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Jason D. Marquardt
Winona State University

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Veteran's Deaths Due to Suicide Have Increased to an Alarming Rate

Jason D. Marquardt

A Capstone Project submitted in partial fulfillment of the

Requirements for the Master of Science Degree in

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Abstract

With Veterans Suicide rates at an all-time high there is more to be done. Twenty or more Veterans in the United States commit suicide on a daily basis with no end in sight. Despite all of the research being done, there are still no clear answers to why this epidemic continues. The facts currently are that there are not an adequate number of mental health providers to meet the needs of the general population let alone the Veteran population. There are an overwhelming number of risk factors that can lead to suicide like stress, guilt, alcohol and substance abuse, mental health conditions like depression. Even though with treatment this risk can be minimized it still leads back to the issue that there is not enough providers in the Veterans network along with the reality that traditional psychological theories are not tailored to the lives and stress that Veterans and members of the military have experienced.

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Introduction

Suicide in the United States is ranked in the top ten for leading causes of death, equaling about 30,000 deaths annually (Shekelle, Bagley, & Munjas, 2009). Currently, Veterans Suicide Rates are twice that of the civilian population (Suicide Among Veterans and Other Americans 2001-20014, 2016). Veteran suicides account for about 7% to about 27% of all suicides for states that report Veteran status (Appendix D) (Kemp & Bossarte, 2012). Back in 2001, the suicide rate of Veterans served by the Department of Veterans Affairs was 1,609 and rose slightly to 1,909 in 2008 (York, Lamis, Pope, & Egede, 2013). The numbers are not decreasing and the epidemic continues to grow.

To understand the issue of suicide, it is important to know the number of Soldiers, Sailors, Airman, and Marines that have committed suicide. For completed suicides in the year 2015 the active (“active” referring to military members currently serving in the armed forces in some capacity) component included: the Army had 122, Marine Corps 34, Navy 53, and Air Force 60; in the Reserve component of all branches 80, and lastly the Army and Air National Guard was at 89 (Pruitt, Smolenski, Reger, Bush, Skopp, & Campise, 2014). This data shows that in one year there were a total of 438 members of the military that committed suicide. There were another 1,126 suicide attempts that were reported from the four branches of the military (Pruitt, Smolenski, Reger, Bush, Skopp, & Campise, 2014). In the total Veteran population, there is an average of 20 Veterans whom died from suicide each day, equaling about 7300 per year (Suicide Prevention Fact SheetNew VA Stats, n.d). The suicide rate of the military as a whole was equal to twenty-two suicides per 100,000 service members, which exceeds the general population in the US which is eighteen per 100,000 persons (Lee, 2011).

Mental health issues and suicide

Failed relationships and administrative and or legal issues 90 days prior to suicide were one the most commonly cited psychosocial stressors in suicide (Pruitt, Smolenski, Reger, Bush, Skopp, & Campise, 2014). Studies suggest suicide can be understood as a multifactorial phenomenon, with biological, psychological, with social and/or environmental triggers (Shekelle, Bagley, & Munjas, 2009). Research shows that in both civilian and military, the populations being male, White, and elderly is where the highest risk can exist (York, Lamis, Pope, & Egede, 2013). Other factors suggest that suicide of current and former military members can be associated with increased combat exposure, stigma, along with decreased perceptions of resilience and social support (Pietrzak, Goldstein, Malley, Rivers, Johnson, & Southwick, 2010).

Unique characteristics of veterans

Vietnam veterans with post traumatic-stress disorder are four times more likely to die by suicide than veterans without post traumatic-stress disorder (Hendin, 2014). When the Veteran of the Afghanistan and Iraq wars compare to the Veterans of the Vietnam War, one could think that they are not as strong due to the increased number of suicide attempts, but that is not the case. The Veterans of today have to deploy more than Veterans did in the past. In Vietnam, the service member would be deployed for twelve months and then return home and not have to worry about going again because of the draft (Hendin, 2014). Today's military members can deploy from one to ten times during their time in the military because it is an all-volunteer force.

The more time a Veteran has to deploy and be in fear for their life, the greater chance there can be for PTSD or other mental health issues. A look back in history shows that suicide has always been an issue during and after a war or conflict. For Veterans of the Vietnam War,

nineteen out of one hundred combat Veterans have attempted suicide since returning home (Hendin, 2014). Guilt and Post-Traumatic Stress Disorder from combat were the two most noted causes for suicide among these Veterans. Other symptoms that these Vietnam Veterans as well as the Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) Veterans faced were nightmares and flashbacks along with the thoughts of being killed (Hendin, 2014).

Current support system

In combat, the Veteran has a close support network that they have lived with for the deployment, and upon returning home to the United States, they may feel that their close support network is gone. With Veterans, trust is an important component in combat; one learns to trust the person to the right and left of them with their life. Even when trust has been established back in the states with someone in the mental health field, the Veteran most likely will not open up to inform outsiders on how they are feeling {due to the challenges of developing a trusting relationship with someone who does not share their experience (Hendin, 2014).

What needs to change

Another reason that Veterans are not getting the support they need is that all patients, including Veterans, are having more difficulty accessing care under Psychiatrists and other mental health professionals. One study found that the number of psychiatrists in the period 2003– 2013 did not change and in actuality decreased when adjustments for population growth were added (Bishop, Seirup, Pincus, & Ross, 2016). Lower access to mental health services are directly related to lower availability of mental health providers. In Rural hospital settings they generally provide fewer inpatient and outpatient mental health services than urban hospitals. The Health Resources and Service Administration have only qualified 2,289 non-metropolitan mental health professional shortage areas, requiring 1,269 practitioners to be at an acceptable

level (Unknown, 2012). Adding to the burden, an addition, 4,424 practitioners would be needed to achieve target ratios of 10,000 clients to 1 practitioner in rural areas (Unknown, 2012). With needing over 4,000 practitioners to reach a goal of 1 to 10,000, the realization is that the mental health state of the county is in jeopardy.

Additionally, there needs to be more focus on enhancing personal growth, helping the Veterans find purpose in life just like they had in combat (Pietrzak, Goldstein, Malley, Rivers, Johnson, & Southwick, 2010). Counseling that uses theories designed for Veterans will also help them with autonomy, self-control, self-acceptance, and positive relations with others (Pietrzak, Goldstein, Malley, Rivers, Johnson, & Southwick, 2010). Researchers further suggest that mental health professionals incorporate psychodynamic techniques in conjunction with their traditional theories (Hendin, 2014).

The military has programs that assist the current service member with preparation for discharge. They also encourage appropriate help-seeking behavior following discharge, but without the Veterans asking for the help after service the suicide numbers will continue to rise. Unlike the current serving Veterans, Veterans that have been out of the military for many years have a much harder time finding care due to the limited access and stigma attached to seeking mental health services.

The American Foundation for Suicide Prevention along with the SPRC conducted a federally funded systematic review based on the National Registry of Evidence-Based Programs and Practices Criteria of suicide prevention programs and developed a Best Practices Registry (York, Lamis, Pope, & Egede, 2013). The issue with the Best Practices Registry is there is no Veteran-specific interventions but they do include several best practices used by the VA (York, Lamis, Pope, & Egede, 2013).

The Department of Veteran Affairs and the Department of Defense have made great strides to lessen the number of deaths due to suicide, however, the research has proven that there is more to be done. The Department of Veterans Affairs has moved from the traditional means of mental health consultation in a hospital setting. Today they use many resources to include Vet Centers, hotlines, telehealth, and contracting with community providers in conjunction with the inpatient and outpatient approach. Within the Department of Defense they are teaching the leaders from the top down to be more aware for the risks. Providing suicide prevention information to the Military Community or raising their awareness of the risk and protective factors and warning signs for suicide is helpful (Defense, 2015).

It is the worry of researchers that public and congressional support will decrease the further time there is from a conflict (Hendin, 2014). This is a problem because the research shows that there is a higher incident of completed suicides in elderly males, long after services may be decrease for current military members. Mental health providers and researchers must continue to push Congress for research funding to develop and test new treatments that will be more effective for the military and veteran population (Hendin, 2014). The work that is done to aid the Veteran community can affect the general population in a positive manner.

Better use of common counseling theory

Molding existing counseling theories to be more Veteran centered would assist in this process of prevention of suicide of former combat military. Mental health professionals are willing to change and are developing ways to treat Veterans that suffer from mental illness (Hendin, 2014). The Department of Veterans Affairs and the Department of Defense also continue to work with Veterans to combat this epidemic.

Increasing the number of mental health providers, especially in rural areas is a key factor in reducing Veteran suicide. By increasing providers, effective treatment for veterans will be more accessible. A first-line treatment for Post-Traumatic Stress Disorder is cognitive behavioral therapy (Lee, 2011). This theory is usually utilized with prolonged exposure and repeatedly recalling a traumatic event until emotional response tapers to allow cognitive confrontation of the trauma (Lee, 2011). Two additional forms of this theory commonly used are cognitive restructuring which includes the process of verbalizing, challenging, and replacing erroneous thoughts with balanced ones (Lee, 2011). Along with stress inoculation training, a process of reducing anxiety and enhancing coping skills so the thoughts do not compound into more savvy outcomes (Lee, 2011). Skilled mental health providers are needed to implement this strategies that can be utilized to decrease the symptoms of PTSD in veterans.

Review of Literature

Suicide in the United States is ranked in the top ten for leading causes of death, equaling about 30,000 deaths annually (Shekelle, Bagley, & Munjas, 2009). Studies suggest suicide can be understood as a multifactorial phenomenon, with biological, psychological, with social and or environmental triggers (Shekelle, Bagley, & Munjas, 2009). Veterans are a unique population that has been explored more closely in recent years especially with the past fifteen years of conflict and combat. The highest rates of suicide in Veteran populations are no different than the highest rates in the general population. In both the populations being male, White, and elderly is where the highest risk can exist (York, Lamis, Pope, & Egede, 2013).

Currently, Veterans Suicide Rates are twice that of the civilian population (Suicide Among Veterans and Other Americans 2001-20014, 2016). What makes them more at risk? Back in 2001, the suicide rate of Veterans served by the Department of Veterans Affairs was

1,609 and rose slightly to 1,909 in 2008 (York, Lamis, Pope, & Egede, 2013). And today the rates are still continuing to increase within the Veteran populations, even more so for the service men and women who have experienced combat (York, Lamis, Pope, & Egede, 2013). Combat veterans that served in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) are more at risk to commit suicide than others persons their age that have not served in either of these two combat zones (Sher & Yehuda, 2011).

“The U.S. Army reported 32 veterans committed suicide in June of 2010 with 10 of the 21 active duty veterans deployed to Middle East conflict two to four times” (Zoroya, 2010). The suicide rate of the military as a whole was equal to twenty-two suicides per 100,000 service members, which exceeds the general population in the US which is eighteen per 100,000 persons (Lee, 2011).

The Department of Veterans Affairs Health Study screened 2160 male outpatients at Boston-area VA clinics and reported depressive symptoms in thirty-one percent of the population; that sample rate is more than twice the general population (Shekelle, Bagley, & Munjas, 2009). During a different study of over 800,000 depressed veterans reported a suicide rate seven times higher than the general population (Shekelle, Bagley, & Munjas, 2009).

To understand to issue of suicide, it is important to know the number of Soldiers, Sailors, Airman, and Marines that have committed suicide. For completed suicides in the year 2015 the active component included: the Army had 122, Marine Corps 34, Navy 53, and Air Force 60. In the Reserve component of all branches 80, and lastly the Army and Air National Guard was at 89 (Pruitt, Smolenski, Reger, Bush, Skopp, & Campise, 2014). So in one year there were a total of 438 members of the military that committed suicide. There were another 1,126 suicide attempts that were reported from the four branches of the military (Pruitt, Smolenski, Reger, Bush, Skopp,

& Campise, 2014). In the total Veteran population, there is an average of 20 Veterans whom died from suicide each day, equaling about 7300 per year (Suicide Prevention Fact SheetNew VA Stats, n.d).

A look back in history tells that suicide has been an issue during and after a war or conflict. For Veterans of the Vietnam War, nineteen out of one hundred combat Veterans had attempted suicide since returning home (Hendin, 2014). Guilt and Post-Traumatic Stress Disorder from combat were two the most noted causes for suicide amount these Veterans. Other symptoms that these Veterans as well as the Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) faced were nightmares and flashbacks along with the thoughts of being killed (Hendin, 2014).

Other factors suggest that suicide can be associated with increased combat exposure, stigma, along with decreased perceptions of resilience and social support (Pietrzak, Goldstein, Malley, Rivers, Johnson, & Southwick, 2010). In combat, the Veteran has their close support network that they have lived with for the deployment and upon returning home to the United States, they can feel that their close support network is gone. With Veterans, trust is an important component in combat; one learns to trust the person to the right and left of them with their life. Even when trust has been established back in the states with someone in the mental health field, the Veteran most likely will not open up to inform outsiders on how they are feeling (Hendin, 2014).

Suicide has become an epidemic in the United States and it is two times higher in the Veteran population (Sher & Yehuda, 2011). When the Veteran of the Afghanistan and Iraq wars compare to the Veterans of the Vietnam War, one could think that they are not as strong but that is not the case. The Veterans of today have to deploy more than the Veterans did in the past. In

Vietnam, the service member would be deployed for twelve months and then return home and not have to worry about going again because of the draft (Hendin, 2014). Now the Veteran of today can deploy from one to ten times during their time in the military because it is an all-volunteer force.

The more time a Veteran has to deploy and be in fear for their life the more chance there can be for PTSD or other mental health issues. The military has good suicide prevention while the person is in active service, but when they leave the service it is up to them to seek help. And as there is an influx of Veterans leaving the military, a greater need for suicide prevention in the civilian world will continue to grow (Sher & Yehuda, 2011). Vietnam veterans with post traumatic-stress disorder are four times more likely to die by suicide than veterans without post traumatic-stress disorder (Hendin, 2014)

There will also need to be more focused on enhancing personal growth, helping the Veterans find purpose in life just like they had in combat (Pietrzak, Goldstein, Malley, Rivers, Johnson, & Southwick, 2010). Counseling will also help them with autonomy, self-control, self-acceptance, and positive relations with others (Pietrzak, Goldstein, Malley, Rivers, Johnson, & Southwick, 2010).

The military has programs that assist the current service member with preparation for discharge. They also encourage appropriate help-seeking behavior following discharge but without the Veterans asking for the help after service the numbers will continue to rise. Unlike the current serving Veterans, Veterans that have been out of the military for many years have a much harder time finding care.

The American Foundation for Suicide Prevention along with the SPRC conducted a Federally funded systematic review based on the National Registry of Evidence-Based

Programs and Practices Criteria of suicide prevention programs and developed a Best Practices Registry (York, Lamis, Pope, & Egede, 2013). The issue with the Best Practices Registry is there is no Veteran-specific interventions but they do include several best practices used by the VA (York, Lamis, Pope, & Egede, 2013).

Conclusion

The more discussions that are had the more of a possibility where will be to form ideas to put a stop to the epidemic of suicide. Suicide among Veterans is at an all-time high with no end in sight (Shekelle, Bagley, & Munjas, 2009). In looking at the Veterans suicide rates there is much more research to be performed in hopes to mitigate this epidemic. With twenty or more Veterans taking their life every day there are changes that need to be made to identify the persons at risk in a more timely fashion. A history of non-fatal suicide attempts is recognized to be among the most robust risk factors for suicide (Suicide Among Veterans and Other Americans 2001-20014, 2016).

This author recommends the following to improve the mental health of our service men and women and decrease the number of suicides of military and veteran populations:

1. Increase access to mental health services by . . .
2. Research therapeutic interventions that would serve this population, both long term and short term;
3. Train practioners on the experiences of veterans as well as on effective intervention . . .
4. Implement suicide prevention processes into the military;
5. Encourage veterans to trained as practioners . . .

Molding existing counseling theories to be more Veteran centered would assist in this process. Mental heal professional are willing to change and are developing ways to treat Veterans that suffer from mental illness (Hendin, 2014). The Department of Veterans Affairs and the Department of Defense also continue to work with Veterans to combat this epidemic. It is the worry of researchers that public and congressional support will decrease the further time there is from a conflict (Hendin, 2014). Mental health providers and researchers must continue to push congress for research funding to develop and test new treatments that will be more effective (Hendin, 2014).

As any profession would agree increasing the number of mental health providers especially in rural areas is another key factor in reducing Veteran suicide. A first-line treatment for Post-Traumatic Stress Disorder is cognitive behavioral therapy (Lee, 2011). This theory is usually utilized with prolonged exposure and repeatedly recalling a traumatic event until emotional response tapers to allow cognitive confrontation of the trauma (Lee, 2011). Two

additional forms of this theory commonly used are cognitive restructuring which includes the process of verbalizing, challenging, and replacing erroneous thoughts with balanced ones (Lee, 2011). Along with stress inoculation training, a process of reducing anxiety and enhancing coping skills so the thoughts do not compound into more savvy outcomes (Lee, 2011).

The more discussions that are had the more of a possibility there will be to form ideas to put a stop to the epidemic of suicide. Suicide among Veterans is at an all-time high with no end in sight (Shekelle, Bagley, & Munjas, 2009).

Authors Notes

When looking at the Department of Veterans Affairs employment website for mental health careers in my area I found that there were 305 jobs that are in deep need to be filled. (<http://www.vacareers.va.gov/careers/mental-health/search>) openings which in the larger picture seems like a small amount but it does speak to the need for more people to enter the mental health profession.

Within the Army, Navy, Marine Corps, Air Force, and Coast Guard Reserve forces the biggest issue that I have seen in my twenty-three years of service would be not being in daily contact with the members on a daily basis. This meaning that each person lives a life that their brothers and sisters in arms does not see and cannot know what is going on in their lives unless they talk. Also a member of the military does not want to admit weakness in fear that there will be dismissal from the service or that their military family will think of them as weak.

It is time that the military changes the stigma that hangs over admitting that a member needs help. Only then will in my opinion will we be able to save the lives of the victims of suicide. Furthermore until our country starts putting funding into assisting professional in securing the education that is needed to fill the gaps in services the suicides will continue.

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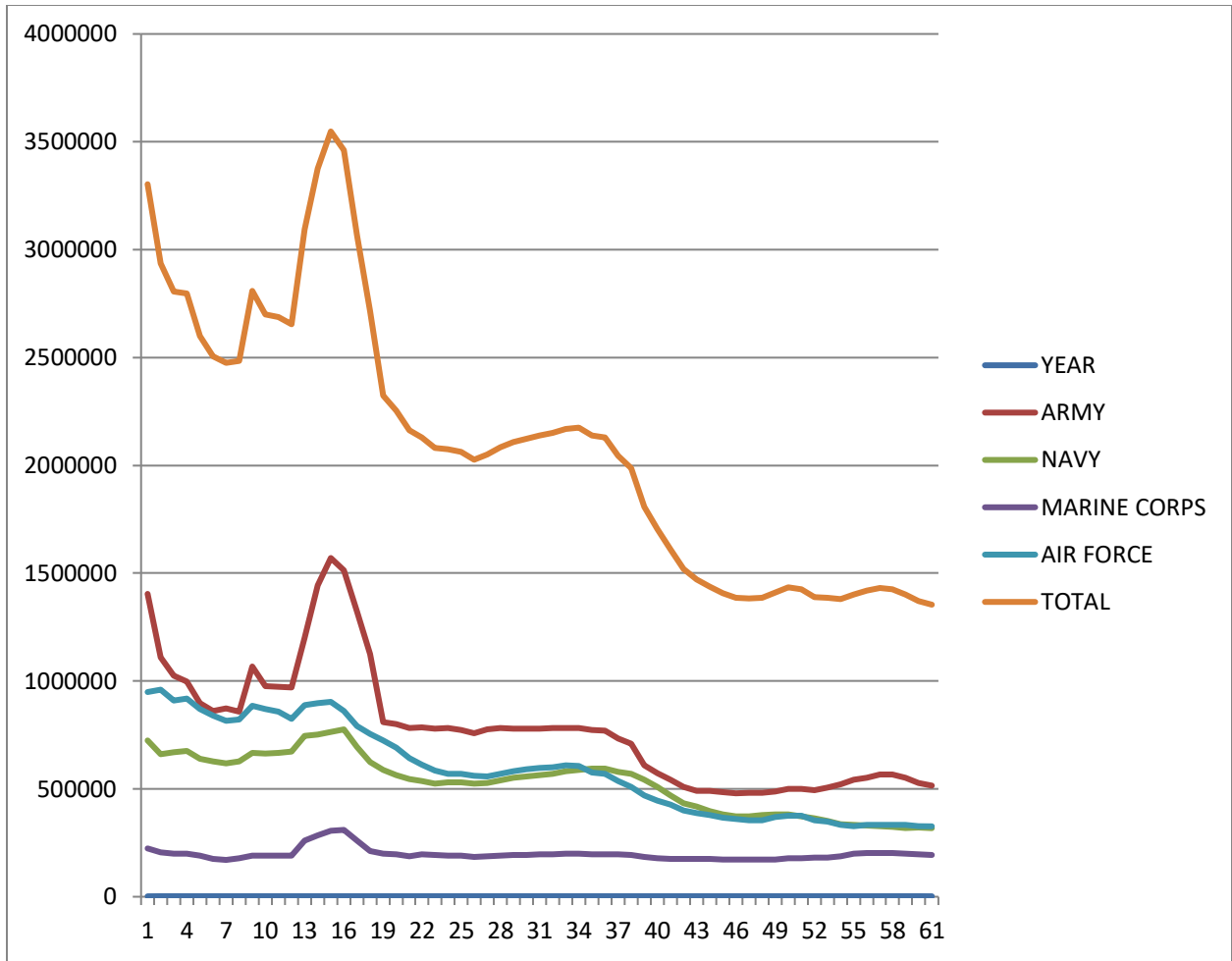
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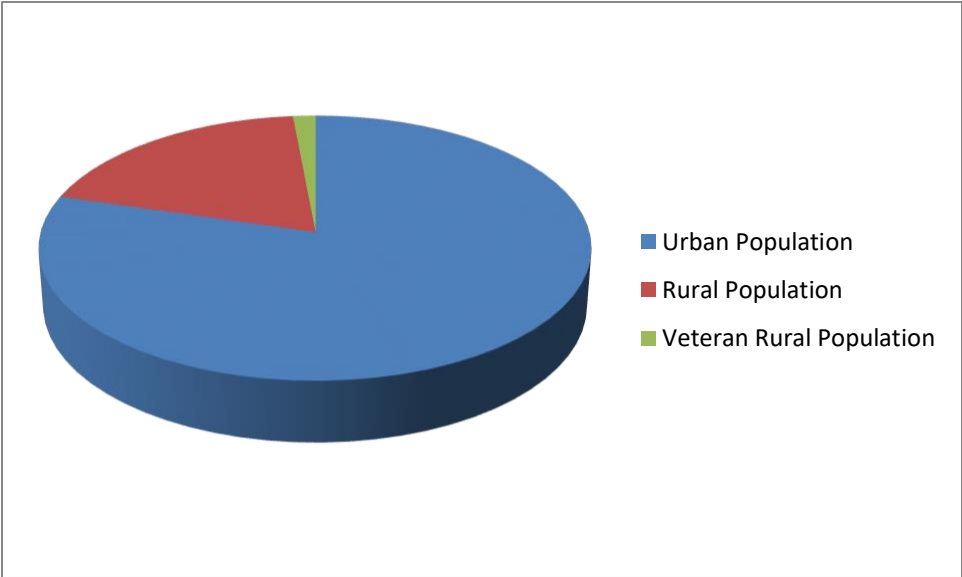
Appendix A

United States Military Personnel 1954-2014

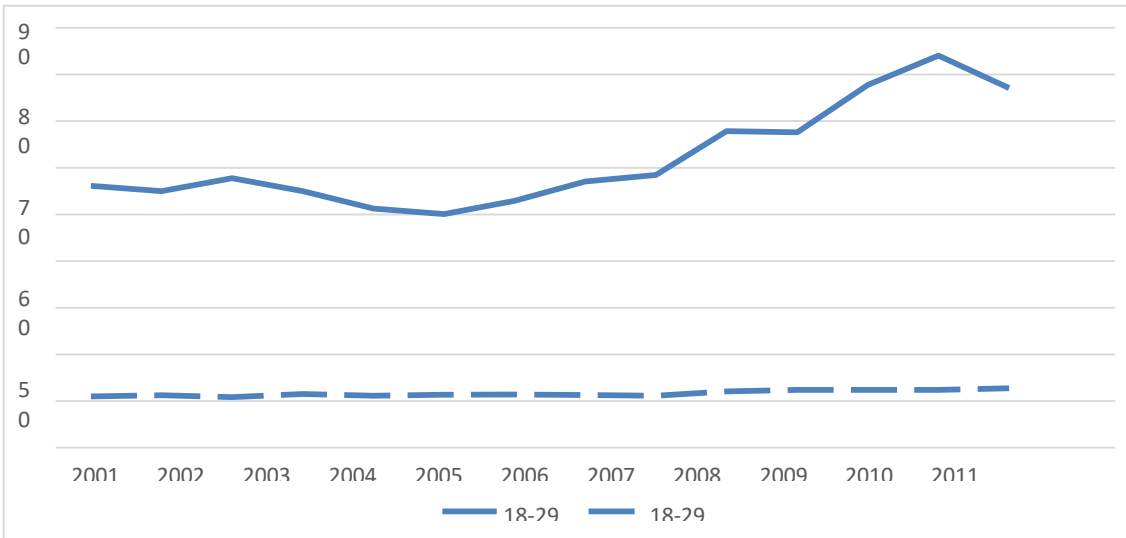


(Coleman)

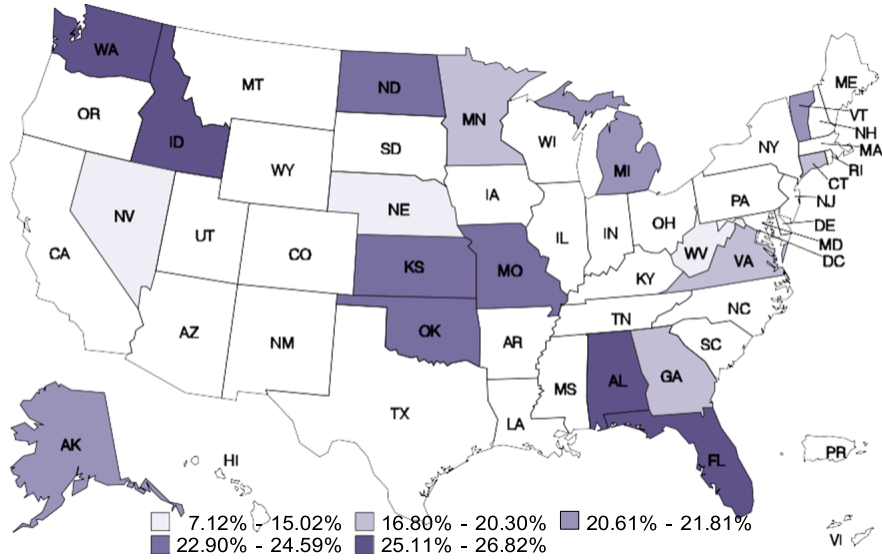
Urban, Rural and Rural population



(Suicide Among Veterans and Other Americans 2001-20014, 2016).



Crude Rates of Suicide by Calendar Year among Veterans (V) and Civilians (C) Ages 18–29 Years, 2001–2014 (Suicide Among Veterans and Other Americans 2001-20014, 2016).



*Among states reporting Veteran status (Suicide Among Veterans and Other Americans 2001-20014, 2016).