



Providing Support for Suicide Survivors: Understanding Pertinent Military/Veteran Issues

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A recent study by Kaplan et al. (2007) suggested that veterans are twice as likely to die by suicide as members of the general population. The reasons for this are complicated, and perhaps only in part highlighted by Kaplan and colleagues' findings. Their results suggested that veterans who were white, had 12 years or less of education, and activity limitations (after adjusting for medical and psychiatric morbidity) were at a greater risk for completing suicide. However, in discussion, the researchers noted the complicated nature between risk factors and behavior, and suggested the need for further exploration of contributors to suicidal behavior in this population. Using both civilian and military literatures, areas for consideration when thinking about activity duty member/veteran suicide are presented below. These include psychiatric and/or medical and military history and culture including exposure to trauma, combat, and deployment.

By in large, people who attempt or die by suicide are individuals who have experienced an inordinate amount of psychological distress. Just as certain medical illnesses may result in death, psychiatric problems have the potential to precipitate behaviors that can also result in fatality (Bryan & Rudd, 2006). Research suggests that as many as 90% of those who commit suicide meet the criteria for having a diagnosable psychiatric condition. Disorders that are most often associated with suicide include depression, bipolar disorder, schizophrenia, and drug/alcohol abuse (Brown, Beck, Steer, & Grisham, 2000; Fleischmann et al., 2005; Kleespies, Deleppo, Gallagher, & Niles, 1999). Having more than one of these diagnoses concurrently further increases an individual's risk for suicide (Cornelius et al., 1995).

As such, the suicide rate amongst veterans may be somewhat attributable to the high rates within this population of depression and co-morbid psychiatric conditions, such as posttraumatic stress disorder (PTSD) and substance abuse disorders (Sutker, Uddo, Brailey, Vasterling, & Errera, 1994; Waller, Lyons, & Costantini-Ferrando, 1999; Zivin et al., 2007). The prevalence of significant depressive symptoms among veterans has been estimated as two to five times that of the civilian population (Hankin, Spiro, Miller, & Kazis, 1999). Moreover, recent findings suggest that approximately one-third of Operation Iraqi Freedom Soldiers sought mental health services during their first year post-deployment (Hoge et al., 2006), with estimated prevalence of PTSD and depression in recent or active duty service members being 5 to 10 percent and 2 to 10 percent, respectively (Rand Report, 2008).

Experiencing certain types of stress does, at times, set the stage for developing psychiatric problems and increase susceptibility to having suicidal thoughts or engaging in lethal and non-lethal suicidal behaviors. Past traumatic experiences have been well-documented in the literature as a predisposing risk factor (Bullman & Kang, 1994; Bullman & Kang, 1996; Cohen, Mannarino,

Zhitova, & Capone, 2003). Understanding how these stressors can affect an individual's outlook on life can help survivors understand the context in which a suicide occurred. Regarding servicemen and servicewomen, exposure to death in war often has a profound impact on a person, potentially causing emotional distress and/or triggering unwanted combat-related memories (Sutker, Uddo, Brailey, Vasterling, & Errera, 1994). As emotions are stirred up, the onset or recurrence of psychiatric symptoms can occur, and/or thoughts of suicide may emerge.

Feelings of isolation, disconnectedness, and perceived ineffectiveness are emotions that can underlie suicidal thoughts and behaviors (Joiner, 2005). Military personnel share camaraderie with one another, often connecting due to the shared experiences they have as members of a uniform culture (Brenner et al., 2008). This connection may be further solidified if shared deployment-related experiences were distressing. No longer being deployed or actively involved in military culture may lead to feelings of failed belongingness and burdensomeness, and subsequent emotional distress. Such feelings can be exacerbated when trying to readjust to civilian life or if an individual is unable to reconcile personal combat experiences with civilian values (Brenner et al., 2008). Non-military persons might have limited understanding regarding the unique experiences of former or current soldiers, especially those with combat experience. Unwanted memories of death and violence, combined with the feeling that no one can understand their experience may contribute to suicidal thoughts and set the stage for behaviors (Brenner, et al., 2008; Bell and Nye 2007).

For some veterans asking for help can be extremely difficult. Men can be resistant to reach out for help when problems present, especially those difficulties with an emotional valence to them (Addis & Mahalik, 2003). Men who hold to traditional Western values often hide, minimize, or lack the ability to express emotions in a way that might naturally raise concerns about their emotional functioning (Cochran, 2005) and corresponding suicide risk. Additionally, rather than the symptoms of depression that are considered the norm, men often experience depression as increased irritability, conflict and anger in interpersonal relationships, substance abuse, physical complaints, etc (Cochran & Rabinowitz, 2003). As a result of this presentation, family members may not recognize that their loved one is depressed. Attempting to "pull themselves up by the bootstraps" and carry on independently, the veteran might spiral further into depression and hopelessness and ultimately conclude that others would be better off without them.

The comorbidity of psychiatric and medical problems amongst veterans is prevalent (Beckham et al., 1997; David et al., 2004). In a veteran population, Boscarino (1997) found associations between PTSD and circulatory, digestive, musculoskeletal, endocrine-nutritional-metabolic, nervous system, respiratory, and nonsexually transmitted infectious diseases. Furthermore, veterans experience high rates of chronic pain (Clark, 2002), which is often a consequence of medical conditions, such as traumatic brain injury (TBI) (Nampiaparampril, 2008). Such medical problems and health conditions add yet another dimension that can contribute to suicidal thoughts and behaviors. Difficulties such as these have the potential to complicate and add stress to one's life, compromising a person's ability to cope in healthy ways and setting the stage for psychiatric problems.

TBI is frequently discussed as a "signature wound" of the current conflicts (Warden 2006). According to research from the civilian literature, rates of suicide in those with TBI (i.e., concussion, cranial fracture, or cerebral contusion or traumatic intracranial hemorrhage) have been found to be

3.0, 2.7, and 4.1 times higher than the population as a whole (Teasdale and Engberg, 2001). Individuals with a history of TBI also have a higher rate of suicide attempts than those without TBI (Silver et al., 2001). Finally, in a study of those receiving outpatient TBI services, 23% had significant suicidal ideation (Simpson and Tate, 2002). Although the etiology of the increased presence of suicidal behavior is not well understood, research suggests that the risk continues for years after injury (Teasdale and Engberg, 2001).

Impact of Suicide on Survivors

The grieving process is complex and unique for each survivor. Feelings may vary and can include shock, confusion, anger, guilt, relief, and sorrow. Questions to consider or things that may impact the grieving process include the following: What was the survivor's relationship with the deceased active duty member/veteran? Were they a caregiver? Who was their main source of support? Were they living with the active duty member/veteran prior to the individual's death?

- ***Guilt and Confusion about Responsibility:*** Suicide is a confusing phenomenon (Cerel, Jordan, & Duberstein, 2008), and when it occurs, it is not uncommon for those closest to the deceased to experience intense feelings of both guilt and blaming following the loss of a loved one (McNiel et al., 1998). Family members may believe they should have recognized the signs their loved one was depressed or feel responsible for having encouraged the deceased to join the service in the first place.

Some studies have found that veterans' PTSD symptoms can negatively affect family relationships and that impaired family relationships may exacerbate a veteran's PTSD and comorbid conditions (Beckman, Feldman, Kirby, Hertzberg, & Moore, 1997; Beckman et al., 1996). Also, the overall divorce rate among Vietnam veterans is significantly higher than for the general population, and even higher for veterans with PTSD (Kulka et al., 1990). Relationship problems, such as separation and divorce, while common among veterans with PTSD, can also increase their risk for suicide. Spouses or significant others of veterans whose suicide occurred in close proximity to a failed relationship or relationship crisis, may feel particularly guilty or assume responsibility for the death.

- ***Anger/Blame:*** In addition to such feelings of guilt, family members may look to externalize these emotions. These are normal responses suicide could be more pronounced if the circumstances around a loved one's suicide are unclear (e.g., if the active duty member died overseas) or if the individual recently returned from an extended period of deployment.
- ***Mixed Emotions and Confusion:*** Suicide can occur after a long period of emotional turmoil and/or persistent mental illness, both of which can have devastating effects on family members. Often times, family members (parents, spouses, siblings) of the deceased were also their caregivers. Taking care of a loved one who has a serious mental illness can place considerable strain not only on the primary caregiver, but also on friends and other members of the family (Loukissa, 1995). If the survivor was closely involved with the deceased, it is likely that he or she felt significantly burdened, emotionally exhausted and at times helpless and scared. Caregiver burden is a particularly salient issue for family members of veterans (Beckman, Lytle, & Feldman, 1996; Calhoun, Beckman, & Bosworth,

2000). For example, Calhoun et al (2000) found that the severity of the veterans' PTSD symptoms was related to the amount of caregiver burden and distress experienced by the spouse. Other studies have shown that veterans' PTSD symptoms have a negative impact on family relationships, marital adjustment, and the mental health of close family members (Mikulincer, Florian, & Solomon, 1995; Riggs, Byrne, Weathers, & Litz, 1998; Ruscio, Weathers, King, & King, 2002). A sense of relief when a difficult situation ends is normal, but when the ending is suicide, feelings of relief may be unexpected and contribute to guilt and shame (Hsu, 2002). It is important to emphasize that such feelings are a typical part of the grief process.

- ***Vicarious Trauma:*** For family members and caregivers who may have lived with the deceased veteran, close contact with an individual who has PTSD does not automatically cause PTSD, but it can produce vicarious or secondary traumatization, which can be similar to having PTSD (Figley, 1989; McCann & Pearlman, 1990). Another prevalent issue for family members of veterans may include issues related to violence. It has been shown that veterans with PTSD have more family violence, more physical and verbal aggression, and more instances of violence against a partner (Jordan et al., 1992). Similarly, Byrne and Riggs (1992) found that 42% of the Vietnam veterans in their study had engaged in at least one act of violence against their partner during the preceding year, and that the severity of the veteran's PTSD symptoms was directly related to the severity of relationship problems and physical and verbal aggression against the partner.

If violence and turmoil were prevalent in the home prior to the suicide (emotional abuse, physical abuse, domestic violence, substance use), family members are at risk for developing PTSD and other emotional difficulties that may further complicate the grief process. For those who may be experiencing symptoms of posttraumatic stress or vicarious trauma while also dealing with the loss of a loved one, mental health treatment and additional support may be needed. Such individuals should be provided with resources and instructed to seek help if they begin to have thoughts of suicide or self-harm.

Helping Child Survivors

If the deceased was a parent or family member, talking to the children about the death may be one of the most difficult tasks you face. Suicide is a complicated form of death and requires honesty with children. However, the explanation provided should fit the child's age and level of understanding. If you're reluctant to talk to a child about suicide, what it means and why it happened, keep in mind that children are likely to hear it from other sources, which will lead to even more confusion, fear, and distress (Tesh, 2007). Furthermore, talking to children can help erase misconceptions or concerns that somehow they are blame for what happened (Tesh, 2007). Coping with loss may be further complicated if the child had been separated from their parent for extended periods of time secondary to deployments. Obtaining an understanding regarding the impact of deployment on the family may be useful.

Facilitating the Process: Issues that may arise with respect to activity duty/veteran survivors

Discussion of Traumatic Details: Consider that active duty/veteran survivors may be experiencing issues around vicarious trauma or PTSD, which may make it particularly distressing and difficult to hear details or specifics of suicides that may be brought up by other group members. For those with a history of trauma, smaller group size and/or adherence to structure regarding the group format may help to decrease feelings of anxiety. At times, simple modifications (e.g., allowing an individual with PTSD to sit near to the closest exit) may increase comfort.

Resources for Veterans and Family Members in Crisis

- **National Suicide Prevention Lifeline** is a 24-hour, toll-free suicide prevention service available to anyone in suicidal crisis. If you need help, please dial 1-800-273-TALK (8255). www.suicidepreventionlifeline.org
- **For veterans:** The Department of Veterans Affairs' (VA) has partnered with the Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Suicide Prevention Lifeline to develop the **Veteran's Hotline**, which provides veteran's in emotional crisis with 24/7 access to trained counselors. Veterans can call the Lifeline number, 1-800-273-TALK (8255), and press "1" to be routed to the Veterans Hotline.

Resources for Survivors and Family Members of Veteran/Military Suicides

- American Foundation for Suicide Prevention (AFSP): Offers a variety of support services and resources for suicide survivors, including online support groups, survivor outreach programs, and financial resources. <http://www.afsp.org/>
- American Association of Suicidology (AAS): <http://www.suicidology.org/>
- Tragedy Assistance Program for Survivors (TAPS) provides a wonderful support network for the surviving families of those who have died in service to America, including those who have died by suicide. <http://taps.org/resources/suicide/>
- Surviving a suicide loss: A financial guide - This booklet was created by the American Foundation for Suicide Prevention Survivor Council and the National Endowment for Financial Education to help suicide survivors negotiate the short- and long-term financial consequences of the suicide of a family member. It can be obtained by calling the Information and Resource Center at 1-800-499-0027.
- VA VISN 19 Mental Illness Research Education and Clinical Center website. <http://www.mirecc.va.gov/visn19.asp>

Resources for Military Families Coping with Trauma

- Substance Abuse and Mental Health Services Administration (SAMSA) <http://www.samhsa.gov/vets/index.aspx#military>
- National Center for Posttraumatic Stress Disorder: <http://www.ncptsd.va.gov/ncmain/veterans/>
- For more information on caregiver burden and related problems: http://www.ncptsd.va.gov/ncmain/ncdocs/fact_shts/fs_partners_veterans.html

Resources for Helping Children: American Foundation for Suicide Prevention (AFSP) lists a number of resources to help child survivors cope with the suicide of family member or loved one. <http://www.afsp.org/>

- ***After a Parent's Suicide: Helping Children Heal***
Margo Requarth, Healing Hearts Press, 2006. Written by a bereavement counselor who lost her own mother to suicide when she was just under four years old, this book offers constructive, compassionate and clear suggestions for helping children
- ***After a Suicide: A Workbook for Grieving Kids***
Developed for use with children, this workbook combines explanations of mental illness and suicide, creative exercises, practical advice, and quotations from child survivors.

- ***But I Didn't Say Goodbye: For Parents and Professionals Helping Child Suicide Survivors*** Barbara Rubel, Griefwork Center, Inc., 2000. Told from the point of view of a child, this book is intended for adults to read and then share with children.
- ***Child Survivors of Suicide: A Guidebook for Those Who Care for Them*** Rebecca Parkin and Karen Dunne-Maxim, 1995. Available through AFSP. This practical guide offers guidance for family members, educators, and others who deal with young survivors.

Other Resources for Talking to Child Survivors:

- ***Talking to Children after a Loved One has Died by Suicide*** Miki Tesh. Provides guidance on communicating with children about the suicide of a loved one.
<http://www.suicidology.org/displaycommon.cfm?an=1&subarticlenbr=226>
- Cammarata, D. (2000). ***Someone I Love Died by Suicide: A Story for Child Survivors and Those Who Care for Them***. Grief Guidance Inc.

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