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Military Veterans' Experiences with Suicidal Ideation: Implications for Intervention and Prevention

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We sought to understand Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) veterans' experiences with suicidal ideation. Semi-structured interviews with 34 OEF/OIF veterans addressed circumstances leading up to disclosure of suicidal ideation during brief clinical assessments. We used an iterative, inductive and deductive thematic analysis approach. Results revealed three pervasive, persistent domains that reinforce the uniqueness of veteran suicidal thoughts: military culture, difficult deployment experiences, and postdeployment adjustment challenges. Within postdeployment, we identified four themes that serve as intervention targets: adjusting to civilian culture, changes to sense of self, feeling overwhelmed by stressors, and lacking life purpose or meaning.

Veterans who receive health care services from the Veterans Health Administration (VHA) are at higher risk for suicide than the general population (Blow et al., 2012; McCarthy et al., 2009); approximately one quarter of veterans who die by suicide make contact with VHA services in the year prior to death (Denneson et al., 2010). Prior research has identified several demographic and clinical characteristics associated with suicide (Britton, Ilgin, Valenstein, et al., 2012; Haney et al., 2012; Martin, Ghahramanlou-Holloway, Lou, & Tucciarone, 2009). Psychiatric diagnoses, such as depression, posttraumatic stress disorder (PTSD) or substance abuse, as well as physical conditions, such as chronic pain or traumatic brain injury (TBI), have become markers of those at highest risk for suicide. These conditions and their related symptoms have also become targets for intervention. However,

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prior work has primarily relied on hospital administrative data sets, reviews of medical records, and national death or health surveys (Basham et al., 2011; Britton, Ilgen, Rudd, & Conner, 2012; Kaplan, McFarland, & Huguet, 2009; Lemaire & Graham, 2011). This top-down approach has yielded demographic and clinical characteristics that adequately describe suicide decedent populations, but do little to explain individual veterans' thoughts regarding suicide or suicidal ideation, which may reveal more effective targets for treatment and intervention.

Few studies have engaged individuals with suicidal ideation as primary sources for understanding suicidal thinking or for advising intervention strategies. A review of qualitative studies investigating how people recover from suicidal thoughts (Lakeman & FitzGerald, 2008) identified 12 relevant studies published between 1997 and 2007. Prevailing themes were as follows: suicidal thoughts often reflect existential struggles, can be seen as both a coping strategy and a failure by those experiencing them, and are influenced by social connections with others (Lakeman & FitzGerald, 2008). The relationship between social connections and suicidal thoughts is reinforced in Ghio and colleagues' (2011) study of individuals who attempted suicide. More recently, the desire for control was identified as the main theme among individuals in Sweden who had attempted suicide (Pavulans, Bolmsjo, Edberg, & Ojehagen, 2012). Together, authors of these studies have concluded that regaining control and a sense of mastery, help with basic social needs (e.g., employment), and establishing relationships with others may be key targets for treatment and recovery (Ghio et al., 2011; Lakeman & FitzGerald, 2008; Pavulans et al., 2012).

Among veterans, fewer studies have investigated perspectives of, or experiences with, suicide, suicidal ideation, or related treatment. A study of veterans with TBI reported that common experiences contributing to suicidal ideation or behavior included a loss of sense of self, cognitive problems, and various psychiatric or emotional disturbances (e.g., feelings of depression, worthlessness, anger, and hopelessness; Brenner, Homaifar, Adler, Wolfman, & Kemp, 2009). Social supports, a sense of purpose, religious beliefs or affiliation, and mental health care were distinguished as protective factors. Relatedly, combat veterans have endorsed suicide as a potential means of coping with interpersonal stressors (Brenner et al., 2008; Gutierrez et al., 2013). Given the uniqueness of military life, a clearer understanding of veteran experiences with suicidal ideation is needed to tailor intervention and prevention approaches. In this study, we sought to understand Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) veterans' experiences with suicidal ideation.

METHODS

In this qualitative study, we conducted 34 individual semistructured interviews with OEF/OIF veterans. Sample, eligibility, and recruitment methods have been reported elsewhere (Ganzini et al., 2013). OEF/OIF veterans who screened positive for depression or PTSD and endorsed suicidal ideation during brief risk assessments conducted in non-mental health ambulatory care settings in 2009 and 2010 at three geographically diverse VA medical centers (Portland, Oregon; Indianapolis, Indiana; and Houston, Texas) were potentially eligible. OEF/OIF status was indicated by the OEF/OIF roster, which is maintained by the Department of Defense Manpower Data Center and contains information on veterans discharged after October 1, 2001, who enrolled in or accessed VHA services. Suicidal ideation was indicated by veterans endorsing thoughts of being better off dead or of taking their own lives in response to either the ninth item of the Patient Health Questionnaire (PHQ-9; Kroenke, Spitzer, & Williams, 2003) or the VA Pocket Card Risk Assessment (U.S. Department Of Veterans Affairs, 2008) in the clinical setting.

OEF/OIF roster data were matched to VA patient record data to identify lists of OEF/OIF veterans recently screened for depression or PTSD. Manual medical record review was then used to determine the screening result and the suicidal ideation assessment status. Purposive selection of eligible veterans was attempted to increase participation of women and ethnically diverse veterans; we prioritized recruitment of veterans in these groups using an enrollment matrix of demographic characteristics. In consultation with the primary treating clinician, the research team contacted eligible veterans by mail within 2 to 6 months after their suicidal ideation assessments. We achieved approximately a 34% response rate to our recruitment letters, with 80% of responses indicating interest in participating. Participants were reimbursed $50 for their time and travel to the VA for the interview. Interviews were transcribed and de-identified. Study staff read transcripts as they were completed and met at least monthly to discuss emerging themes. Recruitment was discontinued when all study staff agreed by consensus that no new themes were emerging from new transcripts (Ganzini et al., 2013). Interviews took place over 2 years (2009–2010). Procedures were reviewed and approved by the institutional review board affiliated with each VA medical center and all participants completed a formal, signed consent to participate.

Interview Guide

Three interviewers conducted the interviews: a psychiatrist, an internist and director of a VA postdeployment clinic, and a research assistant with a background in social work. We previously reported (Ganzini et al., 2013) on veterans' comfort level with suicidal ideation assessment questions, how the care setting of assessments influenced their responses, any hesitancy to discuss suicidal ideation, reactions from providers after disclosing suicidal ideation, and positive and negative views or consequences of disclosing suicidal ideation. In addition to these questions, and the focus of this study, the veterans were asked what events or circumstances led up to their disclosing suicidal ideation, prior suicide attempts, and prior experience with suicidal ideation and mental health care (in the military, VA, or otherwise). The interviews were semi structured, encouraging participants to tell their stories in their own words and allowing for exploration of new topics raised by the participant.

Data Analysis

Interview transcripts were organized using Atlas.ti qualitative software. Coding and analysis focused on perspectives of suicidal thoughts and behaviors, and circumstances contributing to suicidal ideation. Using an inductive and deductive thematic analysis approach, we developed initial codes based on previously established risk factors for suicide (e.g., mental health disorders, substance abuse) and themes from prior qualitative work (e.g., control, relationships). Then, through an iterative process, two of the authors (LD, a social psychologist; AT, a psychiatrist) reviewed transcripts separately, adding new codes to the codebook as new topics emerged from the data. This iterative process also involved honing our research questions to more appropriately reflect and explicate emerging themes. Conceptual memos were used to track developing themes, organize potential relationships among codes, and refine ideas emerging from the participants' thoughts. Between rounds of coding, codes and memos were discussed and refined. A final round of coding was conducted with the revised codebook of 24 codes. Next, four authors (SD and LG, psychiatrists; MB and DH, internists) reviewed the code reports for additional themes, interpretation, and organizational structure. Refinement of themes and organizational structure continued until all authors agreed on content. In the supporting quotes below, we removed words and sounds that are linguistically considered "filler" (e.g., "like," "you know")

and each participant was assigned a letter code that is not related to their name or any other identifying information.

RESULTS

Most of the 34 participants were male (n = 31, 91%), with a mean age of 34.6 years old (range = 24–55). Twenty-five (74%) were White, non-Hispanic, while five (15%) were African American, two (6%) were Hispanic, one (3%) was Pacific Islander, and one (3%) was biracial. Length of time in the military ranged from 3 to 30 years, with an average of 13.9 years. A majority reported serving in the Army or Navy (56%), and 32% indicated National Guard or Reserve status. Length of reported time between the interview and military discharge ranged from 6 months to 5 years; length of reported receipt of VA health care ranged from 6 months to 23 years. All but one participant reported current or prior receipt of mental health treatment at the VA.

Analyses revealed three overarching domains relevant to veteran context of suicidal ideation: military culture, difficult deployment experiences, and postdeployment adjustment challenges (Figure 1). These were the most pervasive themes across all interviews. Within the postdeployment domain, we identified four primary, or prominent, themes: adjusting to civilian culture, changes to sense of self, feeling overwhelmed by stressors, and lacking purpose or meaning in life. Several secondary themes were also identified, which cut across primary themes: struggles for control, discomfort with ambiguity, functional limitations, mental health issues, employment concerns, inadequate contributions to society or group, disrupted relationships, and apathy toward or devaluation of life.

Military Culture

Across all themes, direct and indirect references to military culture were pervasive, reinforcing the uniqueness of the veteran experiences with suicidal thoughts and behaviors as distinct from the general population. Most veterans described a military culture that negatively responds to—either tacitly or implicitly—suicidal individuals. We identified two specific themes connecting military culture and veteran perspectives on suicidal thoughts or behaviors. The first reflected the veterans' perceived need to 'keep silent' and not disclose suicidal thoughts. The second articulated an attitude of insensitivity about suicide in general and specifically toward others experiencing suicidal thoughts.

Many participants emphasized their conviction to keep silent about their thoughts of suicide while in the military. Some indicated they would be treated negatively by superiors if their suicidal thoughts were known, or they feared their unit would view them as unreliable. Although most concluded that the climate of suicide prevention in the military has improved, gains were in name only, not in spirit. Suicide prevention training in the military focused solely on how to identify a suicidal service member, rather than instruction on what to do if one had thoughts of suicide. This approach had the unintended consequence of helping them hide their own thoughts of suicide (Table 1).

Some participants described a military culture that fostered insensitivity toward suicide and individuals experiencing suicidal ideation. For example, veterans talked of service members placed on "suicide watch." These individuals were viewed as a 'burden,' 'a drag on the unit,' since someone else had to take care of them. They reported hearing comments like 'get it over with' or 'just do it already' in reference to those who expressed suicidal ideation. However, this attitude was contrasted by one veteran's experience of feeling protected and supported by the veteran's unit after disclosing suicidal thoughts. Others expressed insensitivity about suicide in more abstract terms. They suggested that suicide was a less-than-sig-

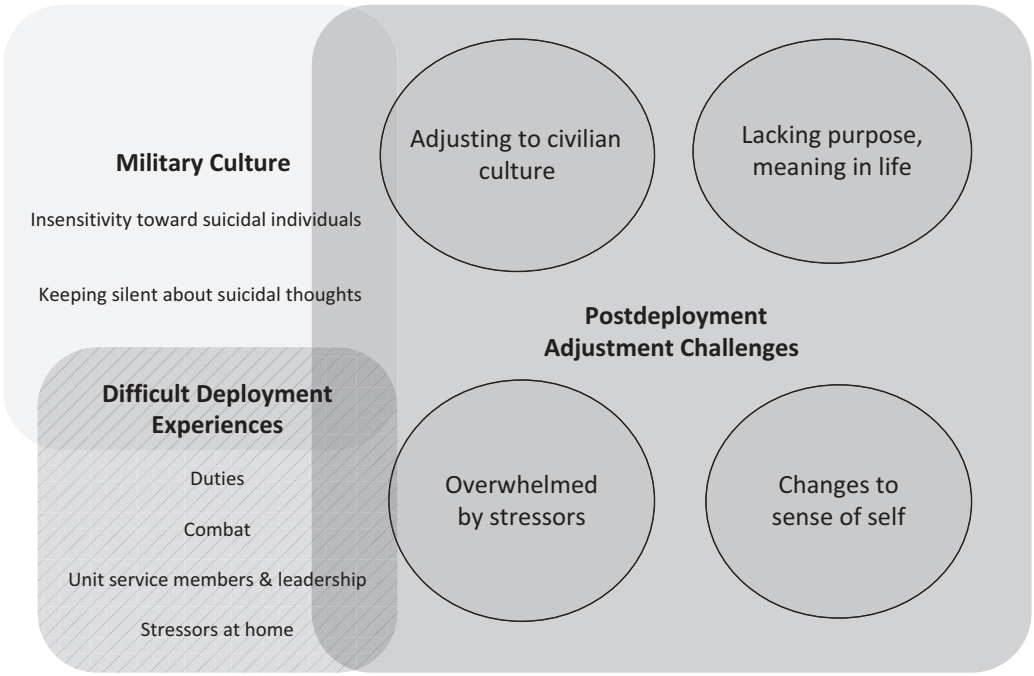

Figure 1. Main themes reflective of Operation Enduring Freedom and Operation Iraqi Freedom veterans' experiences with suicidal ideation.

nificant act: something 'any infantry service member has the guts to do' or simply a 'do or not do' (Table 1).

Difficult Deployment Experiences

Similar to military culture, active duty experiences were brought up spontaneously at times and, in many instances, were identified as directly contributing to veterans' suicidal thoughts. Difficult duties, unit cohesion, unit leadership, and combat experiences varied among participants. One veteran noted specifically that postdeployment debriefing should be tailored to address the variation in individual deployment experiences (Table 2). The strain of an intense work schedule, alienation in one's unit, constant bombardment by mortars and other enemy fire, exposure to death (killing others or handling human remains), sleeplessness, responsibility for others, or pressure from their chain of command were some of the specific experiences characterized as difficult. These experiences fostered a range of emotions, from annoyance to anger and sense of failure to overwhelming intolerance of the situation and strong feelings of guilt.

Situational stressors occurring at home while they were deployed were a primary concern for many participants. Respondents described deaths or illnesses of family members and friends, spousal infidelity, and other worries (e.g., financial) they had regarding loved ones at home. They perceived being unable to do anything about these situations; leaving them feeling frustrated, out of control, and overwhelmed (Table 2).

Postdeployment Adjustment Challenges

Adjustment to Civilian Culture. Upon returning from deployment, many veterans found that civilian culture and lifestyle clashed with what they learned in the military. The structured military environment,

TABLE 1
Military Culture

Keeping silent about suicidal thoughts
Participant AB: I'd quit eating, I'd cry all the time, and I just didn't do anything. But when I was at work as a soldier, that's when I was the soldier, I'd put on the face and nobody saw anything different.
Participant H: I think there were many soldiers that were scared to go just because of the chain of command. And the way the chain of command would have thought of them because the chain of command really classifies you differently once they find out that you are seeking mental health.
Participant AI: You don't joke about that kind of stuff and a lot of people keep it quiet because if you're that low and 'down and out' then you just don't know what they're going to do with you once they find out.
Participant F: You don't have time to stop and complain. Nobody will listen to you. Sometimes they joke around, 'yeah go ahead, if you want to take your life, go ahead. . .' and it's just a joke, I'm just saying . . . it's a no-no, you cannot be weak when your defending, watching over your buddy's back. Everybody's counting on you.
Participant U: It's that whole stigma thing, in part . . . you don't officially want the system thinking that you're damaged goods ever, right? That's the easy one, but you don't want your foxhole buddy thinking that either. So that's a big part of the denial.
Insensitivity toward suicide and individuals with suicidal ideation
Participant F: If you're in the infantry unit, you don't have time to talk about it—taking your life. You just do it. If you have what it takes, if your man enough to be in infantry, you're man enough to take your life anytime you want to.
Participant AF: They would be called stupid or something like that: 'Hey, why would you want to kill yourself? That's pretty stupid.' Of course other ones, which was very few, would say, 'Wow, go ahead and do it, get it done, get it over with.'
Interviewer: What do you think would have happened if more people had found out [you had suicidal ideation]?
Participant S: I just think they would have—it would have turned more into a joke, you know. A hazing, harassment, give me a hard time about it, not really understanding why.
Participant M: I went back and they said basically—the counselor I saw said that I either suck it up or handle it on my own, or they'd have my drill sergeant do it for me. And I was shoved out the door. The military can be very brutal at times.
Participant V: I was feeling bad in about 2005 and my unit, they almost dropped everything. Cause the fear is, if a guy feels bad, he might harm himself and that is part of our family, part of our unit, part of our numbers—it's a numbers game. They want to keep up the strength. But also, we have an investment in that person. We've trained them—we can't just neglect that cry, even though it may just be a comment. So, I was kind of impressed . . . I was surprised that they stopped and they said, 'come in this room,' and they closed the door, and they said, 'what's going on, what can we do?'

with clear guidelines, made it hard to adjust to the relatively unpredictable nature of postdeployment civilian life. For example, one veteran pointed out that in the military everyone knew what they were supposed to do, and precisely how they were supposed to do it, but civilians each have their own way of doing things. Put another way, military life was a known, comfortable entity. In contrast, civilian life was an unknown entity—fostering discomfort. Some found it difficult to make their own decisions and do things their own way after becoming accustomed to being told what to do and when during their military career. Individual control or volition seemed to be an unfamiliar experience. One veteran compared the realization he was now allowed to think for himself—and his struggle to do so—to being the victim of a bully (Table 3).

TABLE 2
Difficult Deployment Experiences

Individual Experiences

Participant Q: I was holding the barrel in front of my face with my thumb on the trigger. It was locked and loaded . . . it was off the safety . . . I was ready to fire. I guess I was just trying to get some good last thoughts. I was sitting there crying. . . . I was thinking about everything good that I could think of . . . but all I was thinking, all I could get through my head was bodies . . . blood. . . everybody I've killed.

Participant E: Medics, in my opinion, got the hardest job in an infantry platoon. They are the most prone to kill themselves when they come back cause they got their nine-millimeter most of the time, and that's all they got, and they're the first ones to see someone's entrails and everything laying out when they have to fix it and if they don't fix it then they feel like it is their fault.

Participant Z: I really think it all starts with when you're coming back. They don't do enough there. It's a big room with thousands of people watching one screen and that's supposed to be your debrief. Different people do different things. These people have been killing, these people haven't, these people just been themselves. They're all in the same room doing the same thing. And, it's not personal, it's not—they don't know what's going though each person's head. It's just, 'watch the movie and y'all are done.'

Participant AH: Well, on first deployment we had a guy that shot himself in the head . . . we had to go get the body. . . . we had to put him on—put him in the bag and everything. Doc had to go with us and pronounce him dead and then we had to take him over to a different camp that had mortuary affairs in it and stuff. . . . It was pretty apparent what had happened. Everybody was like, 'no that's not what happened.' Well, he put the gun right behind his chin and blew the whole top of his head off.

Participant AI: They give you 60 bullets. And they trust that you know what you're doing. But anyone can get a hold of their bullets that are assigned to them and they can shoot themselves. And, in fact, my roommate and I didn't get along, she—she was just—I can't explain it, it's a long story, but anyway we had a falling out and it was a pretty bad one—where she—she and I just had some words. But it was pretty bad and I went to my platoon sergeant and I told him that if she points her weapon at me, I will shoot her. And it was just point blank. No questions asked. If she even had one round in her—I know this sounds bad—but I said, 'you need to take my bullets and you need to take her bullets because if. . .'

Participant J: Well I never had the full 24 hr off, because my command would then put me to work. So, I'd work 48 consecutive hours, get maybe 8 hr sleep, *maybe*, if I didn't have to work at the MWR that night. I mean, it's stupid, ridiculous hours, and you want to know why I was stressed? And then I'd have a sergeant, this one sergeant didn't like me and would publicly say that to command, to me, 'I don't like your attitude.'. . . I lost it one day after 50 hr at work, and tried to stab her.

Participant S: Overseas, I mean, there was so much going on mentally, they were having me go here and there and traveling and getting shot at and having mortars go off and going to the psychiatrist to talk about my problems back home and then to having to go to work and work on a flight schedule, and do all these missions, it was nerve-wracking.

Participant W: I was under too much combat stress. You're awake for two to three, four days, five days—no sleep. You're on missions and you get accused of something that you didn't do. And they find out later that you really didn't do it, all the charges were dropped, but the damage has already been done. You feel like you let down your Marines, you let down everybody, and I mean, you almost kill one of your Marines in the process—in the situation—because the Marine lied and it angers you so much and you're just like, 'I can't deal with this anymore.'

(continued)

Participant M: I mean, just prepping to go over there some of the training that you have to go through and some of the stuff that they tell you, it's like, 'wow.' Basically they tell you point blank, 'hey, you have to evaluate your buddy, see if he's worth saving or not. If something happens to him, you may have to make the judgment call to let him die.' Basically, over there, like when you're in a combat situation like that and all hell breaks loose, you're not allowed to perform CPR. I mean, you're—it's just flat out not allowed. You wrap up bandages—bandage up whatever, like if they are bleeding or something like that, they teach you how to patch them up. But if they stop breathing and stuff, you let them go. I mean, you play Coroner. Okay, that person's dead. Or that person that got blown up is going to die in a few minutes so we'll just talk to him real nice for a couple minutes while they're still alive and then just let them go. And once they're gone, you throw them in the back of your truck. Take them back to base. That part of the training kind of freaks you out a little bit.

Participant D: Another thing that kind of also plays into the suicide thing is, I don't know how to explain it, but I have had to see and mess with a lot of dead people. And a lot of those pictures are always constantly in my head. And I always have to picture them and it's hard—that messes up my concentration and messes up a lot of things too. And another thing that bothers me is, I don't know a lot of the Iraq people, I mean, yeah, some of them are terrorists, some of them are soldiers. And you think, a soldier does what he's told to by a superior officer. I mean, how do I know that he really wanted to do his job, and then I think about how I have a family, then maybe I just took away, I took away everything that he always wanted to do with his future. And, I don't know, I feel bad about a lot of things, I guess.

Stressors at Home

Participant S: You got problems going on back home, you got problems here—they tend to get in each other's way . . . your problems at home are way more important than any problems going on over here. I mean, this is your second set of problems, not your primary set. If you got issues at home, you worry about them first.

Participant AH: I worry a lot about my mom. And being three thousand miles away, nothing you can do, that really tears into you, then you got people dropping mortars on you all the time and you got all these soldiers—when the mortars are dropping, your job is to go make sure everybody is in there and then its—it takes a toll on you.

Changes to Sense of Self. Many veterans discussed how much they had changed since coming back from deployment. While some struggled to identify what was different, others specified clearly how their outlook, personality, or behaviors changed since returning. Some noted being unable to do things they had done prior to deployment, such as a specific job or hobby. Others described difficulty maintaining relationships or simply relating to others. It was tough for one veteran to suddenly realize he did not know how to relate to his family. These changes challenged how they perceived themselves—their capabilities, interests, and disposition. Veterans had a hard time reconciling differences between their sense of self prior to deployment and their postdeployment identity (Table 3).

Overwhelmed by Stressors. Veterans frequently talked about feeling overwhelmed by multiple stressors and changes in their lives. These stressors contributed to their suicidal thoughts or prior suicide attempts. In many cases, feeling overwhelmed, and the associated stressors, developed on their return from military deployment. A few mentioned specifically how their mental health issues served to compound their stress. In fact, mental health issues were almost always mentioned within this context; veterans viewed their mental health conditions as another stressor, or sometimes as something of a handicap, making it more difficult to cope with the other challenges in their lives. For example, posttraumatic stress disorder (PTSD) per se was not the main cause of concern, but the negative impact the symptoms had on their relationships or daily functioning was viewed as most concerning. Stress was sometimes indicated by an absence of things desired, such as 'having nothing left,' 'everything falling apart,' or 'lost everything.' Within these situations, functional limitations and lacking control were evident. Other times, stress was indicated by too many negative things, such as, 'too much to handle' or 'too much on their mind.' While many tried to cope with their stressful situations on their own, veterans commonly referred to coming to a point of "breaking" or reaching a "tipping point." They felt they could no longer continue to live their lives that way. This led to suicide attempts, acknowledgment of suicidal thoughts, and/or seeking help from health professionals (Table 3).

Lacking Purpose or Meaning in Life. Veterans expressed feeling purposeless and indicated a lack of meaning in their postdeployment lives. While some questioned what they were doing 'here,' or how the world benefited from their existence, others were simply directionless and trying to figure out what is important in life. Some expressed apathy toward life and an inability to see the value in life. One veteran, who had grown to feel that life was not important, suggested that suicide does not matter because life does not matter. Specific references to relationships with others, the importance of fitting into society or contributing to a group, and instrumental things like holding down a job—concrete markers of feeling purpose and meaning—were all tied to this larger theme. Meaning in life also appeared to be connected to future outlook; those who were lacking purpose or meaning also felt the future did not hold positive things for them. In fact, one veteran felt he had so little to look forward to that he found comfort in thinking about suicide, because he perceived it as a potentially positive outcome (Table 3).

DISCUSSION

In this qualitative study of OEF/OIF veterans' experiences with suicidal ideation, implicit and explicit references to military culture were pervasive during the interviews, reinforcing the uniqueness of the veteran experience with suicidal thoughts and behaviors as compared to the general population. As such, intervention and prevention approaches for veterans should be responsive to military and veteran culture. Others have recommended consid-

TABLE 3
Postdeployment Adjustment Challenges

Adjusting to Civilian Culture

Participant D: No offense to you, but sometimes coming back to the civilian world, [you] kind of notice that there's a lot of stupid people out there. You get so used to doing something a certain way, and you know how everybody does everything, and you tell somebody to do something and it gets done exactly that way. [The] civilian side is a whole different world where people don't really always give 110. They don't always do everything exactly the way they are told.

Participant B: When you come home, you're not used to really thinking for yourself when you are on military duty. So you are in this mode where you let other people think for you when you come home. So you know I'm just home all this time just letting other people think for me [laughs] and not really making the decision myself or putting my foot down to be the person I was before I left. Stand up for myself. It's like getting bullied or something, you know? Almost feel like the victim of a bully.

Participant H: You have to be watching everything, watching everybody, you know watching everything that's going on around me—you don't know what or who is there to hurt you so... I think that—my problem is that I brought that back with me and, you know, I brought that fear of body—fear of bodily harm, you know, with me back here to the states.

Participant B: And just being able to talk to somebody before you come home too is... you know, mentally prepare you to get your mental wellness back before you walk in your home. And get back to regular society or whatever. Cause that was somethin' I–we didn't get. They just said, 'go home, see you guys later.' It's kind of like, you walk away...from death and destruction in a sense but you know it was peaceful on base for the most part. And you come home and it's like a new battlefield. You know, nobody's happy. Except for the children, of course...everybody has problems. And they look at you like—cause you been overseas–like you're the one with the problem.

Participant K: All I've been is I've been in the military, so I've been going to reserve meetings, I've been on active duty for training, I've been on active duty, I've been in a war. I know the battle rhythm of things, how they're supposed to work, but no one prepares you for retirement.

Changes to Sense of Self

Participant AI: When I came home, I couldn't relate to anybody for a long time...I think I just felt like I was in a different category—my children, you know, they're raised and grown and have families of their own but it was just a weird experience to not be able to really connect ...last year I had my job that I came back to and things had just changed so much that I just—one day I just decided I didn't want my job anymore and I walked away from it. I mean, my personality changed, a lot of things changed for me.

Participant AE: And I'm trying to figure out what's changed, what's happening, is this normal, is there something and you know... I mean I went from being fine in my words to...you know, thinking about killing myself. That's not normal. I mean that's not ok for me, and that's not the same [as I was before].

Participant P: I started to think, 'well, maybe everything the Marine Corp is telling me is bullshit. Maybe I need to start thinking about how I thought before I joined.' 'Cause in the Marine Corp, man, you think one way. It's not really conducive towards a happy lifestyle or towards a good marriage or even... So it made me start really remembering, 'wait a minute, I thought a different way at one time.'

(continued)

Participant O: A friend of mine, he got back and pretty much just lost it. [He turned] into an entirely different person, held a gun to his wife's head one night, he was always waving the damn gun or drinking excessively—changed entirely as a person. Quite a few guys have changed entirely. I changed quite a bit myself. I'd say a lot more riskier behaviors than the majority of us. Less care for ourselves really.
Participant X: I was just extremely unhappy and I was not—my self-confidence was going down and there was just different things that. . .I wasn't myself, it was like looking in a mirror, and it was just a totally different me.

Overwhelmed by Stressors

Participant A: I mean, I lost my home, I lost my husband. It was like everything just went into shambles, basically from the deployment. I found that he was talking to his ex-wife and I just couldn't handle it and I just I didn't want a part of it anymore. So. . .it just seemed like I lost everything.
Participant B: I think, when we're demobilizing, getting ready to come home. . .They kind of just tell you, 'don't take the checkbook away from the spouse immediately' uh. . .'let her stay in control, she's been without you and she's been running the program while you were gone. They don't really prepare you for what if you come home to. . .a bunch of problems. And that's kind of where I got my shocker at. Came home to a bunch of problems and no family support, so I kinda think they should at least prepare you mentally or whatever for disappointment. Hope for the best, expect the worst though, you know.
Participant AE: I fell farther and farther back in my little hole and the next thing you know, that's when I ended up with the whole idea.
Participant AH: I was pretty messed up when I got back, you know, after the death in the family and then having to take care of my mother being sick real bad, and it just messed me up having to go back over. You know. Wasn't enough that the first one got you, but the second one really gets you.
Participant W: I'm going through a divorce, I'm having a hard time, I'm about to be homeless, I'm about to lose everything that I have and, you know, I mean, a normal person would break.
Participant H: Just because, you know, its—life is life. It's like sometimes you feel overwhelmed—I feel down all the time but sometimes you just feel to a point of breaking, you know? Breaking.
Participant W: It was hard. Cause from that point on everybody thought that you were just a huge, psycho, loony-bin and you really aren't. You really aren't psycho or insane. It's just everything stacks up on top of you.
Participant Y: When I first got back I had PTSD—it was apparent, but I tried to ignore it. Because I had a brand new wife, kid on the way, all that good stuff. And the PTSD ended up causing my marriage to dissolve—lost my kid, lost my house—everything I had worked for my whole life was gone. I was basically homeless. And so I was like well, 'you know, rock bottom, cool, I can build myself up.' And I just never really did. I kept trying to build myself up cause I knew I could do it because like I said I have always been very conscious of who I am and what I am doing. I could never seem to get past it.
Participant I: I was saying the word, 'I was going to give up.' Because no one was listening to me, no one knew what was going on. . .plus the prostate cancer, plus the PTSD, plus with my knee, and everything else, and there's no one to talk to.

(continued)

Lacking Purpose or Meaning in Life

Participant AC: After you experienced something in the military, when you get out of that you reflect a lot on your life because people have come back from war and their wife was cheating on them and um kids didn't act like they love them no more and. . .you um, you feel like well why am I even here? I'm not really. . .nobody, I'm not really making any difference in nobody's life.

Participant E: I don't really have a purpose here that is really going anywhere at the moment, so it's kind of just, like, why sit around and waste air if you're not doing anything productive for society or yourself? So that's how I was feeling back then.

Participant E: And I. . .kind of lost my footing in the world so I was kind of floundering around and I had no job, no money, no nothing so it was kind of difficult for me to grasp onto—I was really, I was just thinking about, I don't really care about. . .since Iraq I guess I don't really see life as something that is really that important. I mean it's here and you're gone. . . I'm just bored now, this is stupid, everything is dumb so I was just thinking about it, thinking well, you know whatever, suicide doesn't really matter either way cause your dead. So—it's not going to hurt once you're dead, and it doesn't matter, and what people think about it doesn't matter cause you're not here to hear it, so I was just thinking about it a little bit more than I ever have.

Participant H: But I just know that I was just feeling to that point of just, I didn't matter to the world.

Participant V: I'm thinking, 'If the past is any indication of the future, I don't see a very good future.'

Participant X: Basically I've been unemployed since January. And ever since leaving the military I kind of didn't have as much stuff to do and as much freedom, or, I guess fiscal freedom as well. So it just got to the point where I was just going stir crazy and rummy.

Participant X: I finally got to the point where I figured, I am almost 30 years old and enough is enough and I need to quit going through this cycle over and over again and take a step forward.

Participant Q: I see my therapist every week, and we just talk about how. . . I don't know. . . how I'm doing, what my plans are, make sure I have plans. It's not really suicide based. It's trying to get my life back in order.

Participant F: So I came to that day where I had a tunnel vision, there is nothing else coming, nothing else good, you know, to think about. And I just tell myself, 'I'm tired, struggling, nobody wants to help me, nobody knows me, nobody.' I cannot figure it out from wrong and right. So, all I see is a black hole and I am going down the black hole.

Participant Q: He's like, 'Where's all your pills?' And I wasn't gonna lie to him: 'Dude, I took 'em—see you later. This whole world's full of shit, you're gonna die soon enough. Don't worry about it.'

Participant AD: I mean I didn't call when I [attempted] suicide the first time. Well, I wasn't in the VA then. But I didn't call nobody the first time. I mean we all gotta die so I ain't scared to die.

Participant V: And then I think that I would never even try it because I wouldn't want to disappoint—or I just wouldn't want to cause sadness to a lot of people. But that wouldn't stop me from thinking about it. Because—because if you live in a constant struggle, you want relief. And that's a form of relief. It is—it's thinking about it and saying, 'wow, that's comforting to think that there's possibly something good in the future.'

ering military culture when working with current or former service personnel (Bryan & Morrow, 2011; Makin-Byrd, Gifford, McCutcheon, & Glynn, 2011), and the VA has already called for culturally competent mental health recovery services (Veterans Health Administration, 2008). Meanwhile, we heard many distinct stories of deployment experiences; although veterans share a common military culture, their individual experiences within that culture vary greatly. For this reason, one veteran specifically pointed out that a "one-size-fits-all" approach to postdeployment debriefing is not particularly effective. Intervention assistance offered to recently returning veterans should be culturally appropriate yet flexible enough to address the range of each veteran's specific concerns.

Further, the postdeployment challenges we identified point toward a suicide prevention strategy that incorporates specific targets and activities to enhance postdeployment reintegration into civilian life. Similar to other work (Lakeman & FitzGerald, 2008; Pavulans et al., 2012), these veterans found it difficult to relate to others and to regain their sense of control. Cultural reintegration could address these issues by normalizing civilian social norms, especially norms for functioning in groups, relationships, individual control, assertiveness, and decision making. These veterans also experienced identity challenges postdeployment, which is consistent with work by Brenner and colleagues (2009) who noted that loss of self was a precipitant of suicidal ideation or behaviors. Meanwhile, it has been established that well-being is supported by a clear sense of self, especially in Western cultures (Suh, 2002); reconciling pre- and postdeployment selves toward a clear sense of self may help support overall well-being and functioning. Our finding that recently returning veterans with suicidal ideation feel overwhelmed by stressors is reinforced by previously identified associations between postdeployment adjustment stressors (Kline, Ciccone, Falca-Dodson, Black, & Losonczy, 2011), such as financial instability (Elbogen, Johnson, Wagner, Newton, & Beckham, 2012), and suicidal ideation or behaviors. Problem-solving and coping skills interventions such as Problem-Solving Therapy (Haley, 1987) or Dialectical Behavioral Therapy (Linehan & Read, 2013) may reduce these stressors, helping veterans feel less overwhelmed. Perhaps most importantly, our results underscore that postdeployment reintegration should try to help veterans find meaning or purpose in their lives, corroborating the few available studies on meaning in life and suicide risk (Bryan et al., 2013; Kleiman & Beaver, 2013). Our findings suggest activities such as identifying personally meaningful goals or interests, increasing social networks, enhancing key relationships, and identifying ways to contribute to society may be particularly beneficial.

While these intervention targets are appropriate for veterans already identified as at risk, our findings also suggest upstream suicide prevention efforts are necessary (i.e., prior to veteran endorsement of suicidal ideation or development of known risk factors)—starting with increased efforts to shift military culture to encourage military personnel and veterans to ask for professional help when needed—and providing training that focuses on what one can do for oneself when having thoughts of suicide. Veterans indicated they struggled for some time with stressors before asking for professional help or attempting suicide. Some veterans described this as "breaking." Their tendency to struggle in silence reflects their described military experience: suicide was not taken seriously, they "hid everything," and faced potential ridicule if they admitted they needed help. Furthermore, veterans did not necessarily perceive their situation as requiring mental health care per se, but instead felt their lives were overly stressful —which further challenged their openness to accessing mental health treatment. We know from prior work that identifying suicidal ideation among new-to-care veterans in non-mental health settings does not measurably improve engagement in subsequent specialty mental health care (Denneson,

Corson, Helmer, Bair, & Dobscha, 2014). Non-mental health outreach and prevention services for recently returning veterans may help veterans who would otherwise stay quiet until they are in crisis. For example, the Comprehensive Soldier Fitness Program focuses on building strength across several domains (social, emotional, physical, spiritual, and family) to develop resilience prior to deployment (Cornum, Matthews, & Seligman, 2011).

There are several limitations to our study. Veterans in this study had already accessed VA health care and endorsed suicidal ideation prior to participating in the interviews; it is unclear whether different issues might have been more or less salient to veterans who had not yet discussed thoughts of suicide with their clinician. Relatedly, veterans who were most comfortable discussing thoughts of suicide may have been more likely to participate. We sought to increase participation of women and ethnic minority veterans, but response rates were low among these groups. As such, the proportions of women and minority veterans in this study were slightly lower than respective proportions of OEF/OIF veterans who received suicidal ideation assessments during the same study period (Dobscha et al., 2013). Although individuals with suicidal ideation or behaviors are unique from individuals who die by suicide, there is considerable overlap among these populations (Beautrais, 2001; DeJong, Overholser, & Stockmeier, 2010). In light of ongoing suicide prevention efforts, military culture and experiences may have evolved since these interviews, conducted in 2009–2010, potentially changing veteran attitudes and response to suicide ideation and risk. Finally, it should be noted that the themes and examples discussed here are the veterans' perceptions and interpretations of events.

This analysis of qualitative interviews with OEF/OIF veterans experiencing suicidal ideation presents an opportunity to understand the context and processes underlying suicidal thoughts among a sample of recently deployed veterans, informing intervention and prevention strategies. Suicide prevention efforts should be responsive to military and veteran cultures, yet be flexible enough to be tailored to individual experiences. Our findings suggest four main challenges in veterans' postdeployment reintegration that may be effective targets for intervention: adjusting to civilian culture, feeling overwhelmed by stressors, changes to sense of self, and lacking life purpose and meaning. Further study of these topics may provide clinicians with better understanding of veterans' postdeployment treatment needs. Finally, upstream prevention efforts, prior to crisis or presentation of suicidal ideation, are also warranted.

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