Nearly a decade after he completed active duty in Iraq, Daniel Somers took his own life. The former Army intelligence officer who suffered from traumatic brain injury and PTSD was just 30 years old when he committed suicide on June 10. In a lengthy letter to his family that has since been widely published in the media, Somers poured out his feelings of desperation and hopelessness.

“My body has become nothing but a cage, a source of pain and constant problems ... that not even the strongest medicines could dull. ... My mind is a wasteland, filled with visions of incredible horror, unceasing depression and crippling anxiety ... not only am I better off dead, but the world is better without me in it,” he wrote.

Somers’ letter has given voice to the thousands of veterans who have suffered and taken their own lives. Suicide is now recognized as a growing epidemic among this population, as rates have been rising steadily since 2005.

In an annual survey of 4,000 active-duty military personnel and veterans from the Iraq and Afghanistan conflicts, suicide ranked as the most important issue. Conducted earlier this year by Iraq and Afghanistan Veterans of America (IAVA), it found nearly one-third of respondents said they have thought about taking their own lives; 37 percent said they know a veteran of Iraq or Afghanistan who has committed suicide. Of that 37 percent, more than half know more than one veteran who has died by suicide.

The problem isn’t limited to veterans of the current wars. Suicides by veterans from all conflicts have been increasing, and they now account for 22 percent of all suicide deaths in the United States. Veterans make up only about 10 percent of the U.S. adult population. According to one recent estimate, some 49,000 veter-
Americans, they get their mental health care from their primary care physician. Yet many primary care physicians never inquire about their patients’ veteran status or ask about suicide or depression, Fortin says. “It seems pretty basic, but sometimes some places out in the community don’t even ask if they’re dealing with a veteran or a spouse of a veteran. That in and of it itself does provide information, and a reason to find out more,” she says. “I want to make sure providers incorporate asking if the person is a veteran into their practice, and incorporate a risk assessment or at least asking depression screening questions or post-traumatic stress-related questions to give them a better idea of who they are dealing with.”

Who is at risk?
Until recently, service in a combat area was considered the major factor for determining which veterans are at highest risk of suicide; but a longitudinal study of active and veteran military service personnel identified other causes. The Millennium Cohort Study, the results of which were...
published in the August 7 issue of JAMA, followed 151,560 armed forces personnel who served between 2001 and 2008. Researchers identified 646 deaths during the study period, 83 (12.8 percent) of which were confirmed suicides. The investigators found that military personnel deployed to current operations (both combat and non-combat) were no more likely to die from suicide than those who did not deploy.

The main risk factors identified in the study were underlying and untreated mental illness (specifically manic-depressive disorder and depression), being male, engaging in heavy or binge drinking and having alcohol-related disorders. Other signs that physicians should watch for include relationship challenges, impulsivity, and gambling or other risk-taking behaviors, says Dan Reidenberg, Psy. D., executive director of SAVE (Suicide Awareness Voices of Education), a nonprofit agency based in Minnesota that works to raise awareness and aid suicide survivors and their families.

Reidenberg notes that soldiers returning from Iraq and Afghanistan have already had more experience with trauma than most people ever will. They may have served in combat areas for prolonged periods without a break. Many were on duty for 12 hours a day, he notes, and they often faced an unidentified enemy—one who could appear as a police officer or even a child. Because of that, they often are unable to relax and return to a normal mental state. “They experience such a heightened state of arousal for such a period of time that we know it’s changing their endocrine system, and that’s a bad thing,” he says. “It’s affecting the roots of their functioning.”

Many are reluctant to seek help for mental health issues. In the IAVA survey, 63 percent of respondents said they have a friend in need of mental health care, and half reported they had been advised to seek mental health care by a friend or family member. The reasons most frequently cited for not seeking help were concern about how they would be viewed by others and how it would affect their careers. More than three-quarters of the respondents also said the Department of Defense and the VA are not providing adequate mental health care and support.

A continuum of care
As part of its suicide prevention efforts, the VA has developed “wrap-around” services for at-risk veterans, Fortin says. Those at high-risk are eligible for enhanced care in both the VA’s mental health and primary care clinics. A veteran can receive inpatient care, if needed, until he or she is stabilized, followed by three weeks of treatment in an outpatient day program that includes group and individual therapy, safety planning, cognitive behavior therapy and coping exercises. This is followed by continued outpatient care that may include sessions with a therapist, treatment by a psychiatrist or both. Treatment steps down gradually over two or three months, as the patient improves, Fortin says.

The VA is also working to increase awareness in the community. Fortin and her staff offer suicide awareness training for families, veterans organizations and others, and suicide assessment training for clinicians. The clinical training covers risk factors and warning signs and teaches physicians how to incorporate those into a risk assessment and plan appropriate treatment. It also helps physicians become more comfortable asking patients about suicide and talking about psychological pain and what to do if they feel a veteran is at risk.

That is especially important because primary care physicians are often the last line of defense, Fortin says. Nearly half of the veterans who received care at the Minneapolis VA and died by suicide had only received care from a physician; they were never seen by a mental health specialist. Other studies have shown that about 80 percent of adults who died by suicide saw a physician of some type within a month of their death, 40 percent within week of their death and 20 percent on the day of their death.
“We know that they’re going to their primary care office; they are really, truly the front line,” Reidenberg says. “Everybody needs to be aware of it. Physicians, physician assistants, nurses, even dentists need to be aware of it.”

In addition to asking veterans the right questions, physicians need to look beyond their immediate physical complaints. “They may talk about backaches, headaches, neck aches, stomachaches. That’s what they say hurts,” Reidenberg says. “Physicians pick up on that as a medical issue. They miss the fact that this is about a mental health issue.”

It’s also important to ask patients not just how they’re feeling today but how they felt last week or last month, and to have that conversation over weeks or months. People thinking about suicide often pull away from family, friends and their community, Reidenberg says. “Often, their last hope is somebody outside of their normal group of people, and it’s a doctor. Those doctors have the greatest opportunity to help save somebody,” MM

J. Trout Lowen is a Minneapolis freelance writer and editor.

Resources

For veterans
The 24-hour Veterans Crisis Line offers free confidential support to veterans in crisis and their families. Veterans can call 800-273-8255 and press 1 to speak with someone immediately, chat online at www.veteranscrisisline.net/chat*, or send a text message to 838255.

For providers
The Minneapolis VA offers training for clinicians on how to identify and care for a veteran who may be suicidal. Physicians learn to recognize warning signs and risk factors and how to translate those into a clinical risk assessment and basic intervention steps. For more information or to schedule training, contact Lindy Fortin, the VA’s suicide prevention coordinator, at lindy.fortin@va.gov or 612-467-3620.

You can learn more at www.mentalhealth.va.gov or www.veteranscrisisline.net/Resources/Default.aspx.

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