



## **Building Professional Excellence- Part 2**

### **Session 3: Understanding Suicide and Prevention in Service Members**

#### **Webinar Follow-up Question and Answer Session with Dr. Mary Bartlett.**

##### **1. Question from Lindsay Guenther**

I am a college academic counselor rather than a mental health provider, technically. I have always referred to military members and veterans by their first names, since my relationship to them is student/advisor. Could this assumed first-name basis be offensive to them if they have a high rank?

##### **Answer from Presenter**

Yes, as a norm you want to refer to the person initially by his or her rank out of respect. Or ask the person, "SMSgt Smith, do you want me to refer to you by your rank/status or use your first name? Which are you more comfortable with?" But as a norm, even if an Air Force Command Chief--CCM (or an Army Command Sergeant Major--CSM) invites you to use his or her first name, I flip between the name and calling the person "Chief" as it is a title earned and respectful. But many Generals, etc. will invite you to please use their first name and then doing so is completely acceptable.

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##### **2. Question from Crystal Sharp**

What do you suggest for mental health providers who work with retired military members who have had a traumatic childhood then joined the armed forces and were deployed multiple times; experiencing more traumas that now their behavior fits a personality disorder, where suicide is a symptom, because of the unresolved trauma?

##### **Answer from Presenter**

Suicide is not treated differently whether the onset is from complex trauma, PTSD, childhood trauma, deployments, etc. Treat the psychological pain using the same skills you would use treating anyone presenting with suicidal ideation.

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##### **3. Question from Elizbieta Wojnarowska**

I am interested in gender differences in assessment and intervention of suicidality in service members. What are the things mental professionals need to be sensitive to?

##### **Answer from Presenter**

Keep in mind that gender differences (differences between men and women) include more men completing suicide; more women attempting. Men using more immediate lethal means (guns) and women often choosing less lethal means (pills). Always explore the foundation of the suicidal pain as the core issues are likely different for each person regardless of gender, but will bear similar features such as psychache, burdensomeness, etc.

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#### **4. Question from Patricia Nation**

Why are the statistics being reported to the general public much higher than the numbers you presented? The Battle Buddy Foundation reported last year that between 2000 and 2013 there were 88,330 veteran suicides.

#### **Answer from Presenter**

There are many factors that contribute to numbers differing from one report to another. The Battle Buddy Foundation may use stats from the Department of Defense (DoD) whereas the AAS may use stats on Veterans from the Center for Disease Control (CDC), etc.

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#### **5. Question from Robert Cassman**

What is the difference between a legitimate suicide threat and a Borderline personality disordered person's everyday threats?

#### **Answer from Presenter**

None. All threats should be considered legitimate as they stem from unresolved internal psychological pain. However, the treatment may be different. For a person who discusses and puts into words their desire to die on a daily basis, the work is to help them become mindful that there are other options than to first default to a thought of wanting to die.

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#### **6. Question from Nicholas Kicior**

If someone has expressed suicidal ideations in the past treatment they received, you should request records for what specifically? Would assessing for current lethality be sufficient or is it imperative you demonstrate a request for historical information?

#### **Answer from Presenter**

For every client, an assessment needs to be conducted to determine if he or she has been in prior treatment for mental health services. If the client has been treated in the past for mental health reasons, the provider should ask the client for contact information and request records (or a summary report) of the prior treatment from the former center or treatment provider. The former center or provider does not have to send you information but it is wise for them to. Sometimes the information will come to you in the form of copies of case notes, a summary of treatment with a diagnosis, number of sessions completed, etc. It is up to the former center and/or provider what information will be sent. You are simply making a request for information to get a more complete picture of your new client's status, whether the person (your current client) has been suicidal or not. You want to be able to indicate somewhere in that client record that you sent requests out. This way if there is a suicide, you can at least verify that you attempted to get details to give you a more comprehensive picture of the client.

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### **7. Question from Tayler Shannon**

You stated that more soldiers who haven't yet been to combat are completing suicide rather than those who have been in combat. What are your conclusions about that fact that help explain why this is occurring?

#### Answer from Presenter

There are many hypotheses about why this is in the case including increased work stress in country, already unstable mental health in the person, poor coping skills, lack of resilience in their new role as a service member, unpredictable family stress, transition out of a position of responsibility which he or she enjoyed (when their military counterpart left—and is now returning—so displacement), etc. Data regarding this fact is still being collected annually.

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### **8. Question from Jean Pollock**

Do the connections needed for a good prognosis ideally need to be other warriors --instead of family? In addition, how can PTSD be a significant risk factor if the highest numbers of warriors who suicide haven't even seen combat?

#### Answer from Presenter

A service member can be helped both by another service member and/or a family member, but there does seem to be a stronger response to having a fellow warrior to talk with who understands the military experiences of a fellow warrior. But it is often a family member that first detects something may be amiss with their military loved one.

PTSD is not only experienced by service members who have been to combat. High numbers of civilians as well as service members who have not been to combat can have PTSD for various reasons (e.g. childhood trauma, being mugged, raped, experiencing a natural disaster, etc.).

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### **9. Question from Nisha Talwar**

As a clinician, I continue to at times struggle to assess and determine the risk between having ideations and having intent. I feel for people with PTSD and other mental illness, triggers can be quick and on an impulsive action?

#### Answer from Presenter

Although it is true that some suicides can be impulsive, most seem to have a trajectory of pain. However, the final act is often impulsive when that day (or that hour), their pain became unbearable. This is why removing access to quick means (such as guns) is important and teaching a client with ideation that if he or she can get through the hour, the night, etc. and can seek help the next day survival is possible. Using the assessment instrument (from Dr. Thomas Joiner) presented during the Webinar may help you make more clear distinctions between suicidal desire (ideation comes under desire), capability, and intent.

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**10. Question from Jean Pollock**

If warriors don't have to have been in theater, then how can PTSD be a factor in suicidality?

Answer from Presenter

PTSD is not only experienced by service members who have been to combat. High numbers of civilians as well as service members who have not been to combat can have PTSD for various reasons (e.g. childhood trauma, being mugged, raped, experiencing a natural disaster, etc.).

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