Telephone hotline assessment and counselling of suicidal military service veterans in the USA

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INTRODUCTION

Worldwide statistics show that approximately 360,000 suicides occur every year. In the United States, approximately 30,000 suicides occur annually which breaks down to 80 per day, or one suicide every 18 minutes (US Bureau of Census 1990). But these numbers are actually low because suicide remains the eighth leading cause of death among adolescents, and the second leading cause of death among college students. Further, suicide ranks third behind natural causes of deaths in prisons within the

Studies show that suicide occurs more frequently among people who are elderly, male, single, divorced or widowed, alienated, and among those with a life-threatening illness. Military service veterans are not spared these conditions; in some respect, they represent the ‘down and out’, the lonely and, increasingly, the older isolated people. This correlational descriptive study sought to identify the characteristic profile of telephone hotline users among veterans, their triggering crisis events, and whether the methods commonly used in suicide attempts relate to certain types of crisis. The random sample consisted of 271 veterans of the US military service, ranging in age from 20 to 79 years. Data were collected from nursing notes documented in the hotline suicide telephone call assessment records. The findings portray a sociodemographic profile of military veterans at risk of suicide attempts. Loneliness, alcoholism and unemployment topped the list of triggering events. The most common method used was drug overdose; shooting was a close second. These findings could serve as a base for development of suicide-prevention-focused programmes and optimal use of telephone hotlines for assessment and timely intervention of persons in great crisis.

Keywords: telephone hotline assessment, telephone counselling, military service veterans, crisis, suicidal attempts

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United States (Hayes 1994). In accounting for total years of life lost before the age of 65, only heart disease, HIV and cancer exceed suicide (Fawcett et al. 1993).

The impact of these statistics becomes even greater when we recognize that for every successful suicide there are 10–20 attempted suicides (Galvin et al. 1993, Conrad 1992, Klerman et al. 1992). This figure does not include accidents that appear to be complete suicides such as single-victim car accidents, hunting accidents, fatal injuries, and diagnosed accidental poisoning.

Thus, the purpose of this study was to describe the utilizers of a veterans affairs medical center (VAMC) crisis intervention hotline, and to identify triggering crisis events and coping methods commonly used in suicide attempts.

Problem statement
United States veterans, faced with a myriad of socioeconomic and health problems, are at high risk of suicide or suicide attempts. Findings of a recent study show poverty, unemployment and a variety of health problems among veterans seeking health care in a VAMC emergency room (Porter & Dy Buco 1992). Yet, only a mere 16% had returned to the system for subsequent care. This merits attention because the mounting crisis could become unbearable, rendering the person at risk of suicide.

REVIEW OF THE LITERATURE
Suicide is defined as the intentional taking of one’s own life. A suicide attempt is depicted by those who had tried to kill themselves by whatever means but were prevented by timely intervention. Suicide or suicide attempts occur among all types of people: rich and poor; young and old; people of all religions, occupations and social classes.

In the United States, the suicide rate is higher among men than women. Of annual deaths by suicide, white males comprised 72%, white females 19%; non-white males 7%, and non-white females 2% (Lester 1995). Elderly people still account for a disproportionate number of suicide deaths, even though the suicide rate in this group has decreased threefold since 1940. In contrast, the suicide rate among adolescents has tripled since 1955. Community-based autopsy studies in the United States, the United Kingdom, Sweden and Australia all point to a recent major mental illness as a primary factor in suicide — no less than 93% of cases among adults. Most commonly associated diagnoses are major depression, chronic alcoholism and schizophrenia (Maris & Silverman 1995, Fawcett et al. 1993).

Not all suicides have the same aetiology, pathogenesis and manifestations. The concept of suicidal thoughts or ideation has been operationalized in different ways and is often concerned with different time periods. There is a time-related difference in the characteristics of those who die by suicide. Fawcett et al. (1993) contend that the risk of suicide is greatest during the week after hospital admission, the month immediately after discharge, and the early stages of recovery from a mental illness. Also, there is a strong association between alcoholism, depression and suicidal behaviour (Montgomery et al. 1995).

Theoretical and clinical perspectives
Suicide may be divided into two groups: those in which the point of no return is reached rapidly and those in which it is reached gradually. The more violent and painful the method chosen, the greater the risk. Gunshot wounds, hanging and jumping are associated with previous attempts. Suicide attempts are more serious when a note is written; they are less invidious when the attempt can be determined that a secondary gain is involved.

Threatening suicide may be an effort to bring about a fundamental change in the person’s life situation or to elicit a response from a significant other. Suicide attempts commonly generate feelings of responsibility and guilt in others (Adam 1985).

A complete suicide accomplishes the element of punishing the survivors by a strong feeling of guilt over the death of the individual (Hankoff 1991). It is inferred that suicidal ideas harboured by the individual and not communicated to relatives or friends constitute a grave situation (Rund et al. 1988).

Typically, a person who threatens to commit suicide has for many years complained to the family in times of stress with such comments as, ‘Oh, my God, I wish I were dead’ or ‘God take my life!’ Such comments merit attention because every person has the potential for suicide. Suicide is preventable with timely and appropriate intervention.

Why people commit suicide
Freud (1957) explained that people may repress their anger towards others and turn it inwards on themselves. A stressful event that elicits confusion, guilt and shame activates the death wish, leading the person to commit suicide instead of eliminating the stressor or object that he or she wants destroyed.

Durkheim (1951) identified three kinds of suicide: egoistic, altruistic and anomie. The egoistic suicide happens when the person is not integrated into a group and experiences intense social isolation. The person is then forced to rely on personal resources that are quite inadequate. Altruistic suicide results when the individual is closely bound to the family or society and is driven by a strong commitment to ‘help’ the group. Anomic suicide happens when a person with a clearly defined set of roles and basic need fulfillment experiences a life change. Not knowing how to act, this person feels overwhelmed and tends towards self-destruction as an attempt to escape life.
situations that have become intolerable. Durkheim hypothesized that suicide varies immensely with the degree of integration of religious, domestic and political society.

High-risk populations

There is substantial evidence that people with underlying medical illnesses have a higher risk of suicide than the general population. For example, the suicide rate among cancer patients is higher than among the general population (Marshall et al. 1983). The highest rate of suicide occurs in patients who have a mental illness (Blumenthal & Kupfer 1990, Holland & Tross 1985, Roy 1985). Those who live alone, are single, divorced, widowed and/or unemployed generally have a higher risk of suicide (Hankoff 1991, Durkheim 1951). An intense sense of loneliness or despair may be the overwhelming motive to commit suicide.

Suicidal behaviours are quite difficult to predict in alcoholics and in persons with multiple substance abuse. Intoxicated persons have diminished emotional control and may commit suicide on impulse. Drug users may keep a ready supply of drugs that can be used for suicidal purpose. Underlying depression and diminished impulse control predispose the drug abuser to the same increased risk of suicide as the alcoholic (Rund et al. 1988).

One study (Marzuk et al. 1988) reported that the rate of suicide among persons with AIDS is substantially higher than that of the general population by age and gender. The suicide rate among hospitalized patients with AIDS is even more striking (Navia et al. 1986). Such suicides are sudden and impulsive, raising the possibility that delirium may be the precipitating factor. Secondary depression and other psychiatric syndromes have been associated with AIDS (Noble 1991).

In summary, suicides and/or suicidal attempts depict a complex human–environmental problem calling for a multidisciplinary approach to prevention and treatment. Caring and timely intervention can make the difference between life and death. A comprehensive assessment of risk factors, triggering crisis events, and knowledge of coping methods commonly used in attempted suicides may prevent high-risk persons from repeated suicidal attempts or committing suicide.

THE STUDY

For the purpose of this study, five research questions were delineated:

1 What are the characteristics of the VAMC crisis intervention hotline (CIH) utilizers?
2 What are the triggering crisis events?
3 What methods are commonly used by VAMC CIH utilizers in suicidal attempts?
4 To what extent do the methods used in suicidal attempts correlate with the triggering crisis events?
5 What actions do nurses commonly take with CIH utilizers?

Design

The design used in this study was correlational descriptive. The data were collected via a review of CIH medical records of a random sample of military service veterans.

Sample

The sample consisted of American veterans who contacted the CIH at one VAMC in South Florida in 1992. They were selected by systematic random sampling from a pool of over 2800 telephone calls documented in the standard CIH intake form used at this institution. The first subject was randomly selected from calls recorded in January 1992; thereafter, every tenth call recorded through December 1992 was drawn, yielding a total sample of 271 subjects or 22–23 subjects per month.

As depicted in Table 1, the subjects were predominantly male, young (>80%) in their late 30s, ranging from 20 to 70 years of age.

Table 1 Characteristics of American veterans crisis intervention hotline (CIH) utilizers

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Distribution</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Age group</td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>Young (50 years and under)</td>
<td>218</td>
<td>80.7</td>
</tr>
<tr>
<td>Middle aged (51–59 years)</td>
<td>30</td>
<td>11.1</td>
</tr>
<tr>
<td>Old (60 years and over)</td>
<td>22</td>
<td>8.1</td>
</tr>
<tr>
<td></td>
<td>270</td>
<td>100</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>246</td>
<td>90.8</td>
</tr>
<tr>
<td>Female</td>
<td>25</td>
<td>9.2</td>
</tr>
<tr>
<td></td>
<td>271</td>
<td>100</td>
</tr>
<tr>
<td>Support system</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Good</td>
<td>93</td>
<td>34.3</td>
</tr>
<tr>
<td>None</td>
<td>178</td>
<td>65.7</td>
</tr>
<tr>
<td></td>
<td>271</td>
<td>100</td>
</tr>
<tr>
<td>Past suicide attempts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>108</td>
<td>40.6</td>
</tr>
<tr>
<td>None</td>
<td>158</td>
<td>59.4</td>
</tr>
<tr>
<td></td>
<td>256</td>
<td>100</td>
</tr>
<tr>
<td>Planned to hurt/kill self on CIH contact</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>178</td>
<td>66.4</td>
</tr>
<tr>
<td>No</td>
<td>90</td>
<td>33.6</td>
</tr>
<tr>
<td></td>
<td>168</td>
<td>100</td>
</tr>
</tbody>
</table>
Counselling suicidal veterans

79 years old. Nearly 66% indicated a lack of support system, and about 41% had a history of past suicidal attempts, ranging from six to ‘many’ times. On contact with the CIH, over 66% planned to hurt or kill themselves.

**Instruments**

A suicide call assessment checklist (SCAC) was used for data collection. This tool was based on the standard clinical form used in this VA facility to document CIH client–staff interactions. The data recorded include details of the client’s telephone call, stress assessment, lethality assessment, consciousness level, basic demographics, action plan and outcome.

A panel of clinical experts and members of the research committee at this facility reviewed the SCAC for face and content validity. The tool was judged adequate for its intended use. Inter-rater reliability between two investigators was established at 98%.

**FINDINGS**

**Characteristics of utilizers**

Research question 1 was: What are the characteristics of the utilizers of the VAMC crisis intervention hotline? As depicted in Table 1, nearly 81% of the sample (n=271) fell into the age range of 50 years and under, mostly in their 30s, male (91%), without support system (>65%), and had planned to hurt or kill themselves (>66%) when they contacted the CIH. Nearly 41% had a history of attempted suicide. Over 25% were alert throughout the telephone interview; about 25% were agitated, 15% were sad and tearful, but less than 10% were intoxicated, depressed, afraid, or disgusted, respectively (Table 2).

Based on these data, the CIH utilizers at this VAMC present the profile of a young adult male American veteran, who is lonely, does not have a support system, is troubled, has previously attempted suicide, and is occupied with active suicidal ideation.

Less than 5% of the sample were assessed as highly suicidal, being quite disorganized and distraught upon CIH contact. In this case, the police were immediately contacted for a home crisis visit and appropriate disposition, diffusing the situation with as little disruption as possible.

**Table 2** Common nursing assessments of crisis intervention hotline clients’ presenting behaviours

<table>
<thead>
<tr>
<th>Presenting behaviour</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alert</td>
<td>136</td>
<td>25-2</td>
</tr>
<tr>
<td>Agitated/upset</td>
<td>134</td>
<td>24-9</td>
</tr>
<tr>
<td>Sad/tearful</td>
<td>83</td>
<td>15-4</td>
</tr>
<tr>
<td>Intoxicated</td>
<td>47</td>
<td>8-7</td>
</tr>
<tr>
<td>Depressed</td>
<td>31</td>
<td>5-8</td>
</tr>
<tr>
<td>Slurred speech</td>
<td>29</td>
<td>5-4</td>
</tr>
<tr>
<td>Afraid</td>
<td>28</td>
<td>5-2</td>
</tr>
<tr>
<td>Disgusted</td>
<td>26</td>
<td>4-8</td>
</tr>
<tr>
<td>Drowsy</td>
<td>25</td>
<td>4-6</td>
</tr>
<tr>
<td></td>
<td>539</td>
<td>100</td>
</tr>
</tbody>
</table>

**Triggering crisis events**

Research question 2 was: What are the triggering crisis events? As many as 10 crisis events were identified in this study (Table 3). Loneliness topped the list, with alcoholism a close second. Less than 10% indicated drug abuse or being homeless. Those who identified family hardships were as many as those who stated they were hearing voices.

Unemployment was identified more frequently than having a drug problem, but less than 5% indicated pain or HIV+ as triggering their CIH contact or suicide attempt. Overall, the telephone hotline utilizers indicated suffering from at least two stressful events.

**Methods used in suicide attempts**

Research question 3 was: What methods are commonly used in suicide attempts? At the time of contact with the
CIH, over 68% of the sample indicated a plan to kill/hurt themselves, commonly by pill overdose or the use of a gun (Table 4). Whereas drug overdose was most prevalent, its use reduced by 56% in present suicide attempts. Cocaine overdose remained less than 14% of all overdose cases in both time periods. The use of gun increased, rising from 6-2% in the past to nearly 16% at the present time. Wrist cutting with a knife or razor blade occurred in previous attempts (>16%) twice as much as at the present time (>8%).

Less than 5% used ‘other’ methods of suicide attempts in the past (e.g. burning, drowning). However, this category increased to 41% in present attempts, suggesting more knowledge and choices of modalities. In summary, drug overdose, although not as pervasive as in past attempts, remained the most common method of suicide attempt in this group of American veterans in 1992. Present attempts to shoot oneself increased significantly by over 150% but wrist cutting decreased by about 94%.

Correlations

Research question 4 was: To what extent are the methods used in suicidal attempts correlated with the triggering crisis events? As depicted in Table 5, those who contacted the CIH indicating a plan to kill or hurt themselves were likely to have a history of previous suicidal attempts and with no support system. The lack of support system was strongly correlated with the complexity of the client’s stress situations, the client being very much agitated, irrational and tearful. Drug overdose was highly correlated with a client’s stressful situations.

Nursing action

Research question 5 was: What actions do nurses commonly take with CIH utilizers? An assessment of a lack of support system, along with a plan to kill or hurt oneself, and/or a refusal to give the exact location, correlated strongly with the nursing action to trace relatives and notify the police. CIH interactions under this circumstance lasted 2–6 minutes only, with action and disposition carried out swiftly — often culminating in an admission to the psychiatric inpatient unit.

The duration of nurse–client CIH interactions observed in this study ranged from 2 to 120 minutes, the latter often culminating in the caller feeling much better and professing ‘just wanting to talk to somebody’.
DISCUSSION

The plight of the American veterans merits special attention. The myriad of crisis events experienced in this population segment directs attention to the importance of interdisciplinary, collaborative primary health care services in community-based settings. Prompt recognition and management of signs and symptoms of imminent crisis are important for the patient and the nurse, since these symptoms can affect the person’s ability to cope with prevailing problems. Being young and unemployed, and without a support system, no doubt contribute to loneliness and family problems. The composite of being sad, tearful, drowsy and incoherent with a slurred speech reflects the picture of considerable loneliness and the ‘hotline’ nurse must be alerted to taking immediate action.

CIH utilizers were commonly described as agitated, upset, disgusted, depressed and afraid. Allowing the hotline caller to vent all feelings is particularly important to assure him/her that someone is willing to listen. This underscores the value of active listening and the caring ‘presence’ of the nurse, gradually helping the client to gain an understanding of the crisis and accept reality. In a situation where the caller is assessed to be highly suicidal, assistance of the police for crisis home visit is indicated to possibly avoid irreversible damage or imprisonment or hospitalization.

It is critical that the nurse keeps the caller talking, allowing time to trace the call, contact relatives or the police if necessary, or begin to develop a relationship. Just as the nurse must acknowledge the caller’s feeling of distress, she must explain in a caring manner that the caller does not need to hurt himself/herself in order to emphasize it. She must avoid overusing reflection of feelings, instead, offering direction and solutions to the problems (Merker 1986).

Telephone counselling

Suicide prevention and crisis intervention centres rely heavily on telephone counselling, allowing the caller to remain anonymous, with the goal of providing immediate relief and then long-term follow-up, if necessary. There is little evidence to support the contention that crisis-focused services reduce the incidence of suicide. The bulk of studies which are ecological and observational (Miller et al. 1988, Gingerich et al. 1988) noted the limited impact of such centres on overall suicide rates. Nonetheless, the present findings show that the suicide prevention and crisis intervention hotline in this VA facility is well utilized and appears to be very effective. The use of the Suicide Call Assessment Form seems to facilitate systematic documentation of client-counsellor interactions during intense crisis situations and helps to diffuse suicide attempts.

Suicides or suicide attempts have significant ramifications not only for the family but for all of society. Timely intervention is basic to suicide prevention, directing the suicidal person to go on living despite the pervasive wish to die. As cited earlier, suicide occurs more frequently among people who are elderly, male, single, divorced, widowed, and alienated, and among those with life-threatening illnesses. Thus, the veterans population is a vulnerable one.

IMPLICATIONS FOR NURSING PRACTICE AND RESEARCH

Findings of this study could serve as a base for the development of suicide-prevention-focused programmes and further improvement of the telephone hotline for assessment of veterans in crisis. Nurses do not respond to suicidal clients and their families with ambivalent feelings; such feelings serve as a barometer of what is happening in the nurse–client interaction, which includes assessment, diagnosis, goal formulation, intervention and evaluation.

Assessment includes the identification of risk factors, stressors and behavioural manifestations. Assessment of lethality is extremely important in determining the risk for completed suicide. This is the first step in helping self-destructive persons and is the basis on which the nurse formulates subsequent responses.

Diagnosis includes identification and clarification of problems such as perceived lack of support system, loneliness, substance abuse, unemployment or panic anxiety. Nursing goals in CIH client interactions are primarily directed towards protecting the client and others in the immediate environment from danger, then resolving identified problems wherever possible.

Further enquiry

The following questions merit systematic enquiry in order to shed more light on the efficacy/effectiveness of preventive programmes and nurse–client interactions via the telephone hotline or face-to-face situations. To what extent are crisis-focused discussion groups or self-esteem enhancement programmes effective in suicide prevention? Does the assessment of suicide potential provoke anxiety among health care workers?

Limitations

The sample was derived from only one facility which limits the generalizability of the study findings. Also, there was no follow-up of CIH callers and it could not be determined whether they sought subsequent treatment at other times or had in fact committed suicide. Also, no data were collected regarding ethnic background and whether or not the callers were war veterans.
CONCLUSION

Suicidal behaviour is affected by a number of demographic, social and clinical factors. American veterans are faced with scores of stressful life events, some of which could be so overwhelming that their usual problem-solving skills or coping mechanisms are not adequate anymore.

The findings of this study depict a socio-demographic profile of the American veterans who are at high risk of attempting suicide or complete suicide. Common triggering crisis events and coping methods used are discussed. Study limitations and recommendations are presented.

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