THE HIDDEN WOUNDS OF WAR

Military Suicide

Lisa Firestone, Ph.D.

The U.S. Army recently reported that an average of five U.S. soldiers attempt suicide every day. In fact, Army suicides have increased six-fold since the start of the wars in Iraq and Afghanistan. Even these startling statistics may be under-reported, because they may not include many fatalities by soldiers who purposely put themselves in harm's way during combat. In an interview with CNN, Dr. Robert Heinssen of the National Institute of Mental Health, who is conducting research on military suicide said, "The suicide rate may be the equivalent to the canary in the coal mine telling us that the military is under tremendous stress."

This alarming increase in the suicide rate among soldiers has left the Army looking for means to assess and treat those at risk for suicide. Unfortunately, this problem is not likely to end with the war in Iraq, because military suicides occur prior to, during, and after military deployment. Nearly 20% of all suicide attempts are committed by veterans. The realization that these individuals could need treatment for years to come underlines the importance of recognition and intervention.

What are some of the contributing factors to the increase in military suicides?

The political situation has potentially affected the level of military suicides. With the demand for increased military forces, the mental health screening process for recruits has become much more lax. Thus, it is likely that some recruits who have pre-existing mental health conditions, who otherwise might not be accepted, are becoming part of the military. Similarly, with the focus on increasing battlefield numbers, the military may have a higher percentage of soldiers who should not be performing in high-stress situations and, consequently, are not able to cope.

In addition, as we have learned from Vietnam, soldiers can be negatively affected by the fact that they are involved in an unpopular war. Additionally, the increasing frequency of extended deployments for U.S. soldiers in our current wars may contribute to many men and women who have already been traumatized remaining in the stressful conditions of war. This continual redeployment also increases stress and depression levels, as soldiers pin their hopes on an ending that does not come.

How do these conditions lead to suicide and self-destructive behaviors?

In both of our current wars in Iraq and Afghanistan, soldiers face untenable, highly stressful, and often traumatic situations. Such stress causes the release of cortisol which in turn decreases serotonin levels affecting both mood and impulsivity. This constitutes a neuro-chemical contribution to the problem. In addition, a soldier who has any unresolved trauma or grief in his or her past may be much more vulnerable to developing PTSD.

The problem can be compounded by the general attitude of any military organization in which individual human interests are subjugated to the greater good of the unit. This devaluation of individual needs may contribute to feelings of hopelessness or lack of self-worth. Once they are in trouble, soldiers often have difficulty asking for help, because they live in a tough environment in which they are encouraged to be strong and keep their emotions in check. This can make having suicidal thoughts feel all the more shameful and isolating. Soldiers who attempt to get help may be thwarted in their efforts by superiors who do not understand the effects of trauma on their soldiers

The new plan for suicide prevention in the Army aims to make soldiers resilient by changing the way they think in the face of stressors. This plan failed to consider that some soldiers cannot change their thinking. Research on suicide demonstrates (Barnhofer, et al., 2009; Joiner, Rudd, Rouleau, & Wagner, 2000; Mehlum, 2005; Williams, 2008; Williams, Crane, Barnhofer, & Duggan, 2005) that under stress, some people find it impossible to implement the cognitive strategies they have been taught, especially those individuals who are most vulnerable to suicide.

Are There Special Issues that Veterans Face?

Veterans are often traumatized by both the violence they have committed and experienced and the grief over comrades they lost. In addition, when soldiers suffer mild brain damage from Improvised Explosive Devices (IEDs), the soldier's capacity for self-regulation may be further impaired. These injuries can also change soldiers' personalities. Oftentimes, veterans have trouble controlling their tempers. In some cases, their ability to work, to parent, and/or to be by themselves may be impaired.

Even those veterans with no injuries often feel that they don't fit in anymore. They may feel like a burden if they are not functioning well mentally or physically. Self-critical thoughts increase, leading to self-destructive behavior including substance abuse.

What's going on in the mind of a suicidal soldier?

Our research (L. Firestone, 1991; R. Firestone & L. Firestone, 2006; R. Firestone & L. Firestone, 1998) has found that the types of negative thinking that lead to suicide include thoughts of extreme self-hate, (causing the psychological pain and agitation felt by suicidal individuals), thoughts of being a burden to others, ("People would be better off without me."), giving up on oneself ("Nothing matters anymore."), thoughts planning the details of suicide and actual injunctions

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to commit suicide. These types of thoughts are measured on the FAST (Firestone Assessment of Self-Destructive Thoughts) (R. Firestone & L. Firestone, 2007) and the FASI (Firestone Assessment of Suicide Ideation), (R. Firestone & L. Firestone, 2006) which are currently being used in a study at Walter Reed Army Medical Center.

In particular, Thomas Joiner's research on suicide considers three factors to be necessary for suicide to occur (Joiner, 2005; Joiner, Van Orden, Witte, & Rudd, 2009). One of these factors is the acquired ability to kill oneself, related to having been exposed to repeated painful experiences or by witnessing them, common experiences for soldiers. I believe that this acquired ability is related to the capacity to dissociate. Soldiers who have had traumatic experiences are more likely to have developed dissociation as a coping mechanism. Joiner's other two factors are perceived burdensomeness and thwarted belongingness, both covered on the FAST (L. Firestone, 2006; R. Firestone & R. Firestone, 1998).

What are some of the more promising suicide prevention efforts being made?

The Air Force, which began addressing this problem several years ago, found that the rate of suicide risk decreased when the culture surrounding the soldier changed. The program the Air Force developed and implemented involved de-stigmatizing mental health treatment and actively encouraged soldiers to seek help. The Air Force also made suicide prevention everyone's responsibility from the top general down. In addition, the Air Force implemented David Jobes' CAMS (Collaborative Assessment and Management of Suicide Risk, (Jobes, 2006) in which the suicidal individual is regarded as the expert on his or her own affliction. The patient and therapist work collaboratively, instead of following the military's typical hierarchical structure. The program yielded extremely impressive results with a quicker resolution of the suicidal crisis. The Air Force suicide prevention program reduced that service's suicide rate dramatically.

One very positive development is that every Veterans Administration (VA) hospital is now required to have a suicide prevention specialist. The VA has also implemented a help line (1-800-273-TALK), specifically designated for military personnel. (*Please see sidebar, page 15.*) In addition, there is now a yearly suicide prevention conference sponsored by the Department of Defense.

What are some larger-scale efforts that could help?

Everyone who is entering, exiting, or currently serving in the military could be assessed in terms of suicide risk. At the Glendon Association, we have developed a highly successful brief assessment tool, the FASI (R. Firestone & L. Firestone, 2006). Once screened, intervention could be provided to those at risk. We should be able to do more than tell military personnel to change the way they think; we should treat the underlying pain driving their suicidal behavior.

When soldiers return home, efforts must be made to help them reintegrate with their families and communities. In some cases, it would be helpful to have a mentor, perhaps another veteran. This is a cost-effective option. The most important thing to communicate is that although it feels unbearable right now, it can get better. Post-trauma treatment is also essential.

What are some of the actual steps to a treating suicidal soldier?

Therapists should talk to the person directly about suicidal thoughts and impulses. When someone is suicidal, the initial contact may be a one-time intervention and, because of that, the most important thing to do is to ensure the soldier's safety by making a safety plan. Steps to making a safety plan include:

- Look for things that occur naturally in the soldier's daily life that make him or her feel better, an activity in which he or she can engage, people with whom the soldier can spend time, or friends to whom he or she can talk.
- Ask the soldier to commit to the plan to implementing these actions before he or she takes action to hurt him or herself.
- Provide the soldier with a way that he or she can reach you. You should also give the soldier the veteran suicide hotline number (1-800-273-TALK).
- In addition, help the individual identify what triggers the suicidal thoughts and sense of desperation. Identifying these triggers is the first step. The goal is toward reconnecting the individual with a positive sense of self and showing him or her that life can have meaning and value. ▲

Lisa Firestone, Ph.D., is Director of Research and Education at the Glendon Association, www.glendon.org. She is a workshop facilitator and author and developed the Firestone Assessment of Self-Destructive Thoughts (FAST) and Firestone Assessment of Suicide Ideation (FASI).

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What are some of the warning signs for suicide risk?

1. Sleep problems, especially insomnia
2. Personal sense of hopelessness
3. Feeling of despair
4. Feeling like a burden to family and friends
5. Feeling disconnected from oneself and others (dissociation)
6. Feeling of not belonging
7. Suicidal ideation, plans, or preparation
8. A history of self harm
9. Experiencing actual injunctions to commit suicide
10. Withdrawal from family, friends, and favorite activities
11. Giving up on aspects of their identity, i.e., favorite foods, personal standards, aspirations for the future

Helpful Military Suicide Resources:

1-800- 273 TALK (press 1 for military and veteran assistance)

www.suicidepreventionlifeline.org

www.suicidology.org

www.glendon.org

www.suicide.org/suicide-prevention-in-the-military.htm

www.behavioralhealth.army.mil/

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