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Clinicians' voices on suicide prevention for veterans

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Prevention for Veterans

Abstract

This was an exploratory study using a mixed methods design. The purpose of the study was to examine suicide prevention programs from the perspective of clinical practitioners who work or have worked with veterans in therapeutic settings. The data was collected anonymously through Survey Monkey. The study focused on practitioner observations and insights regarding increased risk factors and effective ways to meet the needs of veterans who are at risk for suicide. A total of 40 clinical respondents who work or have worked with veterans in therapeutic settings participated in this qualitative study. Participants were recruited through social media sites of Facebook and LinkedIn, and also through the researcher's personal and professional contacts via email, and snowball sampling methods. Each participant was asked several demographic questions and six open-ended questions related to their observations, experiences and insights concerning veteran suicide and requested to give their recommendations for best practice programs to address this epidemic.

This study presents a rich narrative of clinical practitioners from several disciplines that worked in various capacities and clinical settings. From the qualitative data several exploratory themes emerged, which showed correlation trends among these themes. The study also provided practitioners a venue to discuss their experiences and have their voices heard about their unique clinical experiences of working with veterans with suicidal ideation. Clinical participants offered valuable insights for improving suicide prevention programs. They were: improved mental health care, increased use of peer support programs, and the need for more resources and funding available to veterans and their families.

Clinicians' Voices on Suicide Prevention for Veterans

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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Chapter I

Introduction

Over 2.4 million troops have fought in and around Afghanistan and Iraq since 9/11 (Thompson, 2011); and many of these veterans have now returned home. Many more soldiers, also, will return to the U.S. and will face the shift from warrior-in-combat to civilian life. This shift in role demarcation and the trauma of warfare causes numerous psychiatric disorders, which for an increasing number of soldiers lead to suicide. The tragedy of military suicide has greatly increased in recent years and has reached epidemic proportions. This epidemic has brought attention to the dire problem of access to quality mental health services and the urgent need for effective suicide prevention programs for our Armed Forces. On average, one active duty soldier dies by suicide every day; and a suicide among veterans occurs every 80 minutes (Kemp and Bossarte, 2012). Historically, soldiers have been less likely than civilians to kill themselves but this is no longer the case. Veterans account for approximately 10% of the U.S. adult population; yet they account for 20% of adult suicides. According to the U.S. Department of Defense (DoD) as of June 10, 2012, 4,486 U.S. troops died in Iraq; 1,950 died in Afghanistan; and 2,676 died by suicide. The suicide rate among our soldiers jumped 80% from 2004 to 2008. By June 2012, it jumped another 18% increase over 2010 veteran suicides. Researchers are examining this tragic surge but there continues to be more questions than answers.

Statement of the Problem

Veteran suicides are occurring at an alarming rate; and figures provided by the Department of Veterans Affairs (VA) may indeed be an underestimation of the actual problem. According to a February 2013 report by the VA, "Since 1999, the estimated total number of Veterans who have died by suicide has increased." Because not all states make veteran suicide data available, or count what *are* suicides *as* suicides, the figures can be significantly higher than estimated. There are reasons for this. For example, suicides among homeless veterans who have no one to classify their status or are ashamed of the stigma associated with suicide and mental illness; veterans who intentionally crash their cars or die of a drug overdose with no note left behind; veterans with mental illness who die of "suicide by cop" (i.e., hostage situations, refusal to surrender, or lunging towards police officers); military sexual assault victims overcome by combat stress and betrayal; and veterans with post-traumatic stress disorder and traumatic brain injury, especially from the Afghanistan and Iraq wars all contribute to underreporting. The suicide rate for male veterans aged 18 – 29 increased nearly 44% between 2009 and 2011, and for females the rate increased in excess of 11% (Kemp and Bossarte, 2012). Veterans make up only 10% of the U.S. population but account for nearly one in five suicides; they are twice as likely to commit suicide when compared to civilian suicides. A separate report by the Department of Defense stated that the number of suicides among active-duty troops rose from 301 in 2011 to almost one a day during 2012 (DoDSER, 2012).

A further problem exists with the mission of the Veterans Health Administration (VHA) and the Department of Veterans Affairs (VA). The VHA's mission is to provide medical treatment for veterans and incorporates healthcare to take care of soldiers to keep them combat-ready, which focuses on short-term treatment and combat effectiveness, or physical health. The VA's

mission is to provide long-term health and veterans' well being after their tour of duty, or social integration. This suggests that these two healthcare systems have different philosophies in the treatment and care of active duty soldiers and veterans. One focuses on combat readiness while the other focuses on benefits earned from time of service. The immediate problem of mental and social health, impact of mental illness on soldiers' and veterans' day-to-day functioning, and their silent suffering becomes secondary and often missed. Efforts are made to treat symptoms such as PTSD, substance abuse, combat stress, traumatic brain injury, etc., but not root causes and risk factors or precursors to military suicides.

There is insufficient research on how to prevent military suicides before they happen or what types of intervention and prevention programs may be most effective in addressing this problem. In this thesis project, I will explore risk factors, symptomology, and prevention strategies necessary to meet the needs of veterans at risk for suicide from the perspective of clinical practitioners who work hands on with veterans. Learning about the unique needs of this vulnerable population will be a necessary first step to develop culturally competent prevention programs and treatment plans specific to soldier needs, conditions and transitions; and ultimately can decrease suicides among both active-duty soldiers and veterans.

Purpose of Study

This study examines suicide prevention programs from the perspective of clinical practitioners who work or have worked with veterans in therapeutic settings, and will focus on their observations and insights regarding increased risk factors and effective ways to meet the needs of veterans who are at risk for suicide. Three research questions frame my study:

(1)   What are the most significant and observable suicide risk factors among veterans?

(2)   What are salient protective factors to guard against suicide? and

(3)   What are the most effective ways to meet the needs of veterans who are at risk for

suicide?

Six open-ended questions defined this research and were used to extrapolate data to provide

veteran-specific strategies for suicide prevention and recommendations for best practice

programs to decrease veteran suicide. Specific risk factors for suicide were identified. Each

study participant was asked:

(1)   What do you observe to be unique risk factors among veterans with suicidal

ideation? Risk factors may include military status, age, gender, stressors, mental

illness, physical health, and many other factors.

(2)   What do you identify as unique, veteran-specific protective factors for suicide

prevention?

(3)   What are specific social supports that veterans utilize to maintain hope and

emotional stability despite experiencing suicidal ideation?

(4)   What are barriers to effective suicide prevention interventions?

(5)   Please describe a time when you implemented an intervention for a veteran with

suicidal ideation that was successful. (What worked in the intervention?)

(6)   If funding and resources were not a factor, describe a best practice suicide

prevention program for military personnel, with specific content areas.

Hence, the primary purpose for this research project was to identify suicide risk factors and

effective intervention strategies and programs to prevent suicide among veterans. The secondary

purpose for this research was to provide suicide prevention education to clinical practitioners,

civilian and military personnel who come into contact with veterans about the signs, symptoms,

resources, strategies and programs addressing suicide prevention for veterans. Findings from

this study will ultimately help veterans, family members, clinical practitioners and society to more effectively provide suicide prevention services to our veterans. This research further provides valuable data about suicide risk factors among veterans, current suicide prevention programs, organizations that provide mental health care for veterans and offers an opportunity for clinicians to share insight and advice on best practices for suicide prevention strategies with veterans.

Theoretical Framework

This research is based upon the two main theoretical frameworks that historically examine the study of suicide: These are: "(1) the sociological model, which has its foundation in the works of nineteenth-century French sociologist Emile Durkheim, and (2) the psychological model, which is based on the works of Viennese psychoanalyst Sigmund Freud" (DeSpelder and Strickland, 2011). In my investigation of suicide theories, I have found that a combination of sociological and psychological insights provide what I feel is the most integrated and satisfying approach to studying veteran suicide.

Definition of Terms

The following concepts are used throughout this research.

Veterans – individuals who have separated or retired from any branch of the Armed Services, including National Guard and Reserve Units.

Clinical practitioners – experienced, qualified and trained professionals who work or have worked with American veterans in inpatient and or outpatient treatment facilities, and have certification, licensure and or specialized degree completion such as the following.

BSW – Bachelors in Social Work

MSW – Masters in Social Work

LICDC – Licensed Independent Chemical Dependency Counselor

LCSW - Licensed Clinical Social Worker

LMHC – Licensed Mental Health Counselor

MFC – Marriage and Family Counselor

MFT – Marriage and Family Therapist

APRN – Advanced Practice Registered Nurse

MD – Doctor of Medicine

PhD, PsyD – Doctorate in Psychology

Psychiatry – the specialty of medical practice in mental health

Suicide – the act or an instance of taking one's own life voluntarily and intentionally (Merriam-Webster Dictionary, 2012)

Military Sexual Trauma (MST) – "sexual harassment that is threatening in character or physical assault of a sexual nature that occurred while the victim was in the military, regardless of geographic location of the trauma, gender of the victim, or the relationship to the perpetrator." (Department of Veterans Affairs, 2014)

VHA -Veterans Health Administration

VA – Veterans Affairs or the Department of Veterans Affairs

DOD – Department of Defense

PTSD – Posttraumatic Stress Disorder

TBI – Traumatic Brain Injury

Moral Injury – A sense of alienation from one's internalized code of acceptable behavior and from civil social mores experienced by some combat veterans due to wartime actions.

Limitations of Study

    At-risk veterans are a vulnerable population. In an effort to protect their confidentiality and spare them possible emotional harm, all data in this study is collected from clinical practitioners, which omits the direct voice of veterans. This can be considered a limitation in my study. Another limitation is in regard to the diversity of clinicians who responded to the survey. Respondents have dominant identities such as white, heterosexual, females and males. Efforts were made, using Survey Monkey, to outreach to clinicians of color and in the LGBT community.

    A related limitation is the voluntary nature of participation in this study. It is possible that clinicians with vested interest in veteran suicide were more likely to respond to the survey than others. Access to the online survey may be another consideration. It also is possible that location, visibility and awareness of the survey limited responses. A weakness of this data collection method is the inability to follow up on survey questions in more detail or to observe participants tone of voice or body language as one could in a semi-structured, in-person interview format. Lastly, this study's findings cannot be generalized to the greater population of clinicians. Findings are specific to the voices of clinical practitioners in this study.

Chapter II

Literature Review

This literature review is divided into two sections: theoretical and empirical. The theoretical section discusses trauma and coping; the empirical section discusses PTSD, suicide prevention services, transgender suicide and overt and covert messaging about suicide. Following these overviews, I provide a synopsis of the literature review.

Theoretical Literature on Trauma and Coping

A literature review on trauma and coping yields numerous research articles; and it is evident that trauma is not the same for all individuals. Trauma is different by type, and interpersonal trauma is the most difficult to treat. Interpersonal trauma, often the result of external aggression, is deeply personal and unique (Green et al., 2000); and trauma evolving from combat duty significantly differs from trauma that occurs from natural disasters, illnesses, accidents, death by illness or domestic violence. Linley and Joseph (2004) identified four areas that distinguish combat trauma from other trauma: helplessness, controllability, expectation, and ongoing threat to one's life. Active duty soldiers are trained to kill the perceived enemy and threats, destroy property, take control of situations, remove perceived threats, and to fight on a moment's notice. The reality of death is a constant as soldiers consistently are placed in harm's way. According to Lamer (2013), combat trauma is especially unique because of its reciprocal aggression that requires each individual who experiences this type of trauma to also become an agent of trauma for others. Combat trauma is the most difficult to treat because soldiers often have difficulty

framing their mission to kill and commit atrocities or criminal acts that violate social norms. Often these acts surface as uncontrollable flashbacks, guilt and posttraumatic stress that lead to suicidal ideation, or even suicide.

Lamer (2013) addresses other factors that play a role in how soldiers cope with their military and warfare experiences. He states that many veterans from Iraq and Afghanistan experience several deployments that contribute to their difficulty in overcoming combat trauma. Kline et al. (2010) and Seal et al. (2009) report that these multiple deployments increase the likelihood that combat-related stress builds up over time. How veterans cope or respond to trauma can relate to individual characteristics such as personality, individuality, individually perceived unit cohesion, physiological stress tolerance (Lamer, 2013; Grossman, 2008), and ultimately how each soldier creates meaning to cope with and understand the trauma events (Ark & Ai, 2006; Schok, Kleber & Lensvelt-Mykders, 2010).

Frankl (1992) states that it is important to assign meaning to trauma events, which play a critical role in determining the stressfulness of the event. He theorizes that it is this meaning that soldiers strive for and the acceptance of this meaning helps soldiers to cope with their stress and trauma. How combat soldiers view themselves, their experiences, and their environments can often times be very traumatic. For example, if they fight in a war in which they do not feel Americans support or if they feel they have the blood of women and children on their hands, their stress escalates and the visual trauma becomes long lasting. It is the transformation of these meanings as a central focus that all therapies share (Brewin & Power, 1997; Sprenkle & Blow, 2004).

For many soldiers returning home from war, their experiences shape how they see the world, themselves and their families; and the war they bring home 'in their heads' is a very different

war and existence than their new reality. One of the most brutally honest and powerful accounts of war and its aftermath for soldiers is the widely praised book by Tyler Boudreau, *Packing Inferno: the Unmaking of a Marine*, (2008). In this firsthand account, Tyler E. Boudreau, a twelve-year veteran of the United States Marine Corps infantry, shares his ordeals in battle and then coming home to a society that did not understand the true nature of war. Boudreau describes his very real, now 'stateside battle', with combat stress and his long road to recovery as he details his personal search for conscience, family, and ultimately his real self. Here we see how the impact of trauma extends from psychological pain into the individual's sense of self and how the quality of an attachment to a larger community can sever or build the stability of connection and understanding to make meaning out of events. Judith Herman in her book, *Trauma and Recovery* (1992) states,

 "Traumatized people feel utterly abandoned, utterly alone, cast out of the human and divine systems of care and protection that sustain life. Thereafter, a sense of alienation, of disconnection, pervades every relationship, from the most intimate familial bonds to the most abstract affiliations of community and religion." (p. 52).

Both Boudreau and Herman discuss the psychological impact of war and the reintegration of soldiers into civilian life; and report that their reintegration is directly tied to the community and society to which they return. A rejecting climate compounds their stress and isolation and deepens their combat trauma.

Currently in the United States, there is a widening gap of awareness and understanding between those who serve in the military and the civilians they protect. This increasing divide leads to veterans feeling misunderstood and alienated from the civilian population. In the book, *Bridging the Military-Civilian Divide,* author Bruce Fleming (2010) addresses the subject of

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civilians not only becoming more aware of the necessary actions of warriors in wartime, but also about developing a more realistic and reasonable response. Fleming states that civilians need to learn to separate the warrior function of the military in wartime from the greater need of the nation to have military service members ready to serve their country to keep the peace in peacetime.

Fleming goes on to say that civilians don't have a 'clue' who serves in the military, including what the military does, what it costs Americans and their families, or what it costs those who join the military. Military service is something that other people do; and in turn, members of the military often see themselves as having little to nothing in common with the civilian world. Military soldiers are in many ways different from the civilian population. Many civilians would be unable to endure the trauma and warfare of soldiers; and herein lays an increasing mutual lack of understanding about civil military affairs that sets the stage for the perfect military-civilian divide, and undue stress and trauma for our warriors who return home.

Fleming expresses it this way: "This kind of education is a necessity if we are to bridge the military-civilian divide in the America of the twenty-first century. War isn't the point. It's a means to an end. And that end is peace, which means being back home with family and friends; carrying on the…necessary actions we call life. The military exists to make the civilian world possible" (p.200). If most civilians had this type of attitude toward military forces, then service members would feel less alienated and more understood regarding their purpose in the greater society. Civilians also believe that the experience of being in a combat zone is the most difficult time for veterans; however veterans report that the biggest challenge for them is when they return home carrying the war within and trying to cope with these challenges in a civilian

world. In a lecture as part of an Operation Homecoming veterans' event in 2011, author and professor Robert Meagher made the following powerful remarks,

"It's a truism that no one goes off to war and comes back the same. This is no less true for being a truism. Truisms, after all, are things that we all know to be true but that we rarely spend any time thinking about, often because we prefer not to. Another truth that doesn't quite qualify as a truism because not everyone knows it, although they should, is that wars are not over when they're over. They leave behind wreckage and wounds. Warriors bring their war home with them, not like a tan acquired on holiday but like a secret they wish they hadn't been told. What about that secret? After the wars of the twentieth century — especially those wars labeled "great" and "good"— the common wisdom passed on to veterans from every side regarding what they now knew and others didn't was to: "let it go" — "leave it alone and it will leave you alone" — "leave it behind and it will stay there." All this made — and makes — perfect sense, except to veterans. "Alone"…"behind"… how convenient! To the uninitiated: common sense. To the warrior come home: silent betrayal." (2011).

   In summary, combat trauma and coping among veterans is very different than other traumas in several ways. Because of this, culturally specific treatment for this vulnerable population is urgently needed. A critical area of treatment is helping veterans make meaning of their combat trauma as it relates to their experiences and recovery. This transformation is a process that incorporates resilience, acceptance and validation; and is used to eliminate risk factors leading to suicidal ideation and the taking of one's life. This theoretical review allows thoughtful and detailed insight to identify risk factors, treatment interventions and therapies best suited for suicide prevention among veterans.

Empirical Literature

Suicide among our veterans is a complex but preventable issue. We require rigorous empirical research to help us understand why so many active duty military and veterans are killing themselves. Currently, there is insufficient empirical data to identify risk factors, what works, what leads to suicide, and how to prevent this tragedy from continuing to occur among our military. This section reviews some of these issues.

Investigation of Risk Factors for Increased Suicide Rates in Military Service Members

Hyman, Ireland, Frost and Cottrell (2012) conducted a quantitative study to investigate and identify risk factors for suicide among all active duty members of the U.S. military for 2005 and 2007. The sample included over 2,000,000 active duty members for 2005 and slightly under 2,000,000 in 2007 in a cross-sectional study that used case-control analysis and logistic regression models. Originally, this study was intended to examine Army service member's rates of suicides but later was expanded to include all military branches: Marines, Air Force, Navy, Regular Army, Army Reserves and National Guard personnel. These studies showed that "suicide rates for all branches of service increased during this period" (p.138). This research was groundbreaking in that it included, "Department of Defense (DoD) standardized suicide data, DoD-wide personnel data including deployments and marital status, and DoD-wide medical data with diagnoses and medical treatments" (p. 138). Prior to 2008, analysis of risk factors were performed only on small data samples and there was a lack of consistency among data collection tools, which made it difficult to make comparisons, as well as, discuss statistical limitations based on the small populations studied. Hyman (2012) examined risk factors associated with higher rates of suicide and saw that having an existing mental health condition was a very strong risk factor. Additional associations with suicide rates were: number of mental health visits, use of

selective serotonin reuptake inhibitors (SSRIs), prescriptions for sleep, reduction in rank, separation or divorce, and a deployment to a combat zone (p.139).

The findings of this research were enlightening and represented major strengths and progress in military reporting but several limitations were evident in this study. There were some key variables omitted in this study that included: legal issues, financial or job problems beyond loss of rank, personal relationship issues other than separation or divorce, battle stress, and participation in suicide prevention training and the nature of such training (p. 144). Two other limitations in this study were the use of a very small control group and that medical information and prescription drugs prescribed at deployments were incomplete. These limitations are certainly significant but may be attributed to the sample size. More multifaceted research studies to address the epidemic of increasing suicide rates among both active duty military members and veterans are indeed necessary. Further studies are needed to investigate risk or protective factors related to military medical, mental health, relationship and quality of life issues.

Schoenbaum, Kessler, and Gilman, et al. (2014) explored some of the same mental health and deployment factors in their study that investigated predictors of suicide, accidental death, risk and resilience in Army service members. Participants were exclusively members of the U.S. Regular Army serving any time between 2004 and 2009. A strength of this study is its expanded time frame over the Hyman, Ireland, Frost and Cottrell (2012) study and its focus on only one branch of military service. It did, unfortunately, exclude the U.S. Army National Guard and the U.S. Army Reserve. These researchers designed their study to present data and analysis of rates, suicide trends and basic socio-demographics and Army experience correlates of suicides and accident deaths.

The study used the multi-component design of de-identified secondary data from the Army and Department of Defense administrative data systems, which had 975,057 soldier participants. More than one third of the deaths (569) were classified as suicides and the remaining two thirds (1,331 deaths) were classified as accidents. Data on patterns and correlates of these deaths were analyzed at the person-month level in a case-control framework with cases consisting of the person-months of suicide or accidents as the units of analysis. The researchers aimed "to generate actionable recommendations to reduce Army suicides and to increase knowledge of risk and resilience factors for suicidality" so that a baseline for future investigations could be created (Schoenbaum, Kessler, and Gilman, et al, 2014, p. 493). This study observed higher rates of suicide associated with male, white race/ethnicity, junior enlisted rank, and recent demotion; and predictors were generally similar for suicides and accident deaths. Schoenbaum et al. noted that Army suicides increased during the five years of data collection not only for soldiers who had deployed or previously deployed to a combat zone, but also for soldiers who had never deployed. An increase in suicide rates of women service members during deployments and data regarding the never deployed male soldiers are new areas revealed by this investigation.

There were no findings, contrary to expectations, of higher suicide rates regarding service members impacted by the recent Army practices to stop loss military orders (causing longer deployments), or the granting of accession waivers to recruits "not meeting Army entry criteria (possibly due to low test scores, criminal records, past substance use or medical history)" (p. 495). These findings add credence to the current study's aim to identify specific factors and attribute that lead to increased suicide among active duty soldiers. A strength of the Schoenbaum et al. (2014) study is that it is the first report of suicide trends by deployment category during the years when the Army suicide rate increased beyond the suicide rate of

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civilians (p. 499). A limitation of the study beyond the bias of excluding U.S. Army National Guard and U.S. Army Reserve was incomplete data due to outdated administrative systems that are to be upgraded soon. "A final noteworthy limitation is that the analyses reported herein were all based on bivariate associations involving rather coarse measures (e.g., a simple 3-category measure of deployment history rather than more fine-grained measures that distinguish the number of deployments, recency of deployments, and time between deployments" (p. 502). Additionally, the study was framed in a manner that omitted resilience factors that should be addressed in further research since it is these factors that will best lead to effective strategies to reduce veteran suicide. My study addresses this issue through the observations and quantifiable reports of clinical practitioners.

LeardMann, Powell, and Smith et al. (2013) longitudinal study revealed that increased risk of suicide was associated with male gender, depression, manic-depressive disorder, heavy or binge drinking, and alcohol-related problems. This study included current and former military personnel but differed from the Hyman et al. (2012) and Schoenbaum et al. (2014) studies on risk factors in that it was a prospective longitudinal study with accrual and assessment of participants in 2001, 2004, and 2007. Questionnaire data were linked with the National Death Index and the Department of Defense Medical Mortality Registry through December 31, 2008. Unlike Hyman and Schoenbaum, this study represented all military branches including Reserve and National Guard and used a different design/methodology. Observed strengths of the LeardMann et al. (2013) study are its inclusion of alcohol-related problems, which were found to be significantly correlated with increased risk of suicide as compared to the general U.S. population and that "screening for mental disorders combined with high-quality treatment are likely to provide best potential for mitigating suicide" (p. 505).

Another study by Blow, Bohnert, Ilgen, Ignacio, McCarthy, Valenstein & Knox (2012) tracked the rates of suicide among individuals receiving health care services in Veterans Health Administration (VHA) facilities over an 8-year period and found that suicide was more common among VHA patients than members of the general U.S. population; suicide rates were high among National Guard veterans and Vietnam Veterans and that male veterans between the ages of 30 and 64 years of age were at the highest risk for suicide. These findings suggest that VHA health care system patients are at elevated risk for suicide and are in need of suicide reduction services. The study's strength was its comprehensiveness of VHA veteran patients who completed suicide after the 2003 invasion of Iraq.

Gender: Suicide in Transgender Individuals, a high risk population

The "Don't Ask, Don't Tell" policy that prevented gay, lesbian, and bisexual service members from disclosing their sexual orientation was repealed by the U.S. Military in 2011. It is estimated that more than 1 million of today's veterans identify as gay, lesbian, or bisexual (GLB) (Lueck, 2014). Individuals that experience marginalization through multiple identities (i.e., GLB and black, trans*) experience higher levels of mental health symptoms and suicidal ideation. Transgender individuals have difficulty accessing care providers who are knowledgeable and supportive about gender identity disorder (GID), especially within the military. This is because the Department of Defense Instruction 6130.03, the Medical Standards for Appointment, Enlistment, or Induction in the Military Services, states that "current or history of psychosexual conditions, including but not limited to transsexualism, exhibitionism, transvestism, voyeurism, and other paraphilias" precludes induction. The Department of Defense (DoD) policy also discharges currently serving personnel if they admit to, or are discovered to be, transgender. For enlisted service members, Department of Defense Instruction 1332.14 (the Enlisted

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Administrative Separations) is the controlling regulation. The Army's applicable regulation is Army Regulation 40–501, the Standards of Medical Fitness. Chelsea Manning, who enlisted in the military under the name Bradley Manning, is an example of this policy.

Blosnich, Brown, Shipherd, Kauth, Piegari & Bossarte (2013), using Veterans Health Administration (VHA) records to examine the rates of suicide risk for individuals identified by the DSM-IV as having gender identity disorder (GID), found that incidence for suicide among this high risk population was "more than 20 times higher than were rates for the general VHA population" (p. e 27). The prevalence of GID diagnosis among VHA veterans has nearly doubled over the past 10 years. Their study concludes that more research is needed to examine suicide risk among transgender veterans and how VHA utilization may be enhanced by new VA initiatives on transgender care. There is limited literature, data and research on individuals from the transgender community.

"Relative to data about suicide ideation and attempt, information about suicide among persons with GID is perhaps the most limited, with the only known estimates derived from surveillance in the Netherlands. In a retrospective study of more than 1,400 transsexual outpatients from that country's largest clinic providing transsexual health care, van Kesteren et al. noted substantially higher death by suicide among transsexual patients than among the age- and gender-corresponding general Dutch population rates"(p. e 28).

Many limitations of this study are related to the definition of the subpopulation due to the criteria and cannot fully be generalized to represent transgender veterans. "The specialized nature of this subpopulation (i.e., clinically diagnosed veterans) limits generalizability. Second, the study period was prior to the VHA's June 2011 directive outlining health care for transgender veterans" (p. e 31). A further limitation of the study is that it is difficult to determine bias,

omissions or misdiagnosis of the diagnosis codes, because the researchers could not be sure of the accuracy of individuals identified as transgender. Many inaccuracies may occur regarding individuals who identify themselves as transgender or individuals who were diagnosed with GID but do not identify as transgender. Now that there is an inclusive policy regarding healthcare for transgendered veterans, it is likely that more veterans will seek care and disclose their identity. Further suicide risk studies of this population should be conducted to improve mental health and suicide prevention programs.

Suicide Ideation with PTSD due to Military Sexual Trauma

Military sexual trauma is a risk factor for psychiatric disorders and negative health outcomes; however, little research has been done on sexual assault among military personnel and veterans and even less research has been done on gender differences associated with sexual trauma and suicide. Bryan, Bryan & Clemans (http://www.apa.org/news/press/releases/2014/08/military-sexual-trauma.pdf) found that military sexual trauma (MST) is correlated with increased risk for self-injurious thoughts and behaviors (SITB) among male but not female military personnel and veterans. However, MST is associated with significantly increased risk for suicide ideation, plans, and attempts among male veterans than female veterans, whose risks significantly increases for non-suicidal self-injury (NSSI) behavior. Among U.S. veterans of Iraq and Afghanistan, a history of pre-military sexual abuse is the greater risk factor for suicide ideation.

Surís, Link-Malcolm & North (2011) examined the relationships between PTSD, depression, suicidal ideation (SI) and Military Sexual Trauma (MST). Their sample included 130 Army, Air Force, Navy and Marines veterans with a current diagnosis of PTSD related to MST that occurred at least 3 months prior to study entry, identified the trauma resulting from the sexual assault and, if on medication, had been taking the medication for at least 6 weeks. They found

that slightly more than half of the participants (69) had no thoughts of suicide; a little less than

half (56) had suicide ideation (SI) with no intent; and only 3 endorsed suicidal desire or intent.

PTSD and SI were significant and SI was predicted both by depressive symptom severity and

posttraumatic severity. This study is significant because of its data about sexual assault and

because of the large percentage of female veteran participants (89%). There are however; several

limitations to this study: small sample size, the self-reporting nature of the assessments, and

limited prior research on other traumas with depression, PTSD and SI. Another study conducted

by Kelly, Skelton, Patel & Bradley (2011) found that MST is generally reported by 20 – 40% of

female veterans. The number of female veterans who experience MST is probably much greater.

Female veterans are often sexually assaulted by their superiors or supervisors and feel that there

is no one that they can go to for support. When the individuals who are committing the acts are

the very ones expected to bring charges, a code of silence overshadows accountability. Some

victims feel it's pointless to report. Some feel fear, shame, anger, embarrassment, or guilt; others

fear retaliation. MST can easily be perceived as a culture of dominance and violence in the

military. This creates a toxic environment that lends itself to stress, depression, isolation,

hopelessness and never-ending trauma, which can become factors for suicide.

Improved Access to Suicide Prevention Services

A National Alliance on Mental Illness (NAMI) Report during the Spring of 2010 estimated

that 18 veterans die by suicide every day; and as many as 950 suicide attempts occur each month

among veterans who receive services through the Veterans Administration (VA) (NAMI

Veterans Resource Center). It is speculated that repeated deployments during the extended

conflicts in Iraq and Afghanistan is a contributing factor for soldier suicide; but as mentioned

earlier in this thesis, the high suicide rates are also impacted by post-traumatic stress disorder

(PTSD), traumatic brain injury, and recurring trauma. Prevention and service programs are now targeting veterans who have multiple deployments, or are showing needs for or are requesting mental health services but availability and access to these programs, stigma of being labeled mentally ill or embarrassment to ask for help remain as barriers to utilizing these prevention services.

There also are gender, geographic and age factors among veterans who do seek help. One study at the San Francisco VA found that veterans were less likely to complete PTSD treatment if they were male, under the age of 25, living in a rural area or received a PTSD diagnosis from a primary care clinic rather than a mental health program. Matthieu, Gardiner, Siegemeier & Buxton (2014) found that placing suicide prevention programs within communities, utilizing VA referrals and placing brochures and pamphlets geared towards veterans in medical and health care settings were functional remedies. They found that many of these settings have the capability to help veterans with medical care, mental health and benefits services but lack visibility within communities that needed them the most. A large number of service providers within communities lack information on how "to conceptualize where veterans go for services within their local community" (p.389). Both of these studies seem to suggest a lack of real understanding of veteran needs and how to reach out to them in an effective, meaningful way. A limitation in the Matthieu et al. study was its focus on returning veterans rather than all veterans within the communities. There was also no engagement with churches or with cultural and racial based community networks or programs. The study is important however for its validation of networking with a variety of community agencies to serve veterans. More work needs to be done in order to reach a wider range of potential service providers and increase the outreach and referral of high-risk military service members and veterans.

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Tom Tarantino, Senior Legislative Associate with Iraq and Afghanistan Veterans of America (IAVA) and ten-year veteran of the U.S. Army spoke before IAVA on August 5, 2014 at the Navy Yard and poignantly expressed that there is a fundamental gap when it comes to understanding veteran suicide. He stated,

A critical step to understanding how we can stop veteran and service member's suicides is to understand that suicide itself is not the whole issue. Suicide is the tragic conclusion of the failure to address the spectrum of challenges returning veterans face. These challenges are not just mental health injuries; they include challenges of finding employment, reintegrating to family and community life, dealing with health care and benefits bureaucracy and many others. Fighting suicide is not just about preventing the act of suicide, it is about providing a "soft and productive landing" for our veterans when they return home. Iraq and Afghanistan Veterans of America (http://Iava.org).

Suicide prevention programs for veterans, though emerging, fail to provide adequate access. For example, wait times for mental health care within the VA remain unacceptably high and there are not enough mental health providers to meet the needs of our veterans. Also we see, as pointed out in the Matthieu et al. study, that counselors and mental health professionals often lack the skills to sufficiently engage veterans in talking about their problems or even in knowing what support services are available within the veteran's community. Transition, community support, family, jobs and recognition are crucial issues for veterans. According to Tom Tarantino, suicide prevention services and mental health professionals must be prepared to work with soldiers who did not lose their lives in combat however; they lost much of themselves. They return to us deadened and numbed to emotion, ridden with survival guilt, enduring recurring images of what they witnessed and took part in while fighting to 'protect and serve' the United

States of America. Access to programs that address these needs is what is urgently needed for both our active duty soldiers and returning veterans.

Need for Improved Messaging to Veterans about Suicide

There is a lack of literature on effective messaging regarding suicide prevention communications for military service members and veterans. More effective message campaigns are desperately needed to reach at-risk veterans. Langford, Litts & Pearson (2013) conducted a meta-analysis of several reports to review and critique the messages used in suicide prevention programs, as well as, media representation of suicide among veterans and military personnel. Langford et al. offered "key findings from several bodies of research that offer lessons for creating safe and effective messages that support and enhance military and veteran suicide prevention efforts"(p. 31). The study posits that messages about suicide prevention should be made in ways that diminish the stigma in accessing mental health services and advocate for multiple, coordinated interventions that reduce risk, promote protective factors, and enhance overall wellness, skills, and resiliency. Langford et al. stressed that suicide prevention communications should not explicitly or implicitly characterize suicide as a common reaction to stress, trauma, depression, or other challenges service members and veterans have to deal with. "Other problematic content includes stories of individual suicides, details about suicide means or locations, romanticized or simplistic explanations and presenting suicide as inexplicable or unpreventable" (p. 36). The strength of this research is that it creates awareness of the harmful effects that negative messaging has about mental health issues and suicide among military service members. Due to this type of study, I do not feel that there were biases or limitations and would only hope that more studies of this type would be conducted. "There is an urgent need for strategic, science-based, consistent messaging guidance in this area" (p. 35). The study gives

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many specific evidence-based approaches to target audiences and to avoid the inadvertent increase of stigma, which can cause military service members to avoid seeking treatment.

Providing concrete resource referral information and telling "stories of individuals who struggled, reached out, are now thriving and about early intervention, recovery, and resiliency may help create a more balanced picture of the mental health of military and veteran populations" (p. 36). Hudenko (2014) states that knowing the warning signs can help with improved messaging and communicating with service members and veterans. When warriors face emotional or psychological challenges such as anger, isolation, anxiety, guilt, depression or post-traumatic stress disorder, it is helpful for family and clinical practitioners to talk about observed feelings and behaviors. The Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury has made the identification of risk and protective factors available to warriors and their families. These risk factors include: warriors' thinking about hurting or killing him or herself; talking or writing about death, dying or suicide; inability to sleep or oversleeping; withdrawing from friends, family or society; increasing alcohol or drug consumption; engaging in reckless or risky behavior; experiencing rage, anger, or desire for revenge; having feelings of anxiety, agitation or hopelessness; reliving past stressful experiences; and experiencing dramatic changes in mood (http://www.realwarriors.net/family/support/preventsuicide.php). These are specific warning signs and risk factors that should be included in all media bursts, pamphlets and messaging about veteran suicide.

Synopsis of the Literature

This literature review significantly enhances the merits of my study. While there is increasing literature available on the suicide epidemic among veterans, there is much to be learned about the numerous risk factors, as well as, rather profound omissions in the research. I have discussed

theoretical and empirical research applicable to trauma and coping, PTSD, suicide prevention services, marginalized veterans, gender and messaging about suicide. What is consistently missing is evidence-based suicide prevention program strategies or practical insights from first-line clinicians who treat veterans. My study will add to existing literature about veteran suicide and provide practical applications and treatment approaches to work more effectively with veterans who are at risk for suicide.

Chapter III

Methodology

Study Purpose and Questions

This study examined suicide prevention strategies and programs from the perspective of clinical practitioners who work or have worked with veterans in therapeutic settings, and focused on their observations and insights regarding increased risk factors and effective ways to meet the needs of veterans who are at risk for suicide. The primary purpose of this research project was to identify suicide risk factors and effective intervention strategies and programs to prevent suicide among veterans from the perspective of first-line clinical practitioners.

The Overarching Research Question

This study was guided by primarily one research question, what are the most significant and observable suicide risk factors among veterans, along with salient protective factors that guard against suicide and the most effective ways to meet the needs of veterans who are at risk for suicide from the perspective of clinical practitioners who work with them?

Research Method and Design

This was an exploratory study using qualitative methods. I used convenience sampling and then snowball techniques. Potential participants were contacted in one of the following ways: I contacted various clinical practitioners' professional organizations with my recruitment request email that included a brief description of my project and the link to the screening question and survey, which were both anonymous and confidential. I sent a recruitment request message to social networking sites, i.e., Facebook and LinkedIn via my Facebook and LinkedIn pages.

Finally, I emailed or sent a recruitment request to my personal and professional contacts who are clinical practitioners or who may know clinical practitioners who may have been interested in participating in the study.

The proposed study asked participants to respond to an online questionnaire. The questionnaire consisted of two parts and it was expected that it would take survey participants no longer than 30 minutes to complete. Only if a participant agreed to the informed consent, by clicking on a box that said, "I agree" at the bottom of the screen, were they allowed to continue on to the questionnaire. The first part of the questionnaire collected demographic data from the participant while the following section collected qualitative data on the study topic. The demographic data, collected in the first part of the questionnaire, was used to develop understanding of who the survey participants were.

The second part of the questionnaire consisted of six qualitative questions about the study topic. The quantitative demographic questions were analyzed primarily using descriptive statistics. The qualitative data was analyzed through thematic coding and looking for patterns amongst the responses. This data analyzed questions from the perspective of clinical practitioners who have worked with veterans, and what they felt were the most significant and observable suicide risk factors among veterans. The survey respondents were also asked about salient protective factors that guard against suicide, as well as the clinicians' opinions of the most effective treatment interventions in order to meet the needs of veterans who are at risk for suicide.

Sample

This study included forty clinical practitioners and the qualifying participants for this study were defined as clinical practitioners who currently work or have worked in treatment settings

with American veterans perceived by the practitioners to be at risk for suicide. These clinicians came from varying helping professions with education/certifications/degrees or licenses, including but not limited to the following fields: BSW, MSW, LICDC, LCSW, LMHC, MFC, MFT, APRN, MD, PhD, PsyD and Psychiatry who were located across the country. I selected this population of participants in order to gain a greater picture of professionals experienced in suicide prevention for veterans and to increase the number of potential participants for this study. In regard to representation of diversity in the study, reasonable efforts were made in order to recruit a diverse sample, both in terms of racial and ethnic identification and gender identification, however due to the nature of a snowball sample and limited size, the data is not representative of all clinical providers working with veterans in clinical settings.

Data Collection

The study was facilitated through Survey Monkey, an online based survey tool. Participants for this study were recruited online, by word-of-mouth, by sharing my study with colleagues, and by using snowball sampling. The sample included clinical practitioners who currently work or have worked in treatment settings with American veterans perceived by the practitioners to be at risk for suicide. The purpose of the study was explained, and participants were screened by selection criteria. All of the respondents were anonymous and could not be identified individually from the information they supplied.

Participation in this study was voluntary. If a potential participant answered "yes" to the qualifying question and expressed interest in participating in the study, then they were directed to the informed consent page. The questionnaire consisted of two parts and it was expected that it would take no longer than 30 minutes to complete. As the researcher, the only interaction I had with participants was through the on-line survey process with the exception of participants

sending me an email question regarding the survey or study. I then communicated through an email response.

This methodology permitted gathering a rich narrative from clinical practitioners from several disciplines who worked in varied capacities and clinical settings. This enabled an exploration of themes that emerged in the qualitative data, and the possibility to look for correlation trends among themes. This also gave clinicians a format in which to have their experiences shared and their voices heard about unique clinical experiences working with veterans with suicidal ideation. It is hoped that the participants gained a sense of recognition for their observations and clinical experiences.

Limitations of Study

At-risk veterans are a vulnerable population so in consideration of protecting their confidentiality and sparing them possible emotional harm, all my data was collected from clinical practitioners. Therefore, this was a limitation of the opportunity to hear directly from veterans in my study. Another limitation is in regard to the diversity of clinicians who responded to the survey. I had hoped to have as many diverse clinicians as possible, however I am cognizant of the prevalence of dominant identities such as white, heterosexual, females and males in the helping profession and the limitations of an anonymous survey process. If it had been possible in my resources and time frame, it would have been ideal to collect responses from a targeted diverse range of clinicians representing various ages, ethnicities, genders and sexual orientations.

A related limitation in the research may have been the unpredictable distribution of the survey. It would be ideal if I could have distributed the survey through organizations that provide services for veterans; however getting this type of study approved by the Veterans

Administration (VA) is complicated and was not feasible within my time frame. Also, the findings cannot be generalized to a larger group of the population since the study could not accurately capture a complete range of clinical practitioners. Instead, the study gave the narrow, personal perspective and experience of the individual responding to the survey in this study. Data was collected electronically through Survey Monkey. A weakness of this data collection method is a lack of ability to follow up on survey questions in more detail or to observe the participants tone of voice or body language as one could in an in-person interview. By using this survey method, I lost the opportunity to pursue follow-up questions and to have observations of the participant's reactions to my questions that could have been accomplished in a semi-structured, in-person interview format if I had a greater time frame.

Data Analysis

Descriptive statistics were used to identify the demographic qualities of the participants in the study, such as age, ethnicity, veteran status, gender, clinical work setting, area of specialty, etc. Due to the small sample size, inferential statistics were not used. Qualitative data was coded and analyzed for thematic material.

Chapter IV

Findings

This was an exploratory study using a mixed methods design. The purpose of the study was to examine suicide prevention programs from the perspective of clinical practitioners who work or have worked with veterans in therapeutic settings. The study focused on practitioner observations and insights regarding increased risk factors and effective ways to meet the needs of veterans who are at risk for suicide.

Demographics of the Participants

This chapter contains the responses of 40 clinical practitioners who work or have worked with veterans in therapeutic settings. The participants were 28 females, 11 males and 1 individual who identified as transgender. Thirty-one respondents described their ethnicity as White, 4 as Mixed Ethnicity, 2 as African American, 2 as Jewish and 1 as Hispanic. The primary language of the participants was cited by 39 as English with one identifying their primary language as Other, but reporting fluency in English. In this group of clinical practitioners, 6 were veterans and 34 were non-veterans. The age range of participants was 26 - 69 years old with sixteen reporting being between the ages of 30 - 39.

The amount of time that the respondents have been practicing as clinicians ranged from less than 1 year to over 30 years with 18 having been practicing between 1 and 5 years. Forty percent of the practitioners had worked with veterans between $3 - 5$ years, 20% from $1 - 2$ years and 17% from $6 - 8$ years. One respondent had over 30 years of clinical experience working with veterans.

As Table 1 below demonstrates, 2.5% (n = 1) had attained a Bachelor's Degree, 85% (n = 34) of

the respondents in this study had Master's Degrees, 7.5% (n = 3) had Doctorates and 5% (n = 2)

were MDs.

Table 1. Participant Degree Attainment

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Bachelor's	1	2.5	2.5	2.5
	Master's	34	85.0	85.0	87.5
	Doctorate	3	7.5	7.5	95.0
	Medical Doctor	2	5.0	5.0	100.0
	Total	40	100.0	100.0	

Types of licensure or certification included: social work (45%, n = 18); professional

counselor (5%, n = 2); nursing (2.5%, n = 1); marriage and family therapist (2.5%, n = 1); and

addiction counselor (2.5%, n = 1). The work settings for the clinical practitioners varied form

Veteran Administration (VA) Hospitals to community service facilities and many other

organizations. Table 2 below reveals the vast range of work settings.

Table 2. Participant Work Settings

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	VA Clinic	7	14.0	14.0	14.0
	VA Hospital	3	6.0	6.0	20.0
	VA Branch, not specified	4	8.0	8.0	28.0
	VA Medical Center	5	10.0	10.0	38.0
	VA Office, not specified	1	2.0	2.0	40.0
	VA Administration	1	2.0	2.0	42.0
	Hospital Emergency Room, not specified	4	8.0	8.0	50.0
	Outpatient Clinic, not specified	3	6.0	6.0	56.0

COMMUNITY SERVICES (DIRECT SERVICES)

Direct Services, not specified	4	8.0	8.0	64.0
Hospice	1	2.0	2.0	66.0
Mental Health Facility	1	2.0	2.0	68.0
Homeless Clinic	1	2.0	2.0	70.0
Hospital	3	6.0	6.0	76.0
Primary Care Facility	3	6.0	6.0	82.0
Private Practice	2	4.0	4.0	86.0
Residential Rehab Center	1	2.0	2.0	88.0
Family Practice	1	2.0	2.0	90.0

MILITARY BRANCH SETTINGS

Hospital	2	4.0	4.0	94.0
Treatment Facility	1	2.0	2.0	96.0
Fed Gov't Suicide Prevention Program	1	2.0	2.0	98.0

OTHER

College Counseling Center	1	2.0	2.0	100.0
*Total Work Settings	50	100.0	100.0	

*Number does not total 40 because some participants worked in more than one VA setting.

Clinical practitioners identified multiple areas of specialty. Seven respondents worked in substance abuse; 7 in mental health; 4 in trauma treatment; 3 in suicide prevention and many other areas were represented. Table 3 below shows a detailed listing of all specialty areas.

Table 3. Participant Specialty Work Areas

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Substance Abuse	7	14.0	14.0	14.0
	Mental Health	7	14.0	14.0	28.0
	Suicide Prevention	3	6.0	6.0	34.0
	Trauma	4	8.0	8.0	42.0
	Clinical Psychology	2	4.0	4.0	46.0
	Emergency Medicine	1	2.0	2.0	48.0
	Internal Medicine	1	2.0	2.0	50.0
	End of life Care	1	2.0	2.0	52.0

Couples	1	2.0	2.0	54.0
Veterans	1	2.0	2.0	56.0
Behavioral Health	1	2.0	2.0	58.0
Cognitive Processing Therapy (CPT)	1	2.0	2.0	60.0
VA	1	2.0	2.0	62.0
Homelessness	2	4.0	4.0	66.0
Adult Health	1	2.0	2.0	68.0
Anxiety Disorders	1	2.0	2.0	70.0
Combat Psychiatry + PTSD	1	2.0	2.0	72.0
Army Wounded Warrior Program + Advocacy	1	2.0	2.0	74.0
Social Work	3	6.0	6.0	80.0
Server Mental Illness	3	6.0	6.0	86.0
Geriatrics	1	2.0	2.0	88.0
Mood Disorders	1	2.0	2.0	90.0
Dual Diagnosis	1	2.0	2.0	92.0
Crisis Assess. and Management	3	6.0	6.0	98.0
Psychiatry	1	2.0	2.0	100.0
Total	50	100.0	100.0	

*Number does not total 40 because some participants had more than one specialty.

Results of Open-ended Questions

Each participant was asked to answer six open-ended questions relating to their observations, experiences and insights concerning veteran specific strategies for suicide prevention and to give their recommendations for best practice programs to address this epidemic. The first question focused on specific suicide risk factors for veterans. Fifty-five percent (n = 22) of the clinicians cited PTSD as the number one risk factor for the veteran population. A very close second theme that emerged was mental illness cited by 50% (n = 20) of respondents and the third risk factor was substance abuse listed by 47.5% (n = 19) of the clinicians. Each of six research questions and their findings are presented below.

Research Question 1.

What are the most significant and observable suicide risk factors among veterans?

Respondents identified several biopsychosocial risk factors observed to be significant suicide

indicators for veterans. See Table 4 below.

Table 4. Biopsychosocial Risk Factors for Veteran Suicide

		Frequency out of 40	Percent
Valid	PTSD	22	55.0
	Mental illness	20	50.0
	Substance Abuse	19	47.5
	Lack of Social Support	14	35.0
	Financial Probs.	13	32.5
	Chronic Pain	12	30.0
	Physical Health issues	11	29.0
	Isolation	10	25.0
	Access to Weapons	8	20.0
	Trauma Exposure	7	17.5
	Relationship Problems	7	17.5
	Homelessness	7	17.5
	Male Gender	6	15.0
	Age	5	12.5
	Traumatic Brain Injury	5	12.5
	Sexual Trauma History	5	12.5
	Past Suicide Attempts/Family History of Suicide	4	10.0

    The following quote by one clinician poignantly captures the tragic cycle of PTSD, isolation

and suicide risk:

"A major risk factor is being alone. One of the main risk factors I look for when working with

my clients is human contact. Most of my clients have severe PTSD and many of them spend a

great deal of time closed-up in their homes either alone or with contact with only close family

members. They do not go out and they try not to engage other people. This isolation deepens

their depression and leads to more and more negative self-talk. They also have anger issues,

which cause those closest to them to pull away or to leave completely. This leaves them more isolated, which starts the cycle of their being isolated again. Each time this cycle starts, they find themselves more isolated than they were before."

Another respondent used the following statement to sum up the risk factor of isolation and the veteran's sense of alienation from the community: "No camaraderie....the world does not understand me". When asked in the next question to discuss specific veteran protective factors for suicide prevention, a large majority of the clinicians, 62.5% (n = 25) commented on the powerful bond of peer support. "Being with other veterans to utilize the camaraderie and cohesiveness learned in the military" was a frequently repeated theme. These clinicians recognized that veterans find solace and strength from their common experiences with one another and can draw upon this bond for emotional support. As one clinician stated, "veteran peers can relate to experiences and they "get it".

The second most common protective theme that emerged at 52.5% (n = 21) was the importance of being able to access physical and mental health care services, especially through military and VA facilities. The powerful roles of family and community support were also mentioned by 37.5% (n = 15). Other significant areas cited were: personal resilience, coping skills, engagement in life, some degree of financial security, housing, education opportunities and job training.

The third open-ended question was about specific social supports that veterans utilize to maintain hope and emotional stability despite experiencing suicidal ideation. The responses to this question resounded powerfully in concert with the emergent protective themes related in the previous paragraph. An overwhelming majority of 77.7% (n = 31) again emphasized the tremendous importance of veteran peer support. A second resource identified by clinicians was

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individual and group therapy at 47.5% (n = 19) and the third ranked support system was VA resources and veteran organizations at 45% (n = 18). Next, clinicians reported the importance of families and friends at 35% (n = 14). Community engagement was 10% (n = 4), 12 step groups; such as an Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) were mentioned at 7.5% (n = 3) along with church groups and services at 7.5% (n = 3).

In the following quote, one respondent speaks to the powerful bond among veterans and also makes a strong case for agencies to employ veterans as staff and clinicians.

 "One of the most effective resources that assist veterans with suicidal ideation is peer-to-peer support. Veterans rely on each other. Even though they are no longer in the military they still seek each other out and lean on each other. They are also very proactive and try to reach out to a veteran that is suffering. Even as veterans they have a strong sense of responsibility to each other. There are many support organizations that have been created specifically to assist and support veterans. However, the most powerful long-term support comes from other veterans. Therefore organizations that have strong stable veterans on their staff are far more likely to be effective in dealing with suicidal veterans."

   The next question concerns barriers to treatment. Fifty percent (n = 20) of survey respondents identified 'limited mental health resources' as the number one problem with 47.5% (n = 19) also citing 'less than quality healthcare' as a close second. Forty-five percent (n = 18) made comments about veterans being reluctant to seek help, either due to feelings of shame and stigma or due to misplaced pride about personal toughness, often ingrained in the military and greater American culture. The impact of mental health stigma was also a strong theme at the rate of 40% (n =16). Table 5 below sorts out the other barriers cited by the clinicians in this study.

Research Question 2.

What are barriers to effective suicide prevention interventions with veterans?

Table 5. Barriers to Effective Suicide Prevention

		Frequency out of 40	Percent
Valid	Limited Mental Health Resources	20	50.0
	Less than Quality Care	19	47.5
	Vets reluctant to seek help	18	45.0
	Mental Health Stigma	16	40.0
	Family lacking knowledge or support	5	12.5
	Substance Abuse	4	10.0
	Limited Finances	4	10.0
	Vets lacking knowledge and insight	4	10.0
	"Macho" military culture	3	7.5
	PTSD and Severe Mental Illness	3	7.5
	Access to weapons	3	7.5

One respondent made the following comment about 'less than quality mental health care' regarding understanding veterans, military culture and limited knowledge by medical providers about suicide:

"Lack of knowledge about veterans among community mental health providers. Veterans often prefer to interact with someone who has a basic understanding of the military and is able to navigate the culture. Also, a lack of knowledge/comfort about suicide with all medical providers, including means restriction. There is a large group of veterans (and civilians) who complete suicide that don't access mental health care. If medical professionals understood suicide, were comfortable talking about suicide and understood specific interventions (i.e. means restriction), more people would be recognized at risk and steps would be taken to insure safety."

Another clinician made the following statement, "Feeling that having these thoughts is a weakness; stigma against mental illness, particularly in the DOD; worry that diagnosis may impact ability to gain employment." A third respondent expressed other reasons that veterans are reluctant to seek help. "Often PTSD creates mistrust with professionals and veterans will not seek out treatment. Isolation keeps veterans from getting help."

The fifth open-ended question asked survey participants to describe a time when an intervention they implemented for a suicidal veteran was successful. This question yielded several powerful and fascinating responses and although I did not create a chart of responses for this question, a few major themes emerged from most of the scenarios shared by the clinicians. The following response demonstrates this:

> "The VA program I work in works hard at establishing long-term supportive and trusting relationships. I once had a homeless veteran that I had lost touch with, call me from a park. I met him in the park. He was very disorganized and very psychotic. I talked with him in the park for about an hour. Because of the history of trust, I was able to convince him to let me take him to the hospital."

This response reveals the power of establishing supportive therapeutic bonds with clients, as well as, the flexibility of going to the client. Easily 50% (n = 20) of the clinicians talked about strong therapeutic alliances with clients and establishing trust in order to be most effective in helping veterans with suicidal ideation during crisis points. The following story by one clinician reveals an excellent mobile and multidisciplinary response by making a life-saving home visit and being able to coordinate emergency resources for a desperate veteran:

"I received a voicemail message at my office from my client he'd left during the night, he was confused, had wrecked his apartment, felt hopeless, wanted to die and was ruminating about his

many losses and the ways he'd harmed others. I immediately consulted with our clinic RN and we decided to conduct a home visit when he did not answer his phone. He answered the door, dazed and muttering and crying, with a knife in his hand. We could see he trashed his apartment and he was bleeding. We expressed concern for him and he let us in. We were calm, he gave me the knife when asked and cleared a space for him to sit down. RN assessed his physical condition and provided First Aid. We provided acceptance of him, validated his concerns and experiences, spent unhurried time with him while assessing his mental status and risk. We helped stabilize him by coaching his breathing and reassuring him he was safe and in control, that we were there to support his well being. I contacted our Crisis Unit to see if there was bed availability at our crisis home and reserved it for him in case that was wanted by my client. We reviewed information based on what he told us, what we observed and what options were available. He chose to go to the crisis home and we discussed what he hoped to get from staff while there, formulating a tentative treatment and discharge plan. I made arrangements with crisis for admission while the RN helped our client pack items for his stay and gather his medications and ID. We transported him to the local Emergency room for medical clearance and were met by the mobile crisis team worker. We transferred information and ensured he was comfortable with his choice, then returned to the office. All told, 2.5 hours were spent, not including follow up paperwork. What worked? Relationship and professional caring that was genuine."

This crisis was handled so well in a number of ways that were often cited in the multiple survey respondents' comments. Obviously, there was the call for help and the strength of the prior therapeutic relationship despite the intensely ill state of the suicidal client. Also, it is so impressive how effectively the clinician and the RN worked together to go to the client's home and then to coordinate the process of assessing the client's needs and to have the various

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resources/departments respond quickly to admit the veteran so that he could receive the care he so desperately needed. This scenario depicted an effective, comprehensive and compassionate multidisciplinary community program response.

Another clinician described a less dramatic but equally effective strategy succinctly with the quote, "Accompanied veteran to inpatient facility. Veteran felt understood, did not feel alone, and felt that someone finally heard his pain. Hospitalization, medication and family and support group stabilized the veteran." There were also a few comments by survey respondents that addressed the frustrations of working in the challenging job of suicide prevention and the feeling that sometimes nothing seems to prevent a suicide. As this clinician expressed it, "Besides initiating a psychiatric hospitalization, I'm actually not sure what works. I've made contracts, provided counseling and education, etc., etc., but if someone really wants to kill themselves I don't think there's anything to do besides physically containing and monitoring someone's behavior 24/7."

That quote conveys a stark reality in regard to the lack of control a clinician has over a veteran's ultimate choices or actions. However, the overwhelming number of comments by survey participants were focused on effective intervention strategies and the positive outcomes the clinicians have observed when adequate resources and best practices are dedicated to suicide prevention. This last comment about what worked for a veteran by one survey respondent represents a good summary of many interventions described by other clinicians. "Keeping in touch with him, getting him socially supported by other vets and keeping him busy with work that is of value."

The final survey question asked the clinicians if funding and resources were not a factor, describe what you feel would be the most effective suicide prevention program for veterans with specific content. Most of the suggestions did predictably follow the clinician's responses to the previous open-ended questions with 50% (n = 20) urging improved mental health programs, 37.5% (n = 15) requesting more peer-to-peer veteran support programs and 32.5% (n = 13) expressing that more community programs are needed to reach veterans where they live and interact with the world. Along these same lines, 17.5% (n = 7) wanted to be able to make more home visits and the same number wanted more comprehensive multidisciplinary programs. I have included a final table to submit all the responses for the final survey question regarding the most effective ways to meet the needs of veterans who are risk for suicide.

Research Question 3.

If funding and resources were not a factor, describe what you feel would be the most effective suicide prevention program for veterans with specific content areas?

		Frequency	Percent
Valid	Improved Mental Health Care	20	50.0
	Peer Support Programs	15	37.5
	More Community Programs	13	32.5
	More Resources and Funding	13	32.5
	More Home Visits	7	17.5
	Comprehensive Multidisciplinary Programs	7	17.5
	Family Support and Involvement Programs	5	12.5
	Media Campaigns to De-stigmatize and Educate	5	12.5
	More Housing, Jobs, Education and Financial Help	4	10.0
	Mandatory Counseling For All Military	2	5.0

Clinicians gave several suggestions that were innovative and I have included these comments in the respondent's own words to convey the passion they expressed. The first suggestion includes a fresh idea about an extended process at the end of military service:

"I believe that an overhaul of the DoD's processing for military discharge would be the single best prevention program. During their service, soldiers are provided access to mental health services, though utilizing them is typically seen as a sign of weakness. When veterans leave the service, they do not immediately abandon these notions. A mandatory period of extended exit counseling is in order. Just as new recruits must go through basic training to be processed into military service, there should be an extended period of "processing" back into society at large. Psychoeducation about the challenges faced by veterans in the civilian world can be addressed. Most importantly, peer counseling should be established during this process to continue the sense of family that service members are provided and reduce the sense of abandonment that many returning veterans report."

The idea of extended processing back into the civilian world seems completely logical when presented by this clinician as a parallel to the extended basic training process service members must go through at the beginning of their military training. Currently, most of the military branches deprogramming or separation processes remains extremely brief and do not begin to adequately address reintegration issues. Here is another fascinating suggestion about veteran and family support:

"If we had unlimited funding then we would do more to include the spouses and care givers in the rehabilitation process for every veteran. At this time we offer limited mental health support for the spouses and care givers. We need them to be an intricate part of the process and not an afterthought. We need to provide long-term marriage counseling, couples counseling, family counseling and we need to include the significant others in the mental health treatment process. I have veterans that are suicidal that see their MH

providers once or twice a week for more than a year. Yet the providers have never even

met the care givers, spouses, or family members. As Social Workers we know the

importance of the "whole person" which includes their support network. Yet as a policy

we (those of us in the system) do not work effectively with the support network if at all."

Of course, this suggestion beautifully summarizes the social work perspective of every

individual being part of a family and community support network. In order for an individual to

optimally function, the social world of the veteran needs to be a major part of the ongoing

treatment intervention and support. To end on a positive note about existing services, this

response is most encouraging:

"The VA has a suicide prevention program focusing on Outreach and Awareness,

Training, Tracking and Reporting, Access and Referral, Enhanced Care Delivery, and

Evaluation and Research. I think this program provides a great model for a

comprehensive suicide prevention program for veterans."

Chapter V

Discussion

This study was designed to explore the perspectives of clinical practitioners who work or have worked with veterans in therapeutic settings, and focused on their observations and insights regarding increased risk factors and effective ways to meet the needs of veterans who are at risk for suicide. The study included responses from 40 participating clinical practitioners who worked in therapeutic settings. The goal of this study was to gather firsthand insight and observations about effective suicide prevention programs for veterans from clinical professionals who work with them.

Key Findings

Unique Risk Factors for Veterans. Participants described multiple risk factors among veterans. Several clinicians identified multiple categories, which increased the risk for suicide: PTSD, MST, TBI, mental illness, and physical issues, especially serious or chronic health problems. This is substantiated by a 2010 National Alliance on Mental Illness (NAMI) spring report that estimated that 18 veterans die by suicide every day; and as many as 950 suicide attempts occur each month among veterans who receive services through the Veterans Administration (VA) (NAMI Veterans Resource Center). This report speculated that repeated deployments during the extended conflicts in Iraq and Afghanistan are a contributing factor for soldier suicide; but as mentioned earlier in this thesis, the high suicide rates are also impacted by post-traumatic stress disorder (PTSD), traumatic brain injury, and recurring trauma. Research by

Hyman (2012) also identified existing mental health conditions as a very strong risk factor for suicide.

In my recent fieldwork at the Michael E. DeBakey VA Medical Center in the PTSD clinic it was standard during the initial intake to administer a suicide assessment screening in order to establish a veteran's risk for suicide. In the Primary Predisposing Risk Factors section of the suicide-screening tool, I had to identify if the veteran was diagnosed with serious medical illness and if the veteran was suffering from chronic physical health issues or disabilities. Also, in my survey results, Military Sexual Trauma (MST) was identified by several clinicians as a risk factor. Bryan, Bryan & Clemans (2014) found that military sexual trauma (MST) is correlated with increased risk for self-injurious thoughts and behaviors (SITB) among military personnel and veterans.

During my internship, I had the opportunity to co-facilitate a MST closed 12-week group with 6 participants. Many of these veterans' VA charts were flagged with a "high risk for suicide" warning, which appears to the clinician as a window that pops up when the electronic chart is initially opened. Several survey respondents in this study also identified substance abuse as a high risk factor for veteran suicide. In the VA's suicide risk assessment screening process, there is recognition of this risk factor and clinicians are asked to identify if the veteran is actively using substances. In the survey, clinicians additionally identified social stressors and isolating behaviors as risk factors for veteran suicide. The VA lists living alone as a primary presenting risk factor for suicide.

The risk factors for veterans consist of a multitude of biopsychosocial issues and when one or more of these are present, a veteran's risk for self-harm can result in devastating results. As a social work intern, I saw this happen first-hand with my individual client. I was conducting

Cognitive Processing Therapy (CPT) for PTSD with a young, female veteran. At a certain point, she had stopped taking her medication and was self-medicating with cannabis. She had a history of sexual abuse, combat trauma and she also had a history of cutting herself, which began in adolescence. She reported that she had recently engaged in a verbal fight with a family member and because of this she was moving out and going to a new apartment. As a result of these multiple biopsychosocial factors, she experienced an increase in suicidal ideation. Fortunately, several health team members and I were able to intervene with safety and stabilizing strategies before she became a danger to herself.

   Unique Protective Factors for Veterans. In this study's survey, 62.5% of the clinician respondents strongly endorsed the importance of veteran peer support for suicide prevention. This response correlates with my own experience of working with veterans. In both academic and clinical settings, I have observed the positive power of peer support among veterans. I have also had the privilege of collaborating with veterans who are taking an active role in various organizations that focus on helping other veterans.

   During my field internship, I had the opportunity of co-facilitating veterans Cognitive Processing Therapy (CPT) groups and PTSD 101 groups for veterans diagnosed with PTSD. Frequently, veterans made comments about "not trusting anyone" and feeling uncomfortable in public settings. However, they would note that at the Michael E. DeBakey VA they felt more secure because they were surrounded by other veterans who shared a common understanding of military service. They believed that these veterans "would have their back" if something happened and they needed help or understanding. The veterans also discussed how they felt able to participate in treatment and group therapy sessions because of the shared experience they had with one another. I also observed how veterans provided support and validation for one another

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in the various treatment groups. An example of the impact of social support amongst veterans is reflected in the words of author Tyler Boudreau, a veteran of the recent conflict in Afghanistan. In his book, *Packing Inferno*, Boudreau reflects on the importance of peer support by stating,

> "I realized there are others like me, dealing with the long nights and rage and the regret. And once we find each other, we can see each other's faces. We can touch each other's skin. We can hear each other's voices and the words make sense. When we share our stories, we can feel each other's pain, but we can lose some of it, too, in the transfer. We can save each other's lives. It is the bond we knew in war, and lost (209).

Boudreau has reached out in several efforts to help other veterans to become an outspoken advocate for veteran's causes and to particularly focus on the process of reconciliation. It is also my belief that veterans benefit from not only receiving peer support but also from providing it to other veterans. One veteran with whom I worked explained that his role in the service was to take care of the soldiers in his unit and now that he was in the civilian world he was continuing to help other veterans with their transition from military service.

The Michael E. DeBakey VAMC in Houston has utilized the power of veteran support by creating a position for peer mentors. These individuals are veterans who work alongside LCSWs and psychologists in therapeutic groups and on case management issues. These peer mentors utilize their own military and veteran identities to connect with the veterans at the VA and bridge the military civilian divide between the veteran clients and the civilian clinicians. During my internship I worked with a peer mentor in a Cognitive Processing Therapy group for PTSD clients and observed how the veterans in the group responded positively to the peer mentor's interventions. Using peer support for veterans is beneficial for easing the transition of veterans

and for improving mental health care. I hope that peer support programs will increase in various facilities across the nation.

   Social Supports. An overwhelming 77.7% of study participants stated that the need for veteran peer support was the most important social support. As mentioned in the Protective Factors section of this study discussion, veterans report greatly benefitting from social support and maintaining camaraderie with one another. Repeatedly through my years of work with veterans in multiple settings, I have observed the power of peer support in therapeutic and non-therapeutic groups and activities. Veterans connect because of their shared bond of military service and this can be utilized to help them in their transition into civilian life and to cope with mental health issues such as PTSD, MST and other diagnoses.

   Following this theme of peer support, 47.5% of survey respondents identified individual and group therapy as a source of emotional and social support for veterans. During my social work training all of my mentors have continuously stressed the importance of the therapeutic alliance and the role that the therapeutic relationship plays in the treatment of individuals. In group therapy the ability of individuals in the group to utilize one another for emotional support is helpful in the treatment and progress of all the members. When I was working with a veteran who had suicidal ideation, I feel that our well-established therapeutic relationship was a factor in her ability to reach out for help during her time of crisis and also a key component to conducting a successful crisis intervention.

   Clinicians in this study also identified the importance of VA resources and efforts to engage in the greater community along with veteran organizations as important for suicide prevention efforts. It is important to recognize that veterans are part of a larger network of social supports from peers to families and in their surrounding communities. Clinicians cited the importance of

spiritual communities in the lives of many veterans and of encouraging them to engage in their church activities and services. The Michael E. DeBakey VA recognized this component as important in veterans' community lives and had a chapel within the hospital, as well as several chaplains on staff and a few chaplains who were also veterans themselves.

Barriers to Effective Suicide Prevention Interventions. The most frequently observed barrier to suicide prevention identified by clinicians was limited mental health resources for veterans and the difficulties they faced dealing with the VA bureaucracy; such as long waiting times for appointments and prolonged disability benefit claims processes. The VA is a very large institutional system that can be frustrating for individuals to navigate. Veterans can feel frustrated and uncared for because of the wait to see a clinician. This can also lead veterans to perceive that the VA does not have their best interest in mind and may cause them to be apathetic in seeking treatment.

Additionally, survey participants voiced frustration at the sometimes less than quality care provided by the VA and other healthcare providers in the community. As one participant stated, "Long waiting lists and response times from VA mental health system...or even the perception among veterans that they will have to wait for treatment. The fact that emergent care does not always lead to good follow up and continuing care in a timely fashion." In my own experience working at the VA as an intern, I had some moments of difficulty navigating the bureaucracy and felt frustrated with the system. Another clinician cited a deficit in knowledge about veterans' issues and comfort with suicide in the community mental health settings.

> "Lack of knowledge about veterans among community mental health providers - veterans often prefer to interact with someone who has a basic understanding of the military and is able to navigate the culture. Also, a lack of knowledge/comfort about suicide with all

medical providers, including means restriction. There is a large group of veterans (and

civilians) who complete suicide that don't access mental health care - if medical

professionals understood suicide, were comfortable talking about suicide, and understood

specific interventions (i.e. means restriction), more people would be recognized at risk

and steps would be taken to insure safety."

Suicide is a difficult issue to discuss, but it is important that as a community of care providers,

we are able to communicate and develop knowledge about suicide in order to help veterans in

crisis. Another barrier that was listed by clinicians was stigma, which prevents veterans from

seeking help. I have heard several veterans make comments about initially feeling unwilling to

get treatment for PTSD due to stigma or fear of being classified as "crazy" by others. Stigma

surrounding mental health is prevalent in the military and greater civilian culture. This is a

significant barrier because stigma prevents individuals from seeking much needed mental health

treatment or prolongs suffering from mental health symptoms.

The military has recently implemented efforts to lessen stigma about mental illness and PTSD

and to change the idea that seeking help is a sign of weakness. However, this remains a common

attitude among many who embrace the "macho" military culture. Unfortunately, even after many

veterans have separated from service, they remain hesitant to ask for help because they continue

to interpret that as a sign of weakness. There have also been national efforts to destigmatize

mental illness and campaigns to encourage individuals to seek treatment in the civilian world due

to increasing public awareness of the toll of untreated mental health conditions.

Stories of Clinicians' Implementations of an Intervention for a Veteran with Suicidal

Ideation. The responses of clinicians covered a range of experiences helping clients in crisis and

in most cases focused on timely interventions that resulted in clients receiving the care they

desperately needed. A few survey participants made comments about the limitations of preventing all suicides despite their best efforts. They spoke about the frustrations in working with clients in crisis in the respect that clinical practitioners have a lack of control over their client's actions, even when this could sometimes result in a tragic suicide. It is important to be realistic and emotionally prepared for this traumatic possibility. As a developing social work clinician, I have had discussions with several of my supervisors about a clinician's ability to influence clients in decisions regarding their behaviors and safety. The responses I've received are that therapists do have the ability to enable clients to learn new coping skills and insights into their behaviors, yet it is ultimately the client's choice to utilize these tools. The majority of theories and studies inform us that suicide is a cry for help and that most individuals want to live and receive care. In that regard, many of the survey participants shared inspiring stories of receiving calls for help and being able to implement strategies that resulted in a client receiving the care they needed in order to survive their crisis.

Clinicians shared many stories about interventions with suicidal veterans. In almost all of their experiences, several common themes were present. The most cited factor was the importance of the therapeutic alliance and being able to utilize this trust to encourage the veteran to reach out to the therapist for help. Another major theme was a well-coordinated range of resources and services available to clients dealing with suicidal ideation or in crisis.

I experienced several elements of these respondents' stories in my own experience in crisis intervention during my fieldwork at the Michael E. DeBakey VA. At the time I was providing CPT therapy for a young, female veteran. The pseudonym for her in my case study paper and presentations was "Anna". I saw Anna in weekly individual therapy sessions over several months. At one point Anna made the choice to stop taking her medication and subsequently had

increased PTSD and depression symptoms. During our 10th session, Anna admitted to having some suicidal ideation but minimized any danger to herself. She did admit to owning a gun, which she said that a relative had given her recently for protection. I asked my field supervisor to join us at that point and she agreed with my concerns about Anna possibly being a danger to herself and we created a safety plan.

I accompanied Anna to the medical clinic where we met with her primary care provider and Anna agreed to resume taking her medication. In a follow-up phone call to Anna the next day, she sounded better. Anna was scheduled for a therapy session the following week but she cancelled it. She eventually returned my phone calls and explained that she "hadn't felt like coming in" that day but would come in for her next appointment, which she did. In that session we debriefed about her suicidal ideation from the previous session and her feelings and thoughts about the intervention by clinicians. We also reviewed her safety plan and Anna reported that she had followed through with giving her gun to a relative as had been advised. With Anna present, I did speak on the phone with the relative who confirmed that he had the firearm secured. We continued the weekly therapy sessions and Anna progressed to better stability with less suicidal ideation.

It is my belief that one of the reasons my intervention with Anna was successful was due to the strong therapeutic alliance that we developed in sessions. She recognized that she was able to reach out to me for help when she found herself overwhelmed by suicidal ideation and in need of support. I also recognize that Anna utilized her agency to reach out for help when she was experiencing suicidal thoughts and also chose to take steps for her own safety. As clinicians it is necessary to do all that we can do for suicide prevention and at the same time acknowledge that we cannot do the work for the client. An additional significant resource theme was that the VA

Medical Center facility had a range of services that were available to Anna and to me in providing accessible therapeutic care and medication management as part of the intervention. I greatly value having this experience of successful implementation and gained a better understanding of leading factors for suicidal ideation and warning signs.

Ideal Suicide Prevention Programs for Veterans. Clinicians responded that their ideal programs would reflect an improvement in access to care and quality of care. They also emphasized connecting with veterans through peer programs and community outreach along with increases in research to better understand trends and suicidal behavior. One clinician's comment captures this in the following quote:

> "A specialized, multi disciplinary team of medical and mental health professionals to increase care during elevated periods of risk. Better continuity of care among all medical and mental health providers. Increased staffing for emergency agencies (Suicide Prevention lifeline, Veterans Crisis Line, county crisis, etc.) Increased educational/positive media coverage and education for the general public (gatekeeper trainings, reducing risk, etc.). Better data collection to examine trends."

The trend of veterans experiencing mental health diagnoses and adjustment issues as they reintegrate into civilian life is only going to increase with the numbers of returning veterans from Afghanistan and Iraq in recent years. The VA is making an effort to provide physical and mental health care for the nation's veterans; however this is an enormous undertaking. It is also challenging for the VA to quickly increase its staff of clinicians to be prepared for the large number of veterans expected to need comprehensive care.

37.5% of clinicians in this study believed that utilizing more peer support for veterans would encourage them to seek help and engage with mental health treatment. One clinician suggested a

peer program where veterans who have struggled with suicidal ideation and learned effective coping skills help other veterans who are at high risk for suicide. This idea is similar to the sponsor system in 12 step programs, such as Alcoholics Anonymous (AA) where an individual who is new to the group works with a peer mentor who has been sober for a period of time. In this role, the sponsor acts as an individual coach and support person. Perhaps this model could be used to help individuals dealing with suicidal ideation or mental illness. The theme of peer support has been repeatedly prominent throughout the survey results and this speaks to the need to bridge the military civilian divide.

Furthermore, clinicians strongly advised increasing home visits, community resources and greater flexibility of approaches that were not the traditional 50-minute therapy sessions in a hospital or clinic setting. One participant expressed that we should be, "Establishing portals to treatment in the places veterans are most comfortable being, as opposed to making them come to us. I think treatment should be funded in the community as readily as it is through the VA." Several clinicians also suggested that veteran's family members should be more engaged in their care. As clinicians we understand the importance of strong family support, however in practice the family system is not fully engaged or supported.

Study Strengths and Limitations

This study gathered a rich narrative from clinical practitioners from several disciplines who worked in varied capacities and clinical settings. This enabled an exploration of themes that emerged in the qualitative data, and the ability to look for correlation trends among themes. This also gave clinicians a format in which to have their experiences shared and their voices heard about unique clinical experiences working with veterans with suicidal ideation. It is hoped that the participants gained a sense of recognition for their observations and clinical experiences.

At-risk veterans are a vulnerable population so in consideration of protecting their confidentiality and sparing them possible emotional harm, all my data was collected from clinical practitioners. Therefore, this was a limitation of the opportunity to hear directly from veterans in my study. Another limitation is in regard to the diversity of clinicians who responded to the survey. I had hoped to have as many diverse clinicians as possible, however I am cognizant of the prevalence of dominant identities such as white, heterosexual, females and males in the helping profession and the limitations of an anonymous survey process. If it had been possible in my resources and time frame, it would have been ideal to collect responses from a targeted diverse range of clinicians representing various ages, ethnicities, genders and sexual orientations.

A related limitation in the research may have been the unpredictable distribution of the survey. It would be ideal if I could have distributed the survey through organizations that provide services for veterans; however getting this type of study approved by the Veterans Administration (VA) is complicated and was not feasible in my short time frame. Also, the findings cannot be used to generalize to a larger population since the study could not accurately capture a complete range of clinical practitioners. Instead, the study gave the narrow, personal perspective experience of the individual responding to the survey. Data was collected electronically through Survey Monkey. A weakness of this data collection method is a lack of ability to follow up on survey questions in more detail or to observe the participants tone of voice or body language as one could in an in-person interview. By using this survey method, I lost the opportunity to pursue follow-up questions and to have observations of the participant's reactions to my questions that could have been accomplished in a semi-structured, in-person interview format if I had a greater time frame.

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Appendix A - QUESTIONS LIST

SUICIDE PREVENTION FOR VETERANS

Qualifying Question:
Are you a clinical practitioner with a certificate, degree or a license who is currently working or has worked with veterans experiencing suicidal ideation or whom you believe to be at risk for suicide?
Demographic Questions:
What type of degree, certification, and/or clinical license do you have?

How long have you been practicing as a clinician?

What is your area of specialty?

How many years have you worked with veterans?

In what type of setting are you working or did you work with veterans?

What is your gender?

What is your age?

How do you identify your ethnicity?

What is your primary language?

Are you a veteran?

Survey Issue Questions:
What have you observed to be risk factors among veterans with suicidal ideation? Risk factors may include military status, age, gender, stressors, mental illness, physical health, and many other factors.

What do you identify as veteran-specific protective factors for suicide prevention?

What are specific social supports that veterans utilize to maintain hope and emotional stability despite experiencing suicidal ideation?

What are barriers to effective suicide prevention interventions with veterans?

Please describe a time when you implemented an intervention for a veteran with suicidal ideation that was successful. (What worked in the intervention?)

If funding and resources were not a factor, describe what you feel would be the most effective suicide prevention program for veterans with specific content areas.

Appendix B

Survey Monkey Security Statement

Millions of users have entrusted SurveyMonkey with their survey data, and we make it a priority to take our users' security and privacy concerns seriously. We strive to ensure that user data is kept securely, and that we collect only as much personal data as is required to provide our services to users in an efficient and effective manner.

SurveyMonkey uses some of the most advanced technology for Internet security that is commercially available today. This Security Statement is aimed at being transparent about our security infrastructure and practices, to help reassure you that your data is appropriately protected.

Application and User Security

SSL/TLS Encryption**:** Users can determine whether to collect survey responses over secured, encrypted SSL/TLS connections. All other communications with the surveymonkey.com website are sent over SSL/TLS connections. Secure Sockets Layer (SSL) and Transport Layer Security (TLS) technology (the successor technology to SSL) protect communications by using both server authentication and data encryption. This ensures that user data in transit is safe, secure, and available only to intended recipients.

User Authentication: User data on our database is logically segregated by account-based access rules. User accounts have unique usernames and passwords that must be entered each time a user logs on. SurveyMonkey issues a session cookie only to record encrypted authentication information for the duration of a specific session. The session cookie does not include the password of the user.

User Passwords: User application passwords have minimum complexity requirements. Passwords are individually salted and hashed.

Data Encryption: Certain sensitive user data, such as credit card details and account passwords, is stored in encrypted format.

Data Portability: SurveyMonkey enables you to export your data from our system in a variety of formats so that you can back it up, or use it with other applications.

Privacy: We have a comprehensive privacy policy that provides a very transparent view of how we handle your data, including how we use your data, who we share it with, and how long we retain it.

HIPAA: Enhanced security features for HIPAA-enabled accounts.

Physical Security

Data Centers: Our information systems infrastructure (servers, networking equipment, etc.) is collocated at third party SSAE 16/SOC 2 audited data centers. We own and manage all of our equipment located in those data centers.

Data Center Security: Our data centers are staffed and surveilled 24/7. Access is secured by security guards, visitors logs, and entry requirements such as passcards and biometric recognition. Our equipment is kept in locked cages.

Environmental Controls: Our data center is maintained at controlled temperatures and humidity ranges which are continuously monitored for variations. Smoke and fire detection and response systems are in place.

Location: All user data is stored on servers located in the United States and Luxembourg.

Availability

Connectivity: Fully redundant IP network connections with multiple independent connections to a range of Tier 1 Internet access providers.

Power: Servers have redundant internal and external power supplies. Data center has backup power supplies, and is able to draw power from the multiple substations on the grid, several diesel generators, and backup batteries.

Uptime: Continuous uptime monitoring, with immediate escalation to SurveyMonkey staff for any downtime.

Failover: Our database is log-shipped to standby servers and can failover in less than an hour.

Network Security

Uptime: Continuous uptime monitoring, with immediate escalation to SurveyMonkey staff for any downtime.

Third Party Scans: Weekly security scans are performed by Qualys.

Testing: System functionality and design changes are verified in an isolated test "sandbox" environment and subject to functional and security testing prior to deployment to active production systems.

Firewall: Firewall restricts access to all ports except 80 (http) and 443 (https).

Patching: Latest security patches are applied to all operating system and application files to mitigate newly discovered vulnerabilities.

Access Control: Secure VPN, multifactor authentication, and role-based access is enforced for systems management by authorized engineering staff.

Logging and Auditing: Central logging systems capture and archive all internal systems access including any failed authentication attempts.

Storage Security

Backup Frequency: Backups occur hourly internally, and daily to a centralized backup system for storage in multiple geographically disparate sites.

Production Redundancy: Data stored on a RAID 10 array. O/S stored on a RAID 1 array.

Organizational & Administrative Security

Employee Screening: We perform background screening on all employees.

Training: We provide security and technology use training for employees.

Service Providers: We screen our service providers and bind them under contract to appropriate confidentiality obligations if they deal with any user data.

Access: Access controls to sensitive data in our databases, systems and environments are set on a need-to-know / least privilege necessary basis.

Audit Logging: We maintain and monitor audit logs on our services and systems (our logging systems generate gigabytes of log files each day).

Information Security Policies: We maintain internal information security policies, including incident response plans, and regularly review and update them.

Software Development Practices

Stack: We code in Python and C# and run on SQL Server 2008, Ubuntu Linux, and Windows 2008 Server.

Coding Practices: Our engineers use best practices and industry-standard secure coding guidelines to ensure secure coding.

Handling of Security Breaches

Despite best efforts, no method of transmission over the Internet and no method of electronic storage is perfectly secure. We cannot guarantee absolute security. However, if SurveyMonkey learns of a security breach, we will notify affected users so that they can take appropriate

protective steps. Our breach notification procedures are consistent with our obligations under various state and federal laws and regulation, as well as any industry rules or standards that we adhere to. Notification procedures include providing email notices or posting a notice on our website if a breach occurs.

Your Responsibilities

Keeping your data secure also depends on you ensuring that you maintain the security of your account by using sufficiently complicated passwords and storing them safely. You should also ensure that you have sufficient security on your own systems, to keep any survey data you download to your own computer away from prying eyes. We offer SSL to secure the transmission of survey responses, but it is your responsibility to ensure that your surveys are configured to use that feature where appropriate.

Custom Requests

Due to the number of customers that use our service, specific security questions or custom security forms can only be addressed for customers purchasing a certain volume of user accounts within a SurveyMonkey Enterprise subscription. If your company has a large number of potential or existing users and is interested in exploring such arrangements, please check out www.surveymonkey.com/mp/enterprise.

Last updated: September 9, 2013.

SMITH COLLEGE

Consent to Participate in a Research Study
Smith College School for Social Work ● Northampton, MA
Attachment H – Informed Consent
……………………………………………………………………………..

Title of Study: Suicide Prevention for Veterans
Investigator(s): Katherine Culpepper, MSW Thesis Student, 413-585-7974
Introduction
- You are being asked to be in a research study of how to more effectively prevent veteran suicides.
- You were selected as a possible participant because you are a clinician with a certificate, degree or a license who is currently working or has worked with veterans whom you believe to be at risk for suicide.
- We ask that you read this form and ask any questions that you may have before agreeing to be in the study.

Purpose of Study
- The purpose of the study is to examine suicide prevention strategies and programs from the perspective of clinical practitioners who work or have worked with veterans in therapeutic settings, and will focus on their observations and insights regarding increased risk factors and effective ways to meet the needs of veterans who are at risk for suicide.
- This study is being conducted as a research requirement for my Master's in Social Work degree.
- Ultimately, this research may be published or presented at professional conferences.

Description of the Study Procedures
- If you agree to be in this study, you will be asked to do the following things: the questionnaire will first ask you some general demographic information and then ask open-ended questions about your experiences working with veterans and should take no more than 30 minutes to complete.

Risks/Discomforts of Being in this Study
- The study has the following risks: Participation in this study may bring up difficult feelings in regard to your experience of having worked with suicidal veterans. If you feel that you would like additional support at any point during your involvement in the questionnaire or following your participation, I have provided a list of mental health resources at the end of this letter that you may use at your convenience.

Benefits of Being in the Study
- The benefits of participation are that your responses to the questionnaire will allow you to share your personal and unique perspective on your experience for mental health workers, social service providers, and researchers.
- The benefits to social work/society are that your feedback may help others and will strengthen the existing body of knowledge on suicide prevention among veterans. It may also lead to increased access to services and development of programs to address these veteran needs and further research.

Confidentiality
- This study is anonymous. We will not be collecting or retaining any information about your identity.

Payments/gift
- You will not receive any financial payment for your participation.

Right to Refuse or Withdraw
- The decision to participate in this study is entirely up to you. You may refuse to take part in the study *at any time* (up to the point at which you submit your anonymous survey) without affecting your relationship with the researchers of this study or Smith College. Your decision to refuse will not result in any loss of benefits (including access to services) to which you are otherwise entitled. You have the right not to answer any single question, as well as to withdraw completely up to the point at which you submit your anonymous survey. If you choose to withdraw, I will not use any of your information collected for this study.

 Right to Ask Questions and Report Concerns
- You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study, at any time feel free to contact me, Katherine Culpepper at kculpepper@smith.edu. If you would like a summary of the study results, one will be sent to you once the study is completed. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

Support Resources

It is important for clinicians to remember to engage in self care practices and to be involved with supportive social networks to prevent burnout or discouragement in the demanding field of the helping profession. The following resources have been included in order to help you engage in self-care and seek help if you feel that you have experienced upset or distress from participating in the survey. The American Psychological Association (APA) has an online resource page to help clinicians cope with the loss of a client to suicide.
http://www.apa.org/gradpsych/2008/11/suicide.aspx
Provider Resilience App is a tool for health care providers to protect against burnout and compassion fatigue while they are carrying out the mission of serving veterans, service members, and their families. https://www.t2health.org/apps/provider-resilience
Mood Tracker App is designed to track emotional health. https://www.t2health.org/apps/t2-mood-tracker

The Schwartz Center for Compassionate Healthcare – Supporting Caregivers
http://www.theschwartzcenter.org/supporting-caregivers/default.aspx

I have also added the following tools for clinician survivor wellbeing:
American Association of Suicidology (AAS) - The AAS has a list of multiple resources for "clinicians-survivors" to access help for emotional, cognitive, and behavioral effects of suicide. AAS web site - http://www.suicidology.org/home

Access to personal clinician testimonies - Clinicians can become members of AAS and seek support through education and sharing of testimonies for those who had a patient commit suicide. (http://mypage.iu.edu/~jmcintos/therapists_mainpg.htm)
AAS Guidelines, "Staff as Survivors" – See Appendix II
How do you feel after suicide? – See Appendix III
Questions for writing your experience – See Appendix IV
National Alliance for the Mentally Ill (NAMI) Suicide Postvention Training for Primary Care Providers – "Connect"http://www.theconnectprogram.org/sites/default/files/site-content/docs/TrainingSheet-PV-PCP.pdf and **The American Foundation for Suicide Prevention: www.afp.org is also recommended by APA.**
Consent

☐

BY CHECKING "I AGREE" BELOW, YOU ARE INDICATING THAT YOU HAVE READ AND UNDERSTOOD THE INFORMATION ABOVE AND THAT YOU HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION. AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY. Please print a copy and save it for your records. (Drop box to select "I agree" or "I disagree")

Form updated 9/2

Appendix D

School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950F (413) 585-7994

January 21, 2015
Katherine Culpepper

Dear Katie,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.
In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.
Congratulations and our best wishes on your interesting study.

Sincerely,

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Narviar Barker, Research Advisor