptoms.<sup>8</sup> Hence, to what-

### What saves life and preserves mental health in combat can be destructive to normal functioning and family relationships back home.

ever degree these facets of stigma impede care-seeking, the effect is greater for those who need the care most.

Unfortunately, in some segments of the military there exists a tradition of publicly humiliating unit members who seek mental health care. The Department of Defense (DoD) recently came out with policies prohibiting this treatment; however, as with any harmful cultural norm, it will take repeated, public examples of leaders who engage in the rituals being disciplined for such actions, before the practice is gone.<sup>9</sup>

Fortunately, other segments of the military have for years been sending strong signals to their members that responsibly seeking treatment is a sign of strength, and it is supported by unit leaders. Messages of this type from top leaders in the Air Force were instrumental in pushing down suicide rates among airmen in the 90s when the Air

Force launched its very successful suicide prevention program.<sup>10</sup>

### **BARRIERS FOR VETERANS**

Such complexities that surround receiving treatment while in the service means thousands of military members become veterans with unaddressed, invisible wounds of war. Veterans bring the military's attitudes and norms — good and bad — with them as they re-enter civilian life. Many times, they find similar prejudicial attitudes present in their civilian communities, too.

For veterans holding high security clearances — top secret or above — that clearance can mean eligibility for lucrative work in government or in the defense industry. The perception that visiting a mental health clinician can put a veteran in jeopardy of losing that security clearance is widely held.<sup>11</sup> Recent DoD policy has removed that risk for individuals seeking care for family problems or combat-related stress, however, military members and veterans either are not aware of the protection this policy offers, or they do not yet have enough experience with the policy to trust their clearance to it.<sup>12</sup>

For the veteran, finding access to care brings many challenges. Millions of veterans with service-related health or mental health problems seek treatment from the VA's network of nearly

## **To whatever degree these facets of stigma impede care-seeking, the effect is greater for those who need the care most.**

1,000 medical centers and community-based outpatient clinics. The price is right and the quality is high. Over the past few years, the VA has expended great effort to reach out to veterans of all eras, encouraging them to seek treatment for behavioral health problems. And it has worked.

Unfortunately, access remains an issue for many veterans seeking treatment, due both to geographical distribution of care centers and to shortages of providers. Over the past few years, the VA has increased its staff of mental health professionals by thousands to meet the burgeoning demand for this care; however, in some areas, the growing supply of care is still not meeting the demand.<sup>13</sup> Shortages in these regions can delay initial evaluations for weeks, unless suicide is

identified as a problem when the appointment is requested. In too many cases, the choices for a veteran may be reduced to two, both undesirable: waiting weeks for an evaluation or going to the nearest hospital emergency department. Substantial improvements are being made, though.

### **INTERPERSONAL THEORY OF SUICIDE**

One of the leading new theories of suicide is called the interpersonal theory. Developed by Florida State University psychology professor Thomas Joiner, Ph.D., a nationally known expert on the causes and prevention of suicide, the theory holds that two conditions are necessary for suicide: desire and capability. Desire stems from two factors: a sense of burdensomeness and thwarted belongingness. Capability requires having life experiences that somehow enable one to lose the natural fear of pain and death.

Many veterans who are experiencing the effects of PTSD, loss of cognitive function associated with TBI, depression, anxiety or alcohol abuse may easily become overwhelmed with the feelings of being a burden on his or her family and no longer able to contribute fully to the family unit. The emotional distance many feel after combat, an inability to connect with others, also contributes to thwarted belongingness in the family. That today's veterans rarely see others in the community who share their experience contributes to a sense of aloneness. They believe there is no one who understands or who could understand.

A gained capability to end one's life may be a factor in high suicide rates among several population groups: female physicians, police officers and military veterans, to name a few.<sup>14</sup> Many veterans, especially those with combat experience, have become familiar with death and dying. They are also familiar with pain, whether through their own injuries or through those close to them. They have been trained to be fearless in the face of adversity, in the face of battle and in the face of death. It should not be surprising that when faced with a battle with depression, hopelessness and despair, including the most intense psychological pain, that familiarity with death and a fearlessness toward pain would lower the threshold for suicide. The interpersonal theory of suicide can help us understand at least some significant portion of the suicide attempts occurring among veterans. For some, their military experience and its aftermath have produced a perfect storm.



### EARLY INTERVENTION KEY

Fortunately, for the vast majority of veterans, their resilience, adaptability, innovativeness and determination carry them through. Thousands of those who are experiencing mental and behavioral health problems are taking advantage of the robust treatment services available through the VA and in their communities. They are also reaching out for other services and opportunities available to them, like getting a college education or pursuing vocational training; support, counseling and spiritual care from faith leaders; and support from veteran-serving organizations.

Additionally, in some of the military branches and on some installations, leaders have made a point of opening doors for members to seek treatment, encouraging them to seek it at the first sign that all is not right. Fifteen years ago, the Air Force's top leaders pushed for cultural changes that honored airmen who were strong enough to address their problems, whether they were personal, social, spiritual, emotional or psychological. The program consisted of initiatives in 11 domains that intersected with the population at multiple levels. Social support increased for individuals having temporary difficulties in life, social skills were enhanced through a variety of initiatives at the base level and most airmen who sought care early found that their careers were enhanced, and they went on to be successful.<sup>15</sup>

Independent researchers evaluating it found that not only did the number of suicides decrease by 33 percent during the height of the program, there were other benefits to the population as well. Homicides decreased by 50 percent, unintentional injury deaths decreased by nearly 20 percent and incidents of severe family violence were cut nearly in half. The Air Force population was healthier on just about every social measure.<sup>16</sup>

More recently, the commanding general at Fort Bliss, an Army post in El Paso, Texas, implemented a similar, multilevel approach to increasing life skills, strengthening social supports within the unit and encouraging the use of a variety of social and health services on the post. After only one year, the post reports marked reductions in suicides and in other preventable causes of death.<sup>17</sup>

These leadership initiatives are changing the cultural norms and values that have long been barriers to health and care for veterans and seem to make a very real difference.

### FORMAL TRAINING NEEDED

According to the latest data available, in fiscal year 2008, two-thirds of the 23.4 million veterans sought their health care from non-VA providers,<sup>18</sup> including providers making up the rich fabric of Catholic health systems across the country.

Some of those veterans are at risk of dying at their own hands. There is no generalization as to what their clinical presentation will be, and there are no one or two tips to ensure providers will

## Cultural competence is as essential when treating military veterans as it is when treating members of racial and ethnic minorities.

pick up on those who, after having served their country, carry unbearable psychological and emotional burdens. They could be 22 years old or 92. In fact, Vietnam-era veterans, 7.5 million of them, are the largest group of living veterans and the most frequent callers to the Veterans Crisis Line, the VA's professionally staffed, toll-free telephone, text and chat support resource for military veterans and their families (1-800-273-8255).

To the extent possible, civilian health care providers should learn to appreciate and respect the culture of the American military as one that allows us to enjoy the freedoms guaranteed by the U.S. Constitution. Many veterans see themselves as people who have raised their right hand and sworn to defend that Constitution, even if it meant long separations from their families and friends, uncomfortable conditions in the field and putting their lives on the line.

Whether they were heroes on the battlefield or leaders in their military units or followers who helped get the job done, they are not invulnerable. If, as their caregivers, front-line providers in Catholic health systems are trained to detect hints of hopelessness and despair or under-the-breath comments about a wish to permanently escape the pain of life, then you can be assured there will be many opportunities to save those who have laid it all on the line for the rest of us.

Keep in mind, though, that this opportunity will be missed if a veteran detects prejudice from health care providers who disrespect the institutions of the armed forces, including individuals who have worn a uniform. Cultural competence is

as essential when treating military veterans as it is when treating members of racial and ethnic minorities.

Unfortunately, only a small fraction of the nation's mental health providers are trained to deliver evidence-based treatments for PTSD, and fewer of them have been trained to provide culturally competent care for veterans. The same goes for suicide care. Majorities of community-based behavioral health providers in a large sample indicated they lacked either the skills, training or supports to assist a patient who is suicidal — that is, to provide suicide care.<sup>19</sup>

This is probably true in the Catholic health systems, too. If I could wave a wand and change anything about our health systems, I would make sure that all individuals working in primary care settings know how to detect both PTSD and suicide risk; that all behavioral health providers have been formally trained in providing *suicide care* and a large portion in providing evidence-based treatment for PTSD; and that collaborative care, joining the services of primary care and behavioral health, is available to all.

Our health systems fail uncounted thousands of times every year when patients are discharged from emergency departments and psychiatric units only to die days or weeks later by suicide. Among patients at high risk of suicide, the period following acute hospital-based care is the highest risk period for a patient being treated for suicide risk.<sup>20</sup> It doesn't have to be. We know enough now about providing continuity of care after discharge, including simple telephone or mail contacts, to reduce the toll. Catholic health systems should lead the way in providing the kind of compassionate, life-affirming care that will reduce the suicide toll on our nation's veterans.

**DAVID LITTS** is executive secretary of the National Action Alliance for

Suicide Prevention. He served as colonel in the U.S. Air Force Medical Service, where he led the first suicide prevention program to significantly reduce suicide across a population. In 2010 he was a White House-approved expert on the congressionally mandated DoD Task Force on the Prevention of Suicide among Members of the Armed Forces. For additional information on training and resources to support evidence-based suicide care in primary care and specialty settings, go to the Suicide Prevention Resource Center, [www.sprc.org](http://www.sprc.org).

#### NOTES

1. U. S. Department of Defense Task Force on the Prevention of Suicide by Members of the Armed Forces, *The Challenge and the Promise: Strengthening the Force, Preventing Suicide and Saving Lives* (Washington, D.C.: Department of Defense, 2010).
2. Janet Kemp and Robert Bossarte, *Suicide Data Report 2012* (Washington, D.C.: Department of Veterans Affairs, 2013), [www.va.gov/opa/docs/Suicide-Data-Report-2012-final.pdf](http://www.va.gov/opa/docs/Suicide-Data-Report-2012-final.pdf).
3. Grahame Simpson and Robyn Tate, "Suicidality in People Surviving a Traumatic Brain Injury: Prevalence, Risk Factors and Implications for Clinical Management," *Brain Injury* 21 (December 2007): 1335-51.
4. Bennet Omalu et al., "Chronic Encephalopathy in an Iraqi War Veteran with Post-traumatic Stress Disorder Who Committed Suicide," *Neurosurgery Focus* 31, no. 5 (2011): E3.
5. Charles W. Hoge, "Interventions for War-Related Posttraumatic Stress Disorder: Meeting Veterans Where They Are," *JAMA* 306, no. 5 (Aug. 3, 2011): 549.
6. Sue Ann Garrison, "Military Sexual Trauma, Prevalence, Themes and Treatment Issues," presentation, <http://uwf.edu/cap/HCW/materials/GarrisonMay08.pdf>.
7. Jetta Hansen, *Suicide Risk in Male Military Sexual Trauma Victims* (Tallahassee, Fla.: Military Suicide Research Consortium, 2012) <https://msrc.fsu.edu/sites/msrc.fsu.edu/>

- files//MSRC%20Sexual%20assault%20and%20suicide%20among%20males.pdf.
8. Charles W. Hoge et al., "Combat Duty in Iraq and Afghanistan, Mental Health Problems and Barriers to Care," *New England Journal of Medicine* 351, no. 1 (2004): 13-22.
9. U.S. Secretary of Defense, "Memorandum on Policy Implementation — Mental Health Question, Standard Form (SF) 86, Questionnaire for National Security Positions," April 18, 2008, [www.pdhealth.mil/downloads/OSD\\_Meantal\\_health\\_Question\\_SF86.pdf](http://www.pdhealth.mil/downloads/OSD_Meantal_health_Question_SF86.pdf).
10. Kerry L. Knox et al., "Risk of Suicide and Related Adverse Outcomes after Exposure to a Suicide Prevention Programme in the U.S. Air Force: Cohort Study," *BMJ* 327, no. 13 (December 2003).
11. DoD Task Force report.
12. DoD Task Force report.
13. Larry Abramson, "Report: VA Mental Health Treatment Stats Misleading," *National Public Radio*, <http://www.npr.org/2012/04/25/151387001/report-va-mental-health-treatment-stats-misleading>.
14. Claudia Center et al., "Confronting Depression and Suicide in Physicians: A Consensus Statement," *JAMA* 289, no. 23 (June 18, 2003): 3161-66.
15. Knox, "Cohort Study."
16. Knox, "Cohort Study."
17. Donna Miles, "Army Post Sets Example in Curbing Suicides, Preventable Deaths," *Armed Forces Press Service*, Feb. 15, 2013, [www.defense.gov/News/NewsArticle.aspx?ID=119313](http://www.defense.gov/News/NewsArticle.aspx?ID=119313).
18. National Center for Veterans Analysis and Statistics, *Analysis of Unique Veterans Utilization of VA Benefits and Services* (Washington, D.C.: Dept. of Veterans Affairs, 2009), [www.va.gov/vetdata/](http://www.va.gov/vetdata/).
19. Unpublished survey data by members of the National Action Alliance for Suicide Prevention.
20. David J. Knesper, *Continuity of Care for Suicide Prevention and Research* (Newton, Mass.: Education Development Center, Inc., 2010): 20, [www.sprc.org/library\\_resources/items/continuity-care-suicide-prevention-and-research](http://www.sprc.org/library_resources/items/continuity-care-suicide-prevention-and-research).

JOURNAL OF THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES

[www.chausa.org](http://www.chausa.org)

# HEALTH PROGRESS®

---

Reprinted from *Health Progress*, May-June 2013  
Copyright © 2013 by The Catholic Health Association of the United States

---