

A Comparative Review of U.S. Military and Civilian Suicide Behavior: Implications for OEF/OIF Suicide Prevention Efforts

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Suicide is a significant public health concern within the United States military. Suicide may occur before, during, and after military deployment or service for a multitude of reasons that may or may not be directly related to deployment. Therefore, it is crucial that mental health counselors are trained to identify risk at an early stage so they can offer evidence-based practices to manage and reduce it. Enhanced understanding of the similarities and differences in suicide risk and protective factors for civilian and military individuals is crucial for counselors who work directly with Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) active-duty personnel, veterans, and family members. This review aims to educate counselors about the role of demographic, life event, psychopathology, and behavioral and psychological variables in exacerbating or alleviating the desire to die. The information presented is based on an electronic search of medical and psychological databases for terms related to suicide by military service members. Recommendations related to identification, prevention, and management of suicide risk in OEF/OIF service members and beneficiaries are presented.

Public Health Significance of Suicide

Suicide is a serious public health problem throughout the world. Globally it accounts for nearly half of all violence-related deaths (World Health Organization [WHO], 2006). In the United States (U.S.) suicide is the 11th leading cause of death, with about 30,000 deaths annually (Centers for Disease Control [CDC], 2007). Among those aged 15–24 suicide is the third leading cause of death, at a rate of 10.3 per 100,000 (U.S. Department of Health and Human Services [DHHS], 2004). In the U.S. between 1999 and 2004, 54.6% of suicide deaths were attributed to firearms, 20.4% to suffocation, and 17.2% to poisoning (CDC). On average, more than 80 Americans die by suicide every

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day. Males are four times more likely to die by suicide than females (CDC, 2006). One common assumption for this disparity¹ is related to the method of suicide: males use firearms in 50–60% of cases (CDC, 2007).

The National Mental Health Association (2006) estimates that there are 500,000 nonfatal suicide events in the U.S. every year. In 2002 more than 90,000 hospitalizations and 324,000 emergency room evaluations were attributed to nonfatal suicide events (CDC, 2004). Moscicki (2001) found that 2–5% of the U.S. population has attempted suicide at some point. Of about 6,000 respondents aged 15–54 responding to the National Comorbidity Survey (NCS), 13.5% had experienced suicide ideation, 3.9% had engaged in some type of preparatory behavior, and 4.6% had attempted suicide (Kessler, Borges, & Walters, 1999). Suicide death and injuries in the U.S. are estimated to result in over \$25 billion annually in direct costs and such indirect costs as lost productivity (CDC, 2006).

The U.S. active-duty military is comprised predominantly of young male adults; about 50% are aged 17–26 (Eaton, Messer, Wilson, & Hoge, 2006). According to CDC data (2004), suicide is the third leading cause of death among this age group generally. In the U.S. military, suicide has historically ranked as the second leading cause after accidents (Ritchie, Keppler, & Rothberg, 2003). In 2005, the reported Department of Defense (DoD) average suicide rate was 11.4 per 100,000 (ranging from 8.9 for the Air Force to 13.7 for the Army). Carr, Hoge, Gardner, and Potter (2004) suggested that correcting reporting and classification mistakes might increase suicide rates in the military by as much as 21%. To date, there are no reliable data on suicide attempts in the military. Recent findings from the Post-Deployment Health Assessment survey (Hoge, Auchterlonie, & Milliken, 2006) indicated that of 222,620 soldiers and Marines returning from Operation Iraqi Freedom (OIF), 1.1% ($n = 2,411$) reported “some” suicide ideation and 0.2% ($n = 467$) reported “a lot.”

Purpose and Methodology of Current Review

The U.S. National Strategy for Suicide Prevention identifies suicide as a “public health problem that is preventable.” One of its goals is the development and promotion of effective clinical and professional practices (U.S. Public Health Service [USPHS], 2001, p. 46). The DoD and the Department of Veterans Affairs (DVA) have demonstrated their commitment to preventing suicide by funding research on military suicide, setting up groups like the DoD Suicide Prevention and Risk Reduction Committee, and providing training,

¹ Researchers like Canetto (1997, 2006) highlight the importance of challenging such assumptions by attending to the role of language and socially constructed narratives in our cultural explanations for differences in suicide epidemiology.

such as the Military Suicide Prevention Conference.

Enhanced understanding of the similarities and differences in suicide risk and protective factors for civilian and military individuals is crucial for mental health counselors who work directly with Operation Enduring Freedom (OEF) and OIF active-duty personnel, veterans, and family members. Our review of the literature highlights unique assessment and treatment implications that need to be carefully considered when working with these clients. Because suicide behavior may occur before, during, and after deployment or service for a multitude of reasons that may or may not be directly related to deployment, it is crucial that we as counselors identify the risks early and offer evidence-based practices to manage and reduce them.

This review is based on a search of the electronic databases of PsycINFO and PubMed for terms related to suicide in military service members. Various combinations of the following search terms were used: *suicide, prevention, military, deployment, risk factors, protective factors, OEF/OIF*. A review of the abstracts determined whether the queried articles were relevant. Government sites were also searched for documents related to specific subtopics. In some cases reference lists of articles were used to locate and verify source documents.

CIVILIAN RISK AND PROTECTIVE FACTORS FOR SUICIDE BEHAVIOR

Risk and protective factors identified for the civilian population will serve as a point of comparison for this review of the literature pertaining to the military. A risk factor is any hazard that increases the likelihood of suicide behavior. A protective factor in general reduces or prevents the likelihood of suicide behavior and at times may counteract the deleterious impact of risk factors (Substance Abuse and Mental Health Services Administration [SAMHSA], 1999).

Risk Factors

Demographic. Although the elderly account for about 10% of the U.S. population, they account for 20% of national suicide deaths (Hoyert, Arias, Smith, Murphy, & Kochanek, 2001). The highest suicide rate consists of men 75 and older (Pearson, Conwell, Lindesay, Takahashi, & Caine, 1997). While females attempt suicide more often than males, the aggregate U.S. suicide rate of females from 1999–2004 was about four times less than for males (CDC, 2007). Divorce, particularly for males, has long been considered a risk factor (Goldsmith, Pellmar, Kleinman & Bunney, 2002; Kposowa, 2000). White and American Indian/Alaska Native males and females have consistently (1950–2005) had the highest suicide rates of all races (DHHS, 2007).

Clinical Psychopathology. Although most individuals with a mental disorder do not engage in suicide behavior, the majority of those involved in

suicide events have some clinical psychopathology. Overall, a mood disorder (particularly major depressive disorder) is antecedent to 30–90% of all suicide deaths (Arsenault-Lapierre, Kim, & Turecki, 2004; Isometsa, 2001; Rihmer, 2007). The second most often co-occurring mental disorder among those who die by suicide, present in 26–55% of deaths, is a substance-related disorder (Rihmer, 2007). Among drug-related suicide attempts by individuals 18 or older, 33.2% involve alcohol, 28.4% illicit drugs like cocaine or marijuana, 58.9% psychotropic medications, and 36% pain medications, such as opioids, nonsteroidal anti-inflammatory agents, and acetaminophen (SAMHSA, 2006). Cavanagh, Carson, Sharpe, and Lawrie (2003) found that comorbidity of mental disorder and substance disorders preceded deaths in significantly more suicide cases (38%) than nonsuicide controls (6%).

Behavioral and Psychological Features. Histories of suicide attempt or hospitalization, family history of suicide, impulsivity, hopelessness, and maladaptive problem-solving are among the behavioral and psychological features that have been linked to increased risk for suicide. The most predictive factor for future suicide behavior is past suicide behavior (Nordstrom, Asberg, Aberg-Wistedt, & Nordin, 1995; Paykel & Dienelt, 1971). Family history of suicide is also associated with increased risk (Moscicki, 1995). In a large-scale study using the Swedish cause of death registry, the rate of suicide was found to be twice as high in families of suicide decedents even when controlling for mental disorder severity (Runeson & Asberg, 2003). A family history of suicide has also been associated with an earlier age of first attempt (Roy, 2004) and a greater likelihood of multiple attempts than for individuals who attempted without a family history of suicide (Jeglic, Sharp, Chapman, Brown, & Beck, 2005; Treméau et al., 2005).

Impulsivity is frequently cited as a risk factor for suicide behavior (Brent et al., 2003; Mann, Waternaux, Haas, & Malone, 1999) and is commonly conceptualized as “the inability to resist a drive or stimulus, or a behavior that occurs without reflection or consideration for [its] consequences” (Zouk, Tousignant, Seguin, Lesage, & Turecki, 2006, p. 195). In suicide behavior impulsivity may serve both as a trait of the individual and as a distinct component of the suicidal act itself (Zouk et al., 2006). Moreover, individuals who engage in suicide behaviors appear to have deficits in problem-solving ability (Rudd, Rajab, & Dahm, 1994). Cognitive rigidity, defined as the inability to adequately identify problems and potential solutions, is one factor believed to be related to poor problem-solving.

Hopelessness is a core cognitive component of depression that appears to be particularly relevant to suicide behavior (Beck, Rush, Shaw, & Emery, 1979) and a better predictor of suicide intent than other aspects of depression, such as guilt, loss of appetite, or irritability (Lester, Beck, & Mitchell, 1979). In one study (Brown, Beck, Steer, & Grisham, 2000), patients who scored nine or

more on the Beck Hopelessness Scale (Beck & Steer, 1988) were over four times more likely than those who scored eight or below to die by suicide in the following year.

Stressful Life Events. While the factors already discussed may create a vulnerability for suicide behavior, it is commonly the individual's perception and appraisal of a given life event as stressful beyond current coping resources that serves as the tipping point. In comparison to controls, individuals who die by suicide are more likely to have experienced recent adverse life events (Cavanagh, Owens, & Johnstone, 1999; Cheng, Chen, Chen, & Jenkins, 2000; Phillips, Yang, Zhang, Wang, Ji, & Zhou, 2002). Interpersonal conflict or loss; work, financial, or legal problems; and major illness or chronic pain (Tang & Crane, 2006) are commonly cited events preceding suicide death. The number of life events does not appear as important a risk for suicide as the meaning and likely outcome (disposition) of the events (Kolves, Varnik, Tooding, & Wasserman, 2006). Clearly, many individuals encounter adverse life events yet do not engage in suicide behavior. Since suicide is a complex behavior, it can rarely be attributed to a single factor. However, stress has a cumulative impact, and combined with poor problem-solving and possibly other factors it may increase the likelihood of suicide behavior.

Protective Factors

Restricted Access to Lethal Means. There is a significant positive association between accessibility to lethal means and suicide events (Resnick et al., 1997; Shenassa, Rogers, Spalding, & Roberts, 2004). A recent review (Humeau et al., 2007) found that 18 of 19 studies showed a positive correlation between firearm availability and suicide risk, and 15 of 16 studies showed a decline in suicide rates when gun laws were more restrictive.

Social Support and Connectedness. Social support—the perception of belonging or being connected to a social network—is a buffer against psychological stressors. High levels of social support and a sense of connectedness have been associated with reduced suicide ideation and behaviors (Resnick et al., 1997; Stroebe, Stroebe, & Abakoumkin, 2005). Likewise, the presence of a spouse or significant other or having feelings of responsibility for children can protect against suicide (Smith, Mercy, & Conn, 1988).

For some individuals religion is an avenue for achieving and maintaining the sense of community and social integration. Dervic et al. (2004) found that countries reporting high religiosity have lower suicide rates than nonreligious countries, and there is evidence of an inverse relationship between degree of commitment to a religion and suicide behavior. It is unclear, though, whether the reductions in suicide behavior associated with religiosity are a function of greater moral objections to suicide, lower individual aggression, or some other variable. One possible explanation is that individuals with high religious com-

mitment have a stronger sense of social support, purpose, and reasons for living (De Leo, Hickey, Neulinger, & Cantor, 1999).

MILITARY-RELEVANT RISK AND PROTECTIVE FACTORS

While military service members are certainly susceptible to the same biopsychosocial risk factors outlined in the U.S. Surgeon General's Call to Action (USPHS, 1999), they also have distinct features associated with their profession and lifestyle. Considering the synergistic power of converging risk factors, military individuals present with unique constellations that can result in increased risk for suicide behavior. Risk factors like exposure to extreme stressors, posttraumatic stress disorder (PTSD), impulsivity, and traumatic brain injury (TBI) are not necessarily unique to service members. However, deployment and exposure to combat have been shown to confer considerable risk for such psychiatric disorders as PTSD, major depressive disorder, and substance abuse/dependence that are associated with an increased risk for suicide (Hoge et al., 2004; Kang & Bullman, 2008). These factors deserve special consideration when examining suicide behavior in service members; enhanced understanding of them is instrumental in our targeted suicide prevention efforts.

Stressful Military Life Events. The relation between stress and suicide has been well established, with stress often acting as a precipitating factor for suicide (Staal & Hughes, 2002). Clinical and research evidence suggest that military deployments are stressful life events. Hoge and colleagues (2006) highlighted the additional mental health risks faced by troops returning from deployment in support of the Global War on Terror (GWOT). They found that 19.1% of troops returning from OIF met the Post Deployment Health Assessment (PDHA) criteria for a mental health concern, 9.8% showed symptoms of PTSD, about 1.1% reported some suicidal ideation, and 0.2% reported a lot. Based on anecdotal evidence, psychological distress reported on the PDHA underestimates the actual rates of difficulties such as suicide ideation because service members' desire to return home as soon as possible could be delayed by additional screenings.

However, other suicide risk factors, such as a failing intimate relationship, occupational dissatisfaction, alcohol abuse/dependence, easy access to firearms, and legal difficulties, may be especially relevant in the military (Patterson, Jones, Marsh, & Drummond, 2001; Trent, 1999). To illustrate: extended separations due to mandatory deployment and training can place strain on intimate relationships; legal difficulties have more serious implications on several life domains (e.g., eligibility for re-enlistment, promotion, permanent change of station); certain military occupations have daily access to firearms; and the majority of military personnel have at least some weapons training.

Furthermore, participation in military operations, especially during war, may place personnel at increased risk for suicide behavior (Bullman & Kang, 1996). According to the National Violent Death Reporting System, 20% of U.S. suicide deaths could be among veterans (Sundararaman, Panangala, & Lister, 2008). However, specific data on OEF/OIF veterans are not yet available. More recently, a study of suicide ideation and attempts in veterans indicated distinct risk profiles for each gender and the long-term impact of combat experience (Brenda, 2005). Whereas childhood abuse, depression, relationship problems, limited social support, and low self-esteem were risk factors for females, alcohol/drug abuse, aggression, combat exposure, combat-related PTSD, and work problems were risk factors for males.

Stressors like failed or failing intimate relationships, administrative or legal problems, psychiatric disorders, death of a spouse, and job conflicts have been found to precede Air Force aviator suicide attempts (Patterson et al., 2001). These findings were based on the management and disposition records of aviators who attempted suicide between 1981 and 1996; failed or failing intimate relationships were the most common stressor. Substance abuse, particularly alcohol, was implicated in 54% of the attempts and 77% of the deaths. Among those who attempted suicide, 77% were considered impulsive, whereas 93% of the deaths were considered well-planned. Of those who attempted suicide, 79% received a recommendation to return to flying duties. Some who have recently attempted suicide but have not yet fully recovered or fully resolved prior life events may perceive return to work as stressful.

Ritchie et al. (2003) performed an electronic chart review on 100 suicide ideation and attempt cases hospitalized at the Walter Reed Army Medical Center (WRAMC). Half these patients were returned to duty after discharge. The military-specific profile of high suicide risk was an unmarried 22-year-old Caucasian male serving his first term as junior enlisted, who perceives himself to have occupational or relationship problems superimposed on symptoms of depression (Ritchie et al., 2003). These findings are concordant with previous reviews. For instance, Allen, Cross, and Swanner (2005) found that unmarried Caucasian males 18–30 years old with firearm access, history of suicide attempt, alcohol abuse, and a diagnosable psychiatric condition were most at risk for suicide behavior. Active involvement in religion, particularly for those who reported conservative Protestant or Muslim beliefs, appeared to reduce suicide risk more than other sects or no religion.

An examination of Marine Corps suicide attempts and deaths in comparison to nonpsychiatric controls (Holmes, Mateczun, Lall, & Wilcove, 1999) indicates that a history of abuse, neglect, rejection, low performance evaluation, depressive symptoms, younger age, alcohol abuse, and hopelessness are significantly associated with suicide risk. Young age, low performance evaluation, and history of military or legal problems differentiated between those who

attempted and those who died.

Impulsivity and Traumatic Brain Injury. The relation between impulsivity and suicide is not clear but deserves attention due to the composition and behavior patterns of U.S. military service members (i.e., a disproportionate number of young Caucasian males with high rates of alcohol misuse). Additionally, given the nature of combat duties, service members are at risk for TBI (Tanielian & Jaycox, 2008), which may trigger or exacerbate impulsivity. The relationship between TBI and impulsivity is thought to be due to damage to the frontal lobes, which can impact executive function, particularly inhibition (Banasik, 2005). This is often seen in coup countercoup injuries where the brain is injured at two opposing sites because it shifts within the skull during rapid acceleration and deceleration (Banasik). There is also growing evidence of a relation between TBI and suicide especially for those with concussion, cranial fracture, or a cerebral contusion and hemorrhage (Teasdale & Engberg, 2001). Approximately 64% of OEF/OIF veterans wounded in action are injured by blast events. The Defense Veterans Brain Injury Center screens 100% of those deemed at risk for TBI from blast injuries, motor vehicle accidents, falls, or gunshot to the head or neck. Of returnees deemed at risk, 59% are eventually diagnosed with mild or greater TBI, constituting about 22% of all wounded returnees (DVA, 2001; Tate, Simpson, Flanagan, & Coffey, 1997; Warden, 2006).

PTSD. There is mounting evidence that severe, untreated PTSD has an increased probability of contributing to suicide behavior. In community samples, 20% of those suffering from PTSD report at least one suicide attempt (Paykel, Prusoff, & Myers, 1975), and studies of Vietnam veterans suffering from PTSD have found increased suicide rates (Goodale, 1999; Fontana & Rosenheck, 1995). Ben-Ya'acov and Amir (2004) highlighted the link between PTSD and suicide but focused on specific PTSD symptom constellations that might indicate increased suicide risk. They reported that risk was significantly associated with arousal (positive correlation) and avoidance (negative correlation)—when arousal was high and avoidance was low, the risk was even greater. However, Bell and Nye (2007) found that the re-experiencing symptom cluster, rather than the avoidance and arousal clusters, significantly correlated with suicide ideation.

Protective Factors

Resilience. As clinicians we know that healthy and adaptive coping protects against suicide behavior, and unhealthy coping (such as impulsive behaviors) exacerbates the risk. To prevent suicide we aim to decrease risk factors and increase protective factors. In military populations, reasons to live (Southwick, Gilmartin, McDonough, & Morrissey, 2006), optimism about the future, problem-solving, coping skills, and strong family/community/social support,

(CDC, 2006; DHHS, 2004) anecdotally appear to hold different meanings due to service culture, organizational climate, training, and a combined sense of purpose. However, there is a distinct need for more intensive research into individual or life context variables that might protect, or fail to protect, service members from suicide (Allen et al., 2005). In the performance of their duties many personnel will be exposed to traumatic events and separated from their family support network for extended deployments. For the military member, *stress* in the stress-diathesis model may be truly unavoidable. To date, there has been virtually no research specifically examining resilience to these stressors as a potential buffer against suicide and related behaviors.

In the early 1960s, the lower suicide rates that were observed in the Air Force were attributed to a screening effect (Eggertsen & Goldstein, 1968). The screening of candidates before entry was considered to have resulted in a relatively healthy force with fewer social problems. Recently, the increased need for service members in support of the GWOT, particularly ground combat troops, has led to a variety of new recruiting and retention practices (e.g., increased enlistment bonuses, revised DoD guidelines for the morals waiver process, additional educational benefits, and increasing the maximum age of enlistment from 35 to 42). The impact of the new selection process on the mental health of service members and its relation to suicide behavior would be an important area to investigate. We must also increase the analysis and publication of data, gather new data, continue to ask questions, and conduct new research more efficiently. With national partnerships it can be possible to follow soldiers out of military service, examine their transition to civilian life, and examine the impact of our suicide prevention efforts.

SUICIDE PREVENTION EFFORTS FOR OEF/OIF ACTIVE-DUTY PERSONNEL AND VETERANS

For counselors who provide assessment and treatment services to OEF/OIF active-duty personnel and veterans, the most significant reminder is that the stigma associated with suicide persists among both civilians and military and prevents many from seeking the help they need. Therefore, we emphasize the clinical power of empathy: Individuals who think and plan for suicide often experience varying degrees of hopelessness. Exposure to even one mental health professional who can demonstrate compassion, understanding, empathy, hope for the future, and a determination to go the extra mile may be instrumental in saving the life of an active-duty military service member, veteran, or family member.

The stigma associated with seeking mental health services may be rooted in beliefs about being damaged, weak in character, or lacking in resilience. Early research on military suicide behavior (e.g., Finn, 1955) cited as primary risk

factors character and behavior disorders, for instance, as well as impulsivity and weak male identification traits. Similarly, a study of U.S. Army suicide attempts that led to psychiatric hospitalizations from 1957 through 1966 (Hauschild, 1968) documented character and behavior disorders in 62% of those admitted. We encourage mental health counselors to think carefully about how the service member's subjective understanding of concepts like strength of character, resilience, and military readiness may contribute to an experience of shame, embarrassment, and reluctance and refusal to seek mental health care.

One strategy for addressing stigma is to implement innovative plans for primary care-based early screening, identification, and management of suicide behavior. This seems especially relevant considering that as few as one-quarter of civilians who die by suicide seek psychiatric treatment beforehand (Appleby et al., 1999), but roughly two-thirds have visited a physician in the 30 days before (Vastag, 2001). Within the military, nearly all service members access primary care annually; the Defense Health System data suggest usage to be 90–95% (Gibson, 2005). Mental health counselors are encouraged to establish collaborative care with primary care providers; in turn, primary care providers are encouraged to seek timely consultation with mental health colleagues for patients who may be at risk.

According to the most recent DoD Report to Congress (2007), improved access to care remains a primary goal throughout the entire active-duty life of a service member. The next level of care must lie in detection at the level of the smallest military unit and may be accomplished with enhanced use of the resources already present. Also important is mission-oriented mental health training of combat leaders. Relating unit mental health to the achievement of military goals is critical to ensure that military commanders understand that suicide prevention is integral to their unit's morale, performance, and ultimate sustainability.

Training of this group can cover the basics and ensure that commanders are aware of resources and medical limitations. Frontline Supervisors Training, for instance, emphasizes the role of good leadership and trains supervisors on how to assist military personnel who may be at risk for suicide behavior. The curriculum educates trainees in the PRESS model of assisting: Prepare, Recognize, Engage, Send, and Sustain (Werbel, Pflanz, Ghahramanlou-Holloway, & Moore, 2008). We encourage counselors to advocate for their patients outside of the therapy milieu by training military leaders in suicide prevention methods like the Question, Persuade, and Refers (QPR) model (see www.qprinstitute.com).

Once service members do find themselves in treatment, outpatient or inpatient, it is helpful to ensure that providers employ as promptly as possible evidence-based assessment and therapeutic interventions (for a review see Ghahramanlou-Holloway, Brown, & Beck, 2008, and Jobs, 2006). To promote

more effective clinical communication and documentation, providers are also encouraged to increase their knowledge of the standardized classification of suicide events (O'Carroll, Berman, Maris, & Moscicki, 1996; Posner, Oquendo, Gould, Stanley, & Davies, 2007; Silverman, Berman, Sanddal, O'Carroll, & Joiner, 2007a, 2007b). Safety planning with the patient is extremely important. The primary aim is to discuss the patient's experiences, specifically maladaptive cognitions and behaviors involving self-injury at times of crisis. The secondary aim is to provide the patient with an individualized, collaboratively generated, and prioritized written list of strategies to cope with future distressing circumstances. Safety plans should include contact information for the therapist, the on-call therapist if there is one, a 24-hour emergency psychiatric hospital or center, and at least one reliable crisis hotline. Patients are asked to sign the safety plan and are given copies to share with family members or friends if they wish.

Recent qualitative research with OEF/OIF veterans suggests that Joiner's interpersonal-psychological theory of suicide may have relevance for them (Brenner et al., 2008). Joiner's theory holds that three components are required for an individual to die by suicide: they must perceive themselves as a burden to others, have a thwarted sense of belongingness, and have the capability to engage in the lethal act as a result of earlier experiences that have habituated them to pain and fear (Joiner, 2005). Brenner et al. found that exposure to combat increased pain tolerance and habituated the veterans interviewed to the fear and pain of combat. OEF/OIF veterans reported a loss of meaning and purpose, felt as if they were a burden to others, and had strained relationships after their return from deployment. Other recent findings (Nademin et al., 2008) also support Joiner's model in demonstrating that the three elements collectively differentiated between living and suicide samples of Air Force personnel. However, after controlling for each element independently, capability to enact suicide significantly predicted suicide status. Removing or restricting access to lethal means such as weapons is thus especially important; the research discussed found a decrease in suicide risk following such safety procedures.

In conclusion, let us emphasize that working with OEF/OIF active-duty personnel and veterans who demonstrate suicide behavior may present considerable challenges for even the most seasoned clinician. Two commonly reported emotional reactions of clinicians working with individuals with suicide behavior are anxiety and hopelessness. In the case of anxiety, a useful question would be, "What is the worst possible scenario in providing assistance to a patient who is in a state of crisis?" Once the worst scenario is imagined, solutions may be generated during supervision or in consultations with colleagues to effectively address the situation and decrease anxiety. The sense of hopelessness is often triggered by poor patient compliance, exacerbation of patients' depressive symptoms, or recurrent suicide behavior. In these cases we suggest

that clinicians be aware of their own degree of hopefulness before and after each session. Once the therapist is aware of the patient's negative impact on the process, various strategies, in collaboration with peers and supervisors, may be adopted to foster and convey a sense of hope.

The management and treatment of individuals with suicide ideation or attempt behavior requires time, effort, careful consideration of complex clinical factors, and decisions about hospitalization and breach of patient confidentiality. We advocate a team approach to maximize quality patient care for OEF/OIF service members and veterans. Collaborating with other providers forms the basis of a support network that can be accessed by all team members so that issues like patient safety, crisis management, and countertransference may be more effectively addressed. Finally, we encourage counselors to keep an up-to-date resource guide that includes information on (a) the national suicide hotline (1-800-273-TALK) and local crisis hotlines; (b) Military Onesource (1-800-342-9647); (c) the nearest emergency department and documentation needed for voluntary and involuntary hospitalizations; and (d) web addresses for the Army, Marine Corps, Navy, and Air Force suicide prevention programs.

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