

Article 44

Suicide Among Veterans and the Implications for Counselors

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Abstract

Although the majority of service members and their families are able to transition from deployment to reintegration without overwhelming distress, studies show that deployment can have significant negative and long-lasting consequences. Veterans of Operations Enduring Freedom, Iraqi Freedom, and New Dawn (OEF/OIF/OND) deployments are at risk for anxiety, depression, and post-traumatic stress disorder. Spouses and children also report social, emotional, and behavioral concerns. For some veterans, mental and physical problems, tension among family relations, and challenges with work, finances, and substance use end in suicidal ideation or death. This manuscript provides an overview of the negative outcomes reported by veterans of OEF/OIF/OND deployments, mental health risks of family members, the increased occurrence of suicide among the Veteran population, and the implications of these deployment consequences for counselors.

Nearly 3 million United States (U.S.) service members have been deployed for Operations Enduring Freedom (OEF), Iraqi Freedom (OIF), and New Dawn (OND; Quinlan, Guaron, Deschere, & Stephens, 2010). Recent research literature is defining the impact of combat deployment and reintegration on service members and their families (Milliken, Auchterlonie, & Hoge, 2007; Tanielian & Jaycox, 2008; Waliski, Bokony, & Kirchner, 2012). Although the majority of service members and their families make the transition without overwhelming distress (Castaneda et al., 2008; Chandra et al., 2010), studies show that deployment can have significant negative and long-lasting consequences (Chandra et al., 2010; Milliken et al., 2007; Mansfield et al., 2010). This manuscript provides an overview of the negative outcomes reported by Veterans of OEF/OIF deployments, mental health risks of family members, the increased occurrence of suicide among the Veteran population, and the implications of these deployment consequences for counselors.

Distress Reported by Veterans

As more service members experienced reintegration to civilian life and reunification with family members the negative consequences of combat-related deployment became more apparent. These negative consequences include unemployment, mental illness, and behavioral difficulties as the following research shows. The unemployment rate for OEF/OIF veterans is approximately 40% higher than it is for the general public (National Council for Behavioral Health, 2012). Approximately one in five soldiers returning from a year of deployment in Iraq experienced at least one traumatic brain injury (TBI; Terrio et al., 2009). These individuals may experience sleep disturbances, sensitivity to light, irritability, or dizziness. It is estimated that 15% to 20% of troops returning from Iraq and Afghanistan report symptoms of post-traumatic stress disorder (PTSD), anxiety, or depression, (Milliken et al., 2007) and many of those serving in their initial deployment sought mental health treatment primarily for anxiety, adjustment disorders, and mood disorders (Schmitz et al., 2012). Additionally, OEF/OIF veterans exposed to combat have been linked to excessive anger, lack of sexual intimacy, substance use, high-risk drinking, and reckless driving (Killgore et al., 2008; McNulty, 2010; Thomas et al., 2010), all of which can lead to deterioration of the family system.

Distress Reported by Family Members

Mental health disorders can be hard for families to handle because their service member displays no visible physical scars to identify that something is wrong. Milliken and colleagues (2007) found that 14% to 21% of OEF/OIF veterans reported problems with family and interpersonal relationships following reintegration and that mental health disorders for veterans increase up to 35.5% six months after deployment. In a group of Army National Guard service members reintegrating to civilian life, Waliski and colleagues (in press) found that parents reporting children's problems had more mental illness symptoms, including depression and anxiety, and lower satisfaction with family and social relations than parents who reported no problems in children.

Spouses of deployed troops have reported fatigue, low self-esteem, poor concentration, sleep disturbances, headaches, weight change, depression, and adjustment disorders (Mansfield et al., 2010; McNulty, 2005; Wood, Scarville, & Gravino, 1995). As parents' distress increases and their family roles blur or deteriorate their children's functioning declines (Waliski, Bokony, & Kirchner, 2012). Chandra and colleagues (2010) found that military children experience emotional and behavioral difficulties at rates above the national average. Further, children whose parents have been deployed are at risk for depression, anxiety, behavior problems, and difficulties in school (Chandra et al., 2010; Chartrand, Frank, White, & Shope, 2008; McFarlane, 2009).

Suicidal Ideation

Sustained feelings of pain, depression, and hopelessness can lead to thoughts of suicide. Tanielian and Jaycox (2008) explained that untreated mental and physical health problems can impair future health, work productivity, and family and social relationships,

leading to co-occurring problems such as substance abuse and homelessness. Individuals so afflicted are at increased risk for attempting suicide (Tanielian & Joycox, 2008).

Suicide

Suicide is the 10th leading cause of death in the U.S. (U. S. Dept. of Health and Human Services Office of the Surgeon General and National Action Alliance for Suicide Prevention [HHS/NAASP], 2012). Annually, about 37,000 Americans commit suicide each year (Office of Patient Care Services & Office of Mental Health Services, 2011). Having a mental health or substance use disorder greatly increases the risk for suicide (Pompili et al., 2010), but the risk and occurrence of suicide are not evenly distributed among persons with mental illness, substance abuse, prior suicide attempts, history of violence, past incarceration, exposure to suicidal behaviors or a family history of mental illness (Bailey et al., 2011). In the general public, those dying from suicide are more likely to be Non-Hispanic white males who live in rural areas, are age 65 or older, and have access to firearms in the home (Bailey et al., 2011; Miller, Azrael, & Barber, 2012). Table 1 indicates the warning signs most often reported prior to suicide.

Table 1

Suicide Warning Signs (HHS/NAASP, 2012).

<ul style="list-style-type: none">• Talking about wanting to die• Looking for a way to kill oneself• Talking about being a burden to others• Acting anxious, agitated or reckless• Displaying extreme mood swings• Previous suicide attempts	<ul style="list-style-type: none">• Feeling hopeless or having no purpose• Sleeping too little or too much• Increasing the use of alcohol or drugs• Withdrawing or feeling isolated• Showing rage or talking about revenge• Talking about feeling trapped or in unbearable pain
<p>The more of these signs a person shows, the greater the risk of suicide. Warning signs are associated with but may not be what causes a suicide.</p>	

Suicide Among Veterans

As many as 20% of the approximately 37,000 suicide deaths reported in the U.S. annually are veterans, which suggests that 18 veterans die by suicide each day (Office of Patient Care Services & Office of Mental Health Services, 2011). Data available from the VA Suicide Prevention Applications Network suggest that more than 1,250 veterans who receive care at facilities of the Veterans Health Administration attempt suicide each month and 15% of all veterans who survive a suicide attempt will make a repeat suicide attempt within the next 12 months (Bossarte, 2012; Office of Patient Care Services & Office of Mental Health Services, 2011). Evaluation of administrative data by Ilgen and colleagues indicates that male veterans with bipolar disorder and female veterans with substance use disorders or chronic pain (including headaches) are at higher risk for suicide than those without these conditions (Ilgen et al., 2010, Ilgen et al., 2012; Ilgen,

Zivin, McCammon, & Valenstein, 2008). In addition, veterans are more likely than the general population to use firearms (Bailey et al., 2011; Bossarte, 2012; Bossarte et al., 2012; Office of Patient Care Services & Office of Mental Health Services, 2011).

Suicide Prevention

Just as there is no single cause for suicide, there is no single strategy that will prevent suicides from occurring. The *2012 National Strategy for Suicide Prevention: Goals and Objectives for Action, a Report of the U.S. Surgeon General and the National Action Alliance for Suicide Prevention* (HHS/NAASP, 2012) suggests that just as with other health promotion efforts, suicide prevention must be comprehensive and coordinated across organizations and systems at the national, state/territorial, tribal, and local levels while integrating the work of a broad range of partners providing supportive services (HHS/NAASP, 2012). Support should include reducing access to lethal means, decreasing prejudice about mental health disorders and suicide through public awareness, and educating and training mental health professionals to identify and treat risk factors of suicide (HHS/NAASP, 2012). The theory being that reducing risk factors and encouraging help-seeking will increase protective factors by offering multiple levels of support. This ultimately will assist the individual, family, and community because suicide shares risk and protective factors with other types of self-directed violence (Swahn et al., 2012), interpersonal violence (Lubbell & Vetter, 2006), and other related problems (HHS/NAASP, 2012). Therefore, efforts to reduce suicide risk will help prevent these and other problems (HHS/NAASP, 2012; Knox et al., 2003).

Effective strategies include cognitive behavior therapy, crisis hotlines, and efforts that promote continuity of care for individuals identifying suicide risks or reporting suicidal ideations (Brown et al., 2005; HHS/NAASP, 2012; Knesper, 2010; Knox, Kemp, McKeon, & Katz, 2012). In addition, system-wide interventions that combine suicide prevention strategies tailored to the individuals involved and sustained over time are showing promising results (HHS/NAASP, 2012). An example of a system-wide intervention is the U.S. Air Force Suicide Prevention Program (AFSPP) described in Figure 1.

The AFSPP increased the knowledge and understanding of suicide while decreasing the stigma of suicide and seeking help for mental problems by involving the leadership and conducting routine assessments for suicide risk. In addition, the AFSPP established response teams and surveillance systems to monitor and reduce suicide fatalities. This example can serve as a model that other systems or organizations can modify and tailor to meet the needs of the individuals involved within the group.

Implications for Counselors

Of veterans who have been discharged, just more than half are using Veteran Administration (VA) care while the rest are using private healthcare (National Council for Behavioral Health). This coupled with the fact that counselors are gaining recognition as mental health providers within the Veterans Healthcare System underscore the need for counselors to be knowledgeable of military life, deployment, and challenges often reported by veterans and their families.

U.S. Air Force Suicide Prevention Program (AFSPP)

Since 1996, the U.S. Air Force has implemented a community-based suicide prevention program featuring 11 initiatives. Strategies include:

- Increasing awareness of mental health services and encouraging help-seeking behaviors;
- Involving leadership;
- Including suicide prevention in professional training;
- Developing a central surveillance system for tracking fatal and non-fatal self-injuries;
- Allowing mental health professionals to deliver community preventive services in non-clinical settings;
- Establishing trauma stress response teams; and
- Conducting a behavioral health survey to help identify suicide risk factors.

Evaluation findings indicate that the program reduced the risk of suicide among Air Force personnel by one-third (Knox et al., 2003). Participation in the program was also linked to decreases in homicide, family violence (including severe family violence), and accidental death.

Figure 1. Air Force Suicide Prevention Program.

The VA funds research to understand and prevent suicide, educates clinicians about suicide, and ensures clinicians routinely inquire about suicidal ideation. As counselors begin to integrate into the Veterans Healthcare System, they must understand the years of effort from the leaders and members of the American Counseling Association, the American Mental Health Counseling Association, and the National Board of Certified Counselors. Counselors within the VA system must make every effort to appreciate the unique characteristics and needs of veterans and their families as well as be knowledgeable of evidence-based practices to assist them.

It is the responsibility of new counselors and researchers entering the system to learn best practices for treating veterans. Counselor should seek continuing education to stay current on the needs and concerns reported by this population. For the growth and recognition of counselors within the VA, seasoned counselors that have a history of working with veterans should share their lessons learned by providing continuing education sessions for their local hospitals and at conferences for the American Counseling Association, its state branches, and regional workshops.

Evidence indicates that the protective nature of social support decreases suicide (Bossarte et al., 2012). As licensed mental health and school counselors identify the needs of veterans in their communities, they are poised to link community resources and

create community awareness for veteran families. Counselors understand the importance of social, emotional, and spiritual health and can assist in decreasing the stigma of seeking help for mental problems. As the awareness of suicide warning signs increases, prevention efforts improve, and individuals choose treatment as opposed to death, the need for and value of counseling professionals will become even more apparent.

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