Chapter 12

YOUNG ADULTS IN THE MILITARY:
RISK AND PREVENTION OF SUICIDE

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ABSTRACT

As a health care provider, the military is poised to approach suicide prevention and intervention systemically. While services only reach a fraction of veterans, strides are being made to improve access. Efforts include adding Suicide Prevention Coordinators at military facilities, increasing the number of mental health professionals across military settings, and screening. Another preventative intervention is the use of gatekeepers, individuals who are not clinically trained, but have jobs that put them into routine contact with veterans. Gatekeepers are trained to notice veterans who are presenting with signs of suicide risk and make effective referrals to mental health providers. Services and awareness are growing for young adults in the military who present with suicidal ideation. Suicide appears to be persistent and affects every branch of military, however providing a holistic approach can provide a balanced distribution of resources, information and knowledge.

INTRODUCTION

Worldwide, suicide is among the leading causes for death in young adults; it is the second leading cause of death among people between the ages of 10 and 24 (1). Given that half of the military population falls between the ages of 17 to 26 years of age, this portion of the population at high risk for suicide (2). Of further concern is that the United States Army’s
suicide rate rose from 15.8 per 100,000 in 1985 to 21.7 per 100,000 in 2009, a record high (3, 4). Other branches have seen increases in suicide rates as well (4). The number may be as much as 21% higher given the frequent misclassification of suicides as accidents or undetermined causes (4). Another challenge is understanding military suicides in relation to civilian suicides. An accurate comparison requires adjusting data to account for the military’s disproportionately large population of young adult males (3, 4).

Regardless of these difficulties, rates of military suicide have risen while rates of civilian suicide remained relatively stable (4). The reason for the discrepancy for rates has been difficult to determine and is likely multifaceted. As discussed by Braswell and Kushner (4), potential factors include longer deployments, repeat deployments, increasing exposure to combat, and lower recruitment standards. Repeat deployments could result in resending individuals who are presenting with mental health and substance abuse concerns into an environment that initially triggered those concerns (5). Financial and marital stress can also increase a soldiers’ suicide risk (6). Long and repeat deployments can place significant stress on a family. Finally, the military’s “warrior culture” may discourage soldiers from speaking openly about their psychological and emotional vulnerabilities and thus present a barrier to intervention before soldiers reach the point where they feel that they must end their lives (7).

A CONCERN

The increasing rate of military suicides concern the Department of Defense (DoD) leadership (8). Prevention activities should include supporting soldiers in coping with stress, supporting soldiers in developing self-awareness and self-care, treating mental illness, and addressing risk factors (e.g., impulsivity and hopelessness) (9, 10). Soldiers at risk for suicide should be identified through screening and be provided with treatment that could include psychotherapy and medication (9, 11). Treatment should provide the opportunity to build skills. In addition, soldiers should have restricted access to lethal weapons. Of course, weapon restriction might be difficult, but should be considered (10). Soldiers who have attempted suicide or who are at imminent risk for doing may need hospitalization, or at the minimum, intensive follow up care. Care should be given to how military suicides are handled in order to prevent imitation (9).

RISK FACTORS

Who should be identified for further intervention? Soldiers (and veterans) with previous suicide attempts, a mental health disorder, a history of substance abuse, and a history of head trauma should be flagged for further intervention (10). American veterans also warrant attention for risk, especially if they are presented with unemployment or a limited support system – factors that can lead to hopelessness and loneliness at a critical point in a young adult’s life (12).
**INTERVENTION**

When soldiers need intervention, several concerns must be considered and addressed. A significant concern is confidentiality. Soldiers may fear they will be blocked from future military involvement if they are labeled as “high risk” for suicide. Soldiers need to be educated about the limits of confidentiality for the services provided so they can make an informed decision about what to share and with whom when seeking help. Another concern is access to evidence-based treatment. Procedures need to be in place to ensure that those who need services can access them. This includes training qualified personnel to engage in suicide-risk assessment and management, as many may not feel competent to do so without further professional development. Clinicians could also benefit from ongoing training so they can reliably implement evidence-based treatment models and update treatment as research indicates is necessary. Another concern is re-evaluation. Soldiers also need access to re-evaluation of risk. Hopefully, treatment is successful or their situation improves. They should not be stuck with the high-risk label (11).

As the nation’s largest health care provider, the military is poised to approach suicide prevention and intervention systemically. While services only reach a fraction of veterans, strides are being made to improve access. Efforts include adding Suicide Prevention Coordinators at military facilities, increasing the number of mental health professionals across military settings, and screening (11). Another preventative intervention is the use of gatekeepers, individuals who are not clinically trained but have jobs that put them into routine contact with veterans. Gatekeepers are trained to notice veterans who are presenting with signs of suicide risk and make effective referrals to mental health providers (9, 11).

**CONCLUSION**

Services and awareness are growing for young adults in the military who present with suicidal ideation. As suggested in this chapter, doing more to reduce suicide rates by providing access to quality care for those at risk and in need will reduce the prevalence of suicides. Suicide appears to be persistent and affects every branch of military, however providing a holistic approach can provide a balanced distribution of resources, information and knowledge.

**REFERENCES**