CASE STUDY SERIES:
APPLICATIONS OF THE PUBLIC HEALTH APPROACH TO SUICIDE PREVENTION FOR THE MILITARY AFFILIATED POPULATION

PREPARED BY:
Duane France, Shauna Springer, Jeff Jernigan, Nancy Jernigan, and Chris Jachimiec (Eds.)
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INTRODUCTION

Dr. Phillip Smith, researcher and professor at the University of South Alabama, describes suicide as both common and rare. Rare, in that many of us can go several years, if not decades, without it impacting us personally; common, in that everyone has been impacted personally in some way. For those who served in the military, this is especially so; every time someone who served in the military hears of another service member, veteran, or military family member death, it is punch in the gut. Another reminder that, regardless of the efforts being made, we are still losing those who served and those who care for them at a significant rate.

For many veterans and those who care for them, there is a “number.” That number is the number of people we’ve served with that died by suicide, and quite often that number is greater than the number that each individual lost in combat. This has, naturally, raised an outcry: what are we doing about it?

A PUBLIC HEALTH APPROACH TO VETERAN SUICIDE

Suicide is not a veteran problem, it’s a national problem; it’s also a public health problem. Like other public health problems…motor vehicle accidents, heart disease, food safety, healthcare associated infections…it can be prevented if we take a public health approach to the problem. That means that the responsibility for “solving the problem of veteran suicide” does not belong to any one organization or any single group of people. It means that the responsibility belongs to all of us.

The Center for Disease Control has provided a framework based on the public health model that has shown to have an impact on veteran suicides. This is a publication that provides policy recommendations, programs, and practices that have been proven to prevent suicide, in some cases, and reduce the risk of suicide in other cases. Similarly, the Department of Veteran’s Affairs National Strategy for Preventing Veteran Suicide advocates a public health approach for addressing suicide.

As you read through these recommendations, you will likely realize that portions of the community are doing each of these things. Why, then, does the problem persist? Because we’re not doing it together. It’s not being coordinated in a mutually supportive manner, and the gaps that exist between these are big enough for a veteran to slip through. It’s also not being applied in a systematic way for diverse populations; one approach may be effective for midwestern urban locations, while another may be necessary for costal urban populations. One method of application could work for communities with a large veteran presence, which typically has a high incidence of SMVF suicides, and another for communities with a small presence of military-affiliated individuals, which typically has a high rate of SMVF suicides.

In a public health framework, it is necessary to identify both protective factors and risk factors. Protective factors are those situations which will keep individuals, or groups of individuals, from experiencing stressful situations which could lead to suicidal ideations and behaviors. This is considered primary prevention, intervening in someone’s situation before negative effects occur, through providing stability and increasing wellness before a crisis. These include creating protective environments, strengthening economic supports, teaching coping and problem-solving skills, and providing education and awareness about suicide risk and prevention.

Primary prevention is not always possible, however. Another aspect of the public health approach is to identify and minimize risk for those individuals who may be experiencing a suicidal crisis. This moves from prevention to intervention; addressing the needs of those at greater immediate risk of suicide in order to minimize the risk and help them build wellness. Risk reduction measures include providing effective treatment for those in crisis, reducing access to lethal means of attempting suicide while an individual is in crisis, and providing postvention support.
These are generally acknowledged to be necessary and important; however, as mentioned above, applying these concepts to a particular community, or in the case of the military affiliated population, a particular cultural group, requires specific understanding of that community and culture. As excellent as the CDC and VA resources are, they describe what can be done to impact SMVF suicide; neither describes how to do it. The goal of this publication is to provide examples of practical applications of the CDC and VA guidance. These case studies provide examples of how individuals from around the country are addressing suicide prevention in the military affiliated population. What follows will focus specifically on six areas: three protective factors and three risk factors, with 2 case studies per factor to provide practical examples of how a public health approach to suicide prevention can be realized. These case studies are not meant to be applied to every situation or sub-population. Readers must use discernment and may need to adapt or develop other ideas to serve within their communities. What we hope to provide are some specific examples to bring the public health approach to life by highlighting innovative applications of theory and research.

Notes
SECTION ONE

Increasing Protective Factors Against Suicide in the Military Affiliated Population

When addressing suicide in the military affiliated population, it is necessary to understand that primary prevention starts with creating a protective environment. This means that service members, veterans and their families are living lives of purpose and meaning, with stability in relationships, housing, and other social determinants of health (SDOH). Increasing protective factors against suicide means providing support so that members of this population do not experience crises that could possibly lead to suicide.

While social determinants of health can be applied across culture and demographic, understanding how these factors apply to the unique experiences of the military affiliated population can help provide resources in different ways. Complicating the application of the social determinants of health is the fact that service members and their families experience the support this provides in different ways than veterans and their families.

According to the U.S. Department of Health and Human Services, SDOH can be grouped into five domains:

- Economic Stability
- Education Access and Quality
- Health Care Access and Quality
- Neighborhood and Built Environment
- Social and Community Context

Considering these five SDOH factors from an active military perspective, a service member has economic stability, health care access, and a comprehensive support system in both a physical and social environment. Non-military education is available, if not always accessed by service members, and all of these factors are provided by the military for family members as well as service members. For non-active-duty service members, the military environment related to SDOH factors is not as strong; while military service provides some benefits, both monetarily and with some health and education support, it is not as significant as it is with active-duty service members.

When a service member transitions out of the military, however, there is a need to address these SDOH factors in different ways. The support of the military in providing economic stability, health care access, and neighborhood and social connection is no longer provided. The veteran and their family must develop these factors for themselves. For most veterans, the opportunity for education and health care access is provided through the Department of Veterans Affairs, as is the opportunity for housing and employment stability. Obtaining these benefits, if readily available in the veteran’s community, is not always simple or obvious to veterans, and requires some effort to navigate the complicated requirements that are associated with obtaining these benefits.

There are a number of different protective factors that may keep a service member, veteran, or their family member from experiencing a suicidal crisis. In this section, we will be providing examples of three protective factors: increasing connectedness, improving economic stability, and providing education and awareness about suicide and suicide prevention. Increasing these protective factors in the military affiliated population may decrease the impact of any risk factors that may be present, as well as providing a protective environment for members of the military-affiliated population.

Chapter 1

Improving Connectedness in the Military-Affiliated Population

Multiple studies show that increasing connectedness and support among veterans significantly reduces suicide. In a 2009 review of military and civilian suicidal behavior, Jeffrey Martin and his colleagues identify social connectedness as one of the significant factors of preventing suicidal action. This makes sense, of course; the more connected we are, the less isolated we feel. When we have people to reach out to, and trust that they’re going to be there, then we’re more likely to do so.

One of the unique challenges with veterans, though, is the fact that we go from a highly connected social environment…you can’t get away from other people when you were in the military, even if you wanted to…to being socially disonnected from that population. Many veterans struggle with the loss of camaraderie in post-military life. They’re no longer part of a team. They feel like strangers in a strange land, where they don’t seem to fit in no matter where they go.

While this can certainly be unsettling and frustrating as veterans navigate the non-military world, there are very real dangers that come with a sense of isolation. A lack of connectedness is an increased risk factor for suicide. This isn’t only true for the veteran population but has been found to be a risk factor for all who attempt to take their own life. Dr. Thomas Joiner’s Interpersonal Theory of Suicide identify three factors that increase the risk of suicide: thwarted belongingness, perceived burdensomeness, and capability for suicide. The first factor, thwarted belongingness (social isolation) is a critical factor. If a veteran perceives themselves to be a burden, but are well connected to family and friends, it is unlikely that hopelessness will develop.

The case studies that follow will show how some organizations are working to increase connectedness for service members and veterans in order to avoid experiencing a suicidal crisis.


Case Study Example #1:

Team Red, White & Blue’s Mobile and Web App to Engage Veterans Virtually During COVID-19 and Beyond

CONTRIBUTORS: John J. Pinter, Daniel F. Brostek, Mark McNamara, Mary Patterson, EdD, Caroline M. Angel, PhD, & Michael S. Erwin

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TEAM RED, WHITE & BLUE BACKGROUND

Team Red, White & Blue is a 501c national veteran serving non-profit organization, founded in 2010 with the mission of “enriching veterans’ lives” by forging America’s leading veterans’ health and wellness community. Since its inception in 2010, RWB has grown to 194 community-based chapters led by over 1,500 volunteer leaders serving over 220,000 members.

Team RWB represents an intergenerational community of 77% veterans, active-duty service members, reservists, and guard members with 23% civilian supporters. For Team RWB’s first decade, programming was primarily focused on providing local, consistent, inclusive community-based in-person events where members could participate in physical fitness, social, and volunteering events together, supplemented by an engaged online community (Angel et al., 2018).

In September 2019, Team RWB launched a mobile app which provides a social platform allowing members to connect with one another while offering the opportunity for volunteer leaders and members to create and engage in thousands of physical and social events, and virtual workouts. While the app launched prior to the onset of the COVID-19 pandemic, in March 2020 Team RWB quickly accelerated its virtual programming to meet the physical and social needs of Team RWB members under quarantine and stay-at-home orders.

In September 2020, Team RWB launched version 2.0 of the member app across iOS, Android, and a new Web App. The new Web App created parity between the mobile app experience and those using the desktop-based version. Moving forward in 2021, virtual physical and social activities programming will continue to expand and adapt as communities nationwide navigate reduced in-person engagement opportunities for the foreseeable future.

THEORETICAL BACKGROUND

Healthy reintegration to civilian life following military service can be challenging for service members. While most demonstrate a resilient trajectory, the process of readjustment is dynamic and replete with potential stressors (Angel, 2016; Elnitsky et al., 2017). Veterans have described feeling a loss of identity and a diminished sense of purpose in the years following transition from service (Mitchell, Frazier, & Sayer, 2020). Many struggle to retain or build social support networks; healthy lifestyles can be difficult to maintain without accountability to fitness standards and environmental support inherent to military service (Goodrich & Hall, 2018).

Chronic physical and mental health conditions have been identified as pressing concerns for separating servicemembers (Vogt et al., 2020). Team RWB leaders have outlined how
participating in enriching activities (i.e., those that promote physical and mental health, a sense of purpose, genuine relationships, and opportunities to volunteer and lead in their communities) can serve as “upstream” approaches to forestall potential fallouts of challenging reintegration processes (separation from previously close ties, criminal justice involvement, financial, housing, and food insecurities, to name a few) (Angel et al., 2018; Angel et al., 2019).

In 2017, Team RWB began a process to evolve its delivery models, user experiences, and infrastructure to create a personalized, ‘always on’ environment for Team RWB members, both offline and online (which culminated in the mobile app launch in 2019). The COVID-19 pandemic served as an organizational forcing function; following the cancellation of hundreds of scheduled nation-wide in-person events, Team RWB quickly ramped up virtual engagement opportunities. Shifting tools that were already in its strategy, Team RWB simultaneously sought to test and validate the delivery of virtual challenges and workouts to drive member engagement.

While the pivot to offering solely virtual engagement occurred practically overnight during the pandemic quarantine, current and future directions will continue to develop the same experiences across multiple channels to meet the needs of Team RWB’s increasingly digitally engaged community. In-person Team RWB events have begun to return coinciding with local, geographically based guidelines. However, Team RWB’s mobile/web apps will continue offering high quality workouts, inspirational content, and social engagement, available no matter where members are.

INTERVENTION, TOOL, OR LINK TO RESOURCE

Team RWB’s app information can be found on the website’s landing page. The mobile and web apps enable Team RWB members to create a profile, track events via the in-app calendar, check-in to events, follow other members, filter/search events according to location and activity interest, as well as comment, “like”, and interact with other members.

The app’s newest feature, “Member-Generated Events”, allows members to create their own social and fitness events and share photos, results, and like/comment on others’ posts. Members can access daily virtual workouts, Zoom yoga and guided meditation, as well as in-person local events, where permitted. A “Groups” feature will roll out in early 2021. Members can easily explore features and functionality of the Team RWB APP v2.0.

OBSERVED OUTCOME

Team RWB members have downloaded the app more than 38,500 times since the 2019 launch. Over 70% of new veteran members joining the organization do so either via the app or download it shortly after. Team RWB event participation metrics show that in 2020, members “checked-in” (a self-reported attendance feature via web/mobile app) to virtual challenges and virtual workouts over 300,000 times.

One example of a successful Team virtual engagement was the 2021 “Take Flight” Challenge. Beginning January 1, 2021, Team RWB launched 31-days of health and wellness content to get veterans active as part of starting the new year off with a healthy foot forward. Content was framed as four separate tracks (yoga, functional fitness, running, and healthy habits) in addition to their ongoing physical activity programming as usual.

Over 2,600 Team RWB members (military-connected and civilians) completed 64,559 workouts (averaging 25 per person throughout the month). Health and wellness journeys were shared
widely across social media, generating 49,500 Twitter and 54,900 Instagram impressions and 17,200 Facebook engagements. 16 live zoom hangouts averaged 30 members per hangout; 19,000 users engaged with Team RWB’s digital platforms during the Take Flight Challenge.

Based upon Team RWB’s 2020 annual member survey administered in November/December 2020), the top three member preferences for future release functions were 1) finding events by “map view” in addition to the existing list function 2) activity tracking by connecting wearables or smartphones to the app to track activities 3) the ability to see featured Team RWB events at the local/national level.

LIMITATIONS

While the web and mobile apps have become important channels of engagement for Team RWB members, its features can only be utilized if members can access and navigate them. Team RWB continues to communicate the development of the app and how to access it to both newer members and existing members who joined the organization prior to the app’s launch in 2019.

REFERENCES


Case Study Example #2:

STACK UP’S Overwatch Program: Online Connectedness and Crisis Intervention for Military/Veteran Video Gamers

CONTRIBUTORS: Michelle Colder Carras, Ph.D. Mat Bergendahl, M.S., NCC, LPC, and Alain B. Labrique, PhD

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ORGANIZATIONAL BACKGROUND

Stack Up Founder and CEO Stephen “Shanghai Six” Machuga is a former Army Infantry/Military Intelligence officer and Airborne Ranger. Machuga says that video gaming "helped keep him sane" while he was deployed in Iraq with the 2nd Infantry Division, and also played a significant role in his successful reintegration back into civilian life. Wanting the same for other veterans and active-duty military members, he founded Stack Up on Veterans Day, November 11, 2015.

Stack Up's mission is to fight the effects of depression, combat injuries, and post-traumatic stress by bringing veterans and military service members together through the "shared language" of video games. A “stack” is a slang term for a formation used in military or law enforcement, when an assault team forms up single file along the entrance or doorway to a room where they believe a threat is located. For Stack Up, the stack represents a strong community of friends, family, brothers and sisters in arms, and supporters, all coming together for the common mission of supporting veterans and military service members through shared gaming experiences.

By providing mental health support through the video game community, Stack Up seeks to meet veterans and military service members where they are—in games and online. Stack Up leadership identified a need in the veteran and military gaming community and responded to it as grassroots organizations do. In 2017 they implemented a new program within their military/veteran gaming community to provide mental health support and crisis intervention through their Discord server. Stack Up's Overwatch Program (StOP) consists of a channel within the Discord server (#the-overwatch-program) and available private messaging interactions. This innovative program takes advantage of the anonymity, support and connection of virtual communities based around shared experiences (military service; life stress) and interests (video gaming) to address gaps in the ability to provide support and connection to veterans and military service members.
THEORETICAL BACKGROUND

Veteran mental health needs
Veterans face many barriers to receiving mental health services (RAND, 2019). Risk factors associated with suicide such as financial problems, loneliness/social isolation and anxiety may be worsened by the pandemic and exacerbate pre-existing mental or behavioral health conditions for veterans (Armstrong, 2020; Gunnell et al., 2020). Providing a wide range of choices for mental health support and treatment makes it easier to address needs and overcome barriers (Hoge, 2016). Peer support is a mandatory offering in the VA system and is well-received (Department of Veterans Affairs, Veterans Health Administration, 2008).

According to Joiner's interpersonal-psychological theory of suicidal behavior (2009), social isolation or a feeling of alienation or lack of connectedness (low belongingness) is a robust predictor of suicidal behavior across various populations. Finding scalable ways to support connectedness and mental health and intervene during times of crisis are still a challenge.

Video games and mental health
The video gaming community has taken an alternative approach to mental health support and crisis intervention by focusing specifically on belonging. Video games and their associated online communities offer opportunities for social connection and support, competence, autonomy, and meaningful roles, all important aspects of mental health. Previous work with the veteran gaming community has shown that playing video games helps veteran gamers in treatment for mental health problems cope with and recover from mental health issues while providing ways to connect and form meaningful bonds with others who play games (Colder Carras et al., 2018).

In 2018-2019 Stack Up conducted a formative program evaluation supported by a CDC Veteran Suicide Prevention grant. A logic model was developed that included goals for connecting members, reducing stigma around seeking help, increasing awareness of suicide prevention, and reducing anxiety after an encounter were identified in a formal logic model (see our published case study: Colder Carras et al., 2021). The follow up summative evaluation was just completed as part of a CDC Coronavirus Response grant and combines four data sources: surveys, interviews, chat analysis, and analysis of encounter forms to evaluate multiple aspects of Stack Up and the Overwatch program. Integration of mixed methods findings (bold) and supporting quotes (italics) are reported below.

INTERVENTION, TOOL, OR LINK TO RESOURCE

Stack Up's Overwatch Program is an online, volunteer-driven crisis intervention program developed by Stack Up and delivered through Discord, a gaming-focused communication platform, that offers real-time, anonymous social interaction between individuals and groups. The platform hosts the Stack Up server, a digital community of 2,727 members that offers many channels for live text or voice chat. Membership is open to anyone. Members use the channels to "hang out"—to talk in a lighthearted way about games and other common interests, share memes and other visual media, and to relieve the stress of daily life (especially during a pandemic).
In 2016, Stack Up leadership recognized that by offering crisis intervention directly, they might be able to reduce veteran suicide and promote good mental health in their online community. Once the Overwatch channel (#the-overwatch-program) was started, many veterans offered to "lend an ear". As the program was formalized, training was developed in partnership with PsychArmor Institute, an organization providing training resources to help groups engage with and support veterans (PsychArmor, n.d.). Team members need not be veterans/military service members or people with the lived experience of mental health problems, although sharing relevant life experiences is considered part of the role.

As shown in the graphic, the service can be accessed through several different ways. Members can enter #the-overwatch-program channel directly and request help. If a member says something in the #general channel like "I'm really down; I just got fired and my VA benefits haven't kicked in. I'm feeling really depressed," another Stack Up member or a StOP Team member might suggest they talk to the StOP Team in #the-overwatch-program. A feed from #the-overwatch-program is displayed on the Stack Up website as a way to illustrate the nature of the chat, normalize help-seeking, and provide another anonymous way to get help.

OBSERVED OUTCOMES

Stack Up members have tried other approaches to address mental health issues. StOP provides a new method when options have been exhausted.

Costs, stigma, and difficulty scheduling appointments were all important barriers to addressing mental health issues for Stack Up Discord members. Most of those who used StOP have sought help from the VA or in a military setting already or from family and friends. Navigating the "complex landscape of the VA" is easier when the StOP Team can offer resources help recommend next steps.

The peer support format answers needs for connection that may be missing in professional mental health encounters.

Users value being able to talk to peers who understand and share their experiences with "passionate volunteers" who care about what they're going through.

"I totally get when a person does not want to talk to a professional... peer to peer support...breaks down the mental barrier of oh hey, I'm going in because I am broken, and there's nothing I can do to fix it. Instead, you're going to a friend, or you're going to a colleague, or you're going to somebody who can help speak to you on your level...it helps alleviate the worry of giving yourself up."

For StOP Team members, support from the rest of the StOP Team feels like "family away from family".

Being a part of the team is a commitment that provides extensive benefits. Although not originally conceived as peer support in the traditional sense (i.e., “mutual support delivered through sharing experiences of distress, difficulty and resilience” Penney, 2018), most, if not all, StOP Team members have some sort of lived experience of mental health challenges. Most members had served in the military or were currently serving. Team members support one another by assisting with user interactions and finding resources in real time, but also by being a
source of encouragement and mental health support. Inspired by their service, several StOP Team members are pursuing careers in psychology or social work.

StOP offers several formats to communicate that appeal to users and work seamlessly.
Users experienced few technical problems and appreciated the ability to communicate through public chatrooms, private text or private chat. Technical or other problems are rare. Using Discord is difficult at first, but can be learned or even taught. The program is accessible 24/7/365.

Users are mostly veterans or active-duty military in crisis who seek help with a variety of life situations and mental health challenges.
Chat from #the-overwatch-channel tells stories of members’ experiences with trauma, anxiety, depression, and suicidal thoughts. Users publicly share the experiences that made them seek help and the frequent barriers that prevent them from receiving it. To protect StOP users’ privacy, we present a reworded quote below:

“I got out after 5 years. I had tried to commit suicide while I was in, but my buddy took me to [the hospital]. When I got out, they told me I would have to wait like 9 weeks to see somebody, so I never ended up getting more help.”

Users come in at various levels of crisis. Some users just want to be heard, but others need higher-level intervention.

A lot of the people that come in are just at wit’s end. They don’t know where to go. They don’t know what to do. And hey, here’s someone to talk to, for free.

StOP Team members work with the user to identify the reason they are seeking help, provide resources and promote user resiliency.
A rubric provides structure to StOP interactions, but some team members felt additional training in building resiliency would help, and suicide risk was not consistently assessed at the time of data collection. Users are satisfied with the resources provided, whether veteran/military-specific or otherwise.

I always do two things for those people who are worried about losing their home or being able to find food. I find them a food pantry or a local soup kitchen or something to work with. And then I find them temporary housing if they need it. And those two little things give them some hope.

StOP users feel connected and heard after an encounter.
The StOP focus on being there, building rapport, and letting clients lead the conversation leverages the advantages of anonymous online communication to promote the type of confiding that is a first step toward working on their issues.

A lot of it is relief because they’re kind of—they’re getting everything out of their head, laying it all out. And then they can start processing better.

Users feel calmer and leave the encounter with resources, coping skills, and next steps.
StOP users value their interactions in StOP, including the feeling of connection and the resources and coping skills promoted by the team. They report feeling calmer, less anxious, and more hopeful. Although not yet ascertained directly through user feedback, StOP Team members recognize how encounters progress toward resolution.

*The wording and the phrasing is usually pretty similar. Like, well, you've helped me, I've calmed down a bit, something to that effect. Like, well, I'm a little bit more, you know, calm and centered now, or something like that, showing that they've gotten information and they have a path.*

**StOP Team members recommend additional health care when necessary, and many users follow up with or attend appointments.**

Not only do Team members provide resources and support, they often recommend additional mental health care and specifically address the stigma military service members and veterans often feel around help-seeking.

*We say … to get the better care for themselves, for them to go and seek more help is actually really, really brave.*

**LIMITATIONS**

This grassroots crisis intervention program has evolved significantly in recent years, even during the evaluation study. Changes in the program have taken place in the months after data collection, including requirement for 100% of interactions to contain a suicide risk assessment. Stack Up is exploring ways to gather feedback after interactions to improve outcome tracking and has implemented several paid supervisory staff to ensure staffing balances the needs of its all-volunteer pool with the 24/7/365 nature of the program.

The evaluation study itself faced challenges. Survey response was low (n=79). Although the Discord server contains thousands of members, few members are regular visitors, so this response is in line with the number of people who visited while the survey was open. Ongoing data collection after each encounter has been inconsistent, resulting in extensive missing data for encounter forms. The results of this study will be used to further improve program implementation and work toward meeting standards for crisis intervention programs as well as to inform translation into similar programs.
REFERENCES


Increasing Economic Stability

A veteran’s psychological wellbeing is directly tied to their economic wellbeing. Some of the challenge is that this wasn’t that big of an issue when we were in the military. Sure, the pay wasn’t great, but it met our needs…especially when other things were provided for us, like a housing allowance, or a barracks room. Separate Rations, as in extra money for food, if you were married, or a meal card if you weren’t married. Again, the food might not have been outstanding…sorry, food service folks…but at least it was plentiful.

When we left the military, however, we had to figure out how to meet those needs…housing, finances, basic necessities. These were old needs that we needed to figure out how to meet in new ways. How do we plan for retirement? I know it’s a long way off when you’re twenty-seven, but what happens when we turn sixty-seven? Or eighty-seven?

If a veteran and their family can’t get their basic needs met, then the risk of suicide increases exponentially. Unemployment, underemployment, homelessness; each of these are factors in life satisfaction. Helping veterans to get their basic needs met is significant in preventing veteran suicide¹.

The case studies to follow highlight initiatives that increase economic stability in the veteran population.

Case Study Example #1:

Small Business Ownership as a Protective Factor in Supporting Veterans’ Wellness and Reducing Suicide Risk

CONTRIBUTORS: Lynn Lowder, Jim Wong, Joe Plenzler, and Dr. Shauna Springer

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GENERAL BACKGROUND

Research shows that financial security is a major protective factor for good mental health, and building and selling a business is the most efficient way to achieve personal wealth in the United States (1). Unfortunately, veteran entrepreneurship is at a low compared to previous generations. Following WWII, 49 percent of returning veterans started or operated a business (2). Through provisions of the Servicemen’s Readjustment Act of 1944, commonly known as the GI Bill of Rights, these veterans had access to debt capital through community banks, with loans guaranteed by the federal government for the purchase of farms and business properties. As a result, the economy boomed. Today, the Small Business Administration estimates 20 percent of returning Iraq and Afghanistan war veterans desire to start a business (3), but significant barriers to entry exist – foremost among them is access to capital. Fewer than 5 percent of Iraq and Afghanistan veterans are in business for themselves today (4). This is largely due to the precipitous decrease in community banks due to consolidation with large enterprises.

Increasing economic stability is one of the protective factors associated with the public health approach to suicide prevention as described in CDC’s technical package (5). This case study will demonstrate how the work of the VETERAN BUSINESS PROJECT supports a public health approach to suicide prevention.

ORGANIZATIONAL BACKGROUND

The VETERAN BUSINESS PROJECT (VBP) is a 501(c)(3) nonprofit whose mission is to promote veteran and military spouse small business ownership opportunities. VBP does this through a program called “vHarmony™” that provides business match-making services, connecting veterans and spouses seeking to acquire established businesses with current business owners looking to sell.

VBP’s services include assigning caseworkers to facilitate business purchases and providing seasoned business mentors to help new business owners launch and scale their organizations. VBP helps business buyers negotiate debt as well as equity financing to support business acquisition and growth.

VBP deploys a comprehensive support approach to serving veteran clients. As part of this approach, VBP provides referrals to affiliated programs to address mental health challenges, and the challenges associated with military transition. In doing this, VBP creates a team of support around the veterans they serve, which is modeled on the strength of military teams and units that helped them thrive in the military.
INDIVIDUAL CASE STUDY

To highlight the work of VBP, this case study will describe the experience of a veteran named Tim (not his real name), a reservist who faced multiple challenges during his transition from the military, to include psycho-social challenges, such as homelessness, financial and occupational challenges, and serious mental health concerns. Tim has had periods of acute suicidality, for which he has been hospitalized, when determined to present a danger to himself.

Tim initially approached VBP for aid in his legal appeal to the VA that had previously denied his claim for benefits. After two years, VBP was able to help Tim obtain his rightful benefits, to include medical treatment for service-connected disabilities and housing and other allowances so he could gain financial and lifestyle stability. During the course of Tim’s reintegration, VBP provided entrepreneurship training and mentorship to enable him to acquire a small foodservice business. His new business has given him purpose, a sense of order, self-confidence and a certain level of financial security.

In addition, VBP continues to mentor Tim in his business, and recently helped him establish his own nonprofit to counsel disadvantaged youth and ex-offenders. This endeavor was personally meaningful to him as he had struggled in a similar way. The mental wellness (and suicide prevention) benefit of this new mission cannot be underestimated. Military transition, as in Tim’s case, involves an identity challenge, as service members move from a culture that promotes teamwork and selfless service to a more individualistic culture.

VBP stands with veterans as a new team that has their back. VBP is led by and staffed by veterans who have successfully navigated the transition from the military. It allows them career options that may be a better fit for their values and strengths and provides them with opportunities to “give back” in a way that aligns with their mission of service.

Veterans Business Project is part of a more holistic program of care - that supports and encourages veterans to engage in mental health and wellness support as part of their transition plan.

OBSERVED OUTCOME

Tim is in regular contact with mentors from VBP, the same core team that has helped him secure healthcare benefits, housing (through VA’s HUDVASH program), and meaningful professional opportunities.

While Tim had struggled with periods of acute mental crisis, he has stabilized. He wakes up every day at the same time and invests ongoing efforts in his business and his non-profit service mission.

Leadership of the VBP articulate the essence of a public health approach to improving veteran wellness and decreasing suicide risk factors. As CEO Charles (Lynn) Lowder explains, ‘Supporting their business growth is not our only mission. We meet with each veteran one-on-one to see what they need, and we help them connect and thrive as they transition from the military and find their place in meaningful ways in society.’ Jim Wong, the COO of VBP, adds, ‘Tim is one example of many more who has benefited from the kind of support we offer at VBP. They trust us because we understand where they’ve been and we can help them get to a better place.’
INTERVENTION, TOOL, OR LINK TO RESOURCE

Veteran Business Project can be found here: https://veteranbusinessproject.org

GRAPHIC: DISTRIBUTION OF VETERAN-OWNED BUSINESSES ACROSS THE U.S.

REFERENCES


BACKGROUND

Veterans have many needs upon departing the military. The list is long and may be burdensome (see Chart 1 in graphics to follow). These factors contribute to an increased lack of societal and employer understanding of a veteran’s experience and needs, and impact their ability to find meaningful employment, which is a key tenet of a successful transition. Current figures indicate that more than half - 53 percent - of separating post-9/11 veterans will face a period of unemployment averaging twenty-two weeks.

As veterans comprise a much lower percentage of the population today, corporate America is currently staffed with the lowest percentage of skilled veterans in executive roles than at any other time in the last two centuries at 2.6 percent (with a nearly 90 percent drop between 1980 and 2006). For transitioning veterans, this results in difficulty finding a suitable civilian role that matches their skills and often leads to underemployment. Further, research shows that 62.6 percent of veterans’ first jobs are not in their chosen career field and last an average of only 1.56 years. While the time spent in subsequent jobs increases slightly (between two to three years in each job), almost half of veterans are still not in a job in their preferred career field by their sixth post-military job. This is a significant – and sustained – failure rate. Veterans tend to take a job just to have any job, not necessarily the right job. And this, of course, tends to result in additional relocation, increased costs, repeated efforts, lost wages, and the corresponding inability to build wealth. The current situation doesn’t help them, their families, or their employers.

Due to this systems failure, in part, studies show there is a positive correlation between an ineffective separation and increased risk of veteran suicide in the post-9/11 cohort, especially for veterans with less than four years of service and those who experienced less than honorable discharges. Even worse, the suicide rate for post-9/11 era veterans, as a percentage of the total number of veterans serving during that era, is much higher than any other group of veterans and continues to increase (see Chart 2 below). In fact, the rate has more than doubled from 22 suicide deaths per 100,000 in 2006 to 45 per 100,000 in 2016.

This background begs the question: How can transitioning veterans realize full employment by avoiding false starts and suboptimal career choices following active duty?

To address this question, Mission Transition: Navigating the Opportunities and Obstacles to Your Post-Military Career was published by HarperCollins in September or 2019. Two factors have prevented its wide-spread adoption and use. First, it was not available in physical form on military installations around the world, as retail outlets on military installations only accept paperback books. Mission Transition was published in hardback copy. Second, service members in today’s society are many times more likely to digest content in video format; and Mission Transition was not yet converted into a series of video courses.
PROJECT DESCRIPTION

A series of 21 video courses that augment Mission Transition is now available for free on my website. These can be accessed at this link: https://matthewljouis.com/home-landing/courses/.

OUTCOMES

Mission Transition has since been awarded a Silver Book Award by the Nonfiction Authors Association and a bronze award in the category of “career: job search/career advancement” in the 2021 Axiom business book awards. More than that, it has been recognized as having a direct impact on the typical failure rate veterans experience (as described above) and its resultant impact on suicide rates in the post-9/11 veteran cohort.

As COL (USA, Ret) Fred Johnson, author of Five Wars: A Soldier’s Journey to Peace, noted: “This is an incredibly powerful and important book. As someone who works with veterans in emotional and mental crisis, we have found a significant contributor to the challenges they face is an unsuccessful transition. Mission Transition has a higher purpose than just securing veterans jobs. It could save a veteran’s life.” More than 45 positive reviews on Amazon alone echo these sentiments. Among them:

I would describe this as a course, not just a book. Matt Louis has done an incredible job creating an operational plan for someone in job transition to follow. Throughout the book, Matt directs the reader back to his web site to take advantage of numerous other valuable resources. If you are a veteran in job transition or someone preparing for a change, this “course” is a must. I encourage you to gift a copy of this book as a valuable tool and morale booster.

Absolutely love this book! I am using it now in my own transition and greatly appreciate how Matt Louis lays out the process, options, and real-world experiences. I have read several guides and books but this is by far the most comprehensive resource. I have purchased some for friends who are currently transitioning and they love it too.

I would highly recommend this book for any service member getting ready to navigate transition. As a board member for Team RWB and Bunker Labs, I have observed firsthand the systemic challenges faced by today’s service members during transition and experienced my own challenges while transitioning from the Army. A work of this quality has been long overdue and badly needed. While there is much written on this topic, you will not find a better, more comprehensive guide for your efforts. The book and accompanying resources on his website help breakdown the transition planning process into discrete, manageable actions to help ensure success.

I am currently separating from the Marine Corps after 20 years. Matt’s book has been a life saver. He breaks the entire process down Barney style and tells you, in a military fashion for a military audience, what decisions are important and when they matter in the process. He strips the varnish off of the private sector and tells you what obstacles you will likely face. The best book for a retiring military professional period.
LIMITATIONS

While the approach and content of these video courses far exceed what any government-sponsored Transition Assistance Program (TAP) provides, nothing can replace the value of an in-person guide or peer coach standing ready to address the unique needs of every service member taking in the content. An optimal delivery of this material would thus involve a tailored approach for each specific audience member, augmented by in-person instructors in real time.

GRAPHICS

CHART 1: TYPICAL VETERAN NEEDS DEPARTING THE MILITARY

- **Daily**
  - Housing
  - Transportation
  - Legal Assistance
  - Access to Finance

- **Employment**
  - Career (not just a job)
  - Translated Competencies
  - Mentorship
  - Education

- **Cultural**
  - Camaraderie
  - Social Network
  - Veteran Peer to Peer Connections
  - Volunteer Opportunities
  - Structure / Order

- **Health**
  - Access to Care
  - Life Counseling
  - Mental Health
  - Insurance (if not eligible via VA)
REFERENCES / ENDNOTES


As an aggregate number, more veteran suicides occur among veteran age groups 55 and over. However, as a percentage of the whole this aggregated sum exhibits a lower suicide rate and is indicative of the much larger number of veterans in the 55 and over age group.


Provide Suicide Prevention Education and Awareness

There continues to be a need to provide education and awareness about suicide. Regardless of the amount of information out there, the myths around veteran suicide and suicide in general still exist. Such as, “if I mention suicide, it might make them do it” or “there’s nothing I can do to stop it.” Much of this comes from a lack of understanding and awareness around suicide; what causes it, who’s at risk, what can be done about it. Many people don’t understand it, and if we don’t understand something and feel helpless to stop it, we’re less likely to engage in it.

The challenge is that, even though many don’t want to talk about it, the problem isn’t going away. Another way to address the problem, in the military and veteran community specifically, is through education. There needs to be community education, medical provider education, and gatekeeper training to address veteran suicide. Often, education and awareness training can be used across a diverse mix of communities and populations, to support and enhance suicide prevention efforts.

Whether it is general community education and awareness, specific education and training for medical and mental health providers or education and training for those who are working with veterans, evidence has shown that education around suicide awareness and prevention can be a protective factor for members of the military affiliated community and for those that serve them1.

Case Study Example #1:

Peer-to-Peer Recovery Coaching

CONTRIBUTORS: Jeff Jernigan, Ph.D. and Nancy Jernigan, Ph.D.

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CASE HISTORY NARRATIVE

Gill (not his real name) is 27-year-old former Army Ranger and combat Veteran. He walked into my office at the hospital one day and announced that his wife had sent him to see me; unorthodox, but effective. When I asked Gill why his wife thought I should see him, he responded with a list of her complaints: he was boring, had difficulty getting things done, especially if they involved more than just a few steps; evidently couldn’t learn from his mistakes, and couldn’t remember the last conversations they had about his changed behavior. Here is the interesting part: Gill had exited active duty nearly two years previously, had sought treatment for Post-Traumatic Stress Disorder before leaving active duty, and felt the treatment was effective and that he was doing well. This was until about six months ago, when things went south in his relationship with his wife. And now he was unemployed and just as exasperated that he was getting worse, not better, as was his wife. Further evaluation determined that Gill had been in multiple combat actions, suffered from a concussive head injury including brief loss of consciousness, and experienced a number of symptoms that did not go away entirely after his earlier treatment. These included difficulty in concentration, focus, memory, and decision-making, which helps explain his wife’s description of his symptoms. The oddity was her comment about him being boring and not being able to learn from his mistakes. These were, however, the most important clues of all.

Case Study Source: Jernigan, J. (2021), PTSD and the Neurology of Learning, American Institute of Stress, Copyright 2021. All Rights Reserved

THEORETICAL NARRATIVE

Prolonged stress breaks down neural pathways, resulting in loss of concentration, focus, memory, and decision making (Miller 2020). When this is associated with a closed head injury, active learning can be impaired (Amen 2020). Active learning takes advantage of the cross talk between various structures in the brain that involve how we create, evaluate, understand, and remember. These complex functions are tied to biological processes in multiple regions of the brain (Springer, Lynch, Okiishi 2020).

Learning involves changing the brain (Amen 2020). More literally, it requires the building and repair of neural pathways. For the brain to produce new brain cells (neurons), it needs stimulation. Mild stress provides the stimulation, while moderate to high stress and trauma can “lock up” the brain due to the effects of introducing epinephrine into the bloodstream (adrenaline). That is when hyper-vigilance, elevated heart rate, and a sense of foreboding distract us from learning. In the case of closed head injury, structures in the brain can actually suffer physical injury. The process of converting perceptions into longer term memories, a key part of learning, comes to an end. Active learning requires involvement in activities that stimulate multiple connections in the brain. If the mind is impaired due to stress and/or injury,
learning does not happen (Jernigan 2021, PTSD and the Neurology of Learning, American Institute of Stress).

The Stella Center, experts in helping trauma victims, followed 327 patients treated in 2016 through 2020, all suffering from traumatic stress symptoms and found that 61 percent had problems with concentration, 54 percent had problems with memory impairment, 49 percent had problems with cognition, and 25 percent had problems with mental confusion (Lipov, Jacobs, Springer, and Candido, 2021; pending publication in a peer reviewed journal). This is not exactly a great learning environment inside their heads. This is the reason Gill seemed unable to learn from his mistakes and lost interest in anything that required focus or concentration. His wife’s impression was that he had slowly become a boring and forgetful husband.

So, how do we get Gill back on his feet, active, engaged, energized, and healthy? We work on the biological and psychological sphere of his life including nutrition, exercise, sleep, and engage his brain in a therapeutic workout routine (Jernigan 2020, The Physical Ramifications of Prolonged Stress, American Institute of Stress). In Gill’s case, his physical condition (Leaky Gut Syndrome) was contributing to his mental health condition (Trin, 2019) and his PTSD was contributing to his physical condition. Both conditions required treatment, the goal being the restoration of a healthy brain. Our brain interactively controls everything psychologically and physiologically within us (Jernigan 2020, Better Brain Health, American Society of Stress).

On the biological side, for example, exercise and sleep are both critical for maintaining brain health. When we exercise with some degree of intensity several times a week a protein, β-hydroxybutyrate, is produced in our muscles and travels to the brain, where it triggers the production of a Brain-Derived Neurotrophic Factor (Sleiman et al 2016). BDNF is crucial to learning and memory. In addition, it triggers the replacement and repair of neural pathways and brain cells. However, this does not happen unless you are sound asleep. This is when BDNF goes to work. Gill was exercising regularly and reported no problems with sleep disturbance.

Gill had not experienced another head trauma. Closed head injuries can take up to six months to a year to resolve; but he did report growing anxiety and stress over his unemployment and the resulting financial pressure on himself and his wife. Prolonged pressure over a long period of time can trigger stress-induced injuries, especially in the presence of PTSD. Gill had improved dramatically during his treatment for PTSD and thought he was cured. Unfortunately, he didn’t understand that PTSD can resurface over the life course (Meichenbaum 1994). With treatment, symptoms often decrease, but may re-emerge at times of heightened stress. During this time, Gill also received news that a former battle buddy had died by suicide. This triggered a struggle with shame and self-blame for not being there for his buddy, anger and grief over the loss, and further isolation from his wife and friends (Springer 2020, WARRIOR: How to Support Those Who Protect Us).

Attention was also focused on Gill’s psychological health. In conversation with Gill and his wife, it became apparent Gill lacked emotional agility and the ability to connect with his wife on the level of feelings. For Gill, this was a matter of maturity. He grew up an only child and had only been married for about two years. His inability to communicate his feelings had to do with emotional intelligence, a skill that can be learned, which frustrated his wife because he seemed not to learn from his mistakes or remember the conversations they had in that regard. Their arguments only produced more stress and less memory. The learning part of this dynamic was something we could repair.
HIGHLIGHTED RESOURCE: PEER-TO-PEER COACHING

Source: Peer-to-Peer Recovery Coaching: Restoring and Improving Veteran Connections; Jeff Jernigan, PhD, and Nancy Jernigan, PhD, October 8, 2020

This article and accompanying infographic are not for academic peer reviewed journals. What is described is not an intervention but rather a guide to conversation for use in peer support that anyone can use. The goal is to equip the average person with where to start a conversation and where to take the conversation. This tool is based upon applied research and is part of SDV and SUD curricula around the world. This peer support conversation can be picked up and continued at any juncture in the progression from Access to What’s Next. Four interactive stages are involved in effective peer-to-peer coaching support.

Access to Peer Coaching - Setting the Stage

The peer recovery coach ideally can provide weekly conversations for up to sixty minutes supported by monthly in-person updates lasting up to ninety minutes. Coaching is not counseling, mentoring, or facilitating. The recovery coach is a companion in the veteran’s journey through recovery and should be comfortable with occasional emergent calls and the full range of emotions that many people have when faced with various challenges in their lives. Providing positive reinforcement within agreed upon clear and appropriate behavioral boundaries is a key element in this journey.

For example, the coach may be confronted with a wide range of emotions showing distress and need to offer a steady presence that deescalates the situation and enables the veteran to lower their intensity and self-regulate their emotions better. This may involve breathing exercises, rehearsing the situation or incident that produced the heightened emotional response with clarity, precision, and compassion; and focusing attention on living in the moment, developing helpful ways to cope with stress.

Your boundaries do not have to be intrusive and should provide for you and the veteran an environment of psychological safety as you interact. Healthy boundaries include confidentiality: what you talk about remains between the two of you. How you talk to one another should be characterized by positive respect. How we behave and act in our daily lives should reflect this same respect for self and others and should be carried into our conversations. If you ever find yourself in a situation where you are not sure a boundary has been crossed, or how to deal with consistent boundary violations, get some help from someone who specializes in veteran peer support.

Access is more than simply being present at the appointed time. It is being a steady presence, appropriately transparent and vulnerable, establishing healthy boundaries in the relationship which allows both of you to feel comfortable and develop positive self-esteem. This will provide a foundation for responding appropriately to emotional challenges to sustaining a healthy peer coaching relationship with the veteran.

Building Growth-Focused Partnerships: The Climate for Conversations

It is important to build and sustain trust throughout each encounter. The peer coach must be committed to maintaining confidentiality as experiences are processed conversationally and
family dynamics and relationships are explored. These are unhurried conversations without criticism or judgement on the part of the coach. Body and mind regulation can be instructive and lead to conversation about behavioral change. This is a processing exercise where the coach guides the conversation and informs as appropriate without teaching or instructing. The words Listen and Silent are spelled using the same letters. You cannot listen if you are not silent more than you are speaking.

For example, active listening is more than absorbing information. Listening is an art when done well. An old saying points out that we have two ears and one mouth, suggesting we should listen at least twice as much as we are speaking. Everyone has a need to be listened to, understood, and taken seriously. This isn’t going to happen if you are talking too much. Here are some practical things you can incorporate into your listening:

- **Face the speaker.** Sit up straight or lean forward slightly to show your attentiveness through body language.
- **Maintain eye contact,** to the degree that you both remain comfortable.
- **Minimize external distractions.** Put down your book or magazine and ask the other person to do the same.
- **Respond appropriately** to show that you understand. Give verbal and visual cues (“uh-huh” and “um-hmm”) and nod. Raise your eyebrows. Say words such as “Really,” “Interesting,” as well as more direct prompts: “What did you do then?” and “What did they say?”
- **Focus solely on what the speaker is saying.** Try not to think about what you are going to say next. The conversation will follow a logical flow after the veteran makes their point.
- **Minimize internal distractions.** If your own thoughts keep pushing in, simply let them go and continuously re-focus your attention on the veteran, much as you would during meditation.
- **Keep an open mind.** Wait until the veteran is finished before deciding that you disagree. Try not to make assumptions about what the veteran is thinking.
- **Avoid letting the speaker know how you handled a similar situation.** Unless they specifically ask for advice, assume they just need to talk it out.
- **Even if the veteran is launching a complaint against you, wait until they finish to respond and do not defend yourself.** The veteran will feel as though their point had been made. They won’t feel the need to repeat it, and you’ll know the whole argument before you respond. Research shows that, on average, we can hear four times faster than we can talk, so we have the ability to sort ideas as they come in…and be ready for more.
- **Engage yourself.** Ask questions for clarification, but, once again, wait until the veteran has finished. That way, you won’t interrupt their train of thought. After you ask questions, paraphrase their point to make sure you didn’t misunderstand. Start with: “So you’re saying…”

**Peer Coaching Skills: Engaging Mind and Emotions**

Stress and trauma are processed cognitively and emotionally and must be shed cognitively and emotionally. Active listening is the ability to focus completely on the speaker, understand their message, comprehend the information and respond thoughtfully. Active listeners use verbal and non-verbal cues to show and keep their attention on the speaker. Building trust and maintaining confidentiality provide psychological safety. Unhurried conversations allow time for responses to catalytic questions.

A catalyst is something that causes a reaction. In chemistry this might be a chemical added to other materials that causes a reaction creating a totally different material. When the catalyst is removed it is still the same. In other words, a catalyst causes change but does not itself change. A great question can be a catalyst in this same way. It can cause someone to pause and think through a response. It may help them to see something in a new and different
A catalytic question can produce a change in someone’s attitude, feelings, and thinking. It can produce a transformation simply by restructuring the veteran’s thinking.

Active listening and catalytic questions go hand-in-hand with developing constructive responses on the part of the veteran to their situation. Here is how to construct good questions.

First choose the appropriate type of question to ask. Questions can be categorized into two basic groups, open and closed. Ask OPEN questions when you want to engage the other person in conversation. Open questions literally “open up” the dialogue. Open questions require more than a word or two to answer adequately. Open questions generally begin with “What” “How” “Who” “When” “Why.” Be careful when asking “Why” questions. Too many can come across as confrontational.

Open questions come in two different types. SUBJECTIVE questions: use these when you ask for an opinion. “What do you think about…?” “What are her qualifications?” “How do you feel about…?” OBJECTIVE questions: these are used to ask for specific information. “What evidence did the police have? How have you thought about handling this process? What factors are necessary to raise your grade point average?” PROBLEM SOLVING questions can be asked when you want action ideas. “What should you do next? How would you implement the steps we just discussed?”

Use CLOSED questions when you want to inhibit long discussion. Closed questions can be answered adequately in only a few words. Closed questions often begin with “Are” “Can” “Did” “Do” etcetera. Closed questions also come in different types:

• Identification question “What kind of car is this?” “Who is responsible for this…?”
• Selection question (these are either / or) “Are closed or open questions better at promoting discussion?” “Who is right, the manager or the dealer?”
• Yes/No question “Does this client have the documentation on the design project?” “Has the questioning process been presented to the managers?”

So, here is the formula: When you want short, crisp answers, ask closed questions. When you want a discussion, ask open questions. If you want to shorten the discussion, ask a closed question. When you desire a narrative, use an open question.

It is important as well to look for any signs of burnout or self-directed violence that may need to be addressed by an appropriate professional. Burnout is the end of a long process involving stress fatigue that has not been managed well. Trauma, as a part of PTSD, is a significant element in stress fatigue. Burnout shows up first in someone’s inability to manage life event stress well. Life is full of stress, both good and bad stressors. Our body doesn’t know the difference and accumulates stress from both sources. Eventually, our mindset or perspective begins to change becoming more and more pessimistic, frustrated, and discouraged. Without changing something in lifestyle and thinking, a crisis is looming where hopelessness sets in along with a deepening need to find release, escape, in uncharacteristic pursuit of pleasure and avoiding pain. If this trajectory is obvious to you, this person is headed for a physiological and psychological crisis we call classical burnout.

Suicidal ideation and Self-Directed-Violence can be part of this trajectory. However, suicidal ideation and suicide can occur quite apart from any signs of burnout. Look for BEHAVIORAL CHANGES including risky behaviors, isolating, substance abuse, chronic anxiety and worry, or withdrawal and isolation. An early sign of trouble is sleep disturbance where there has been none before. If you observe behavioral changes, begin watching more closely for other indicators. SITUATIONAL CLUES include loss of a major relationship, death of a friend or family member (especially if by suicide), legal issues, and financial stress. VERBAL CLUES include statements like, “I just want out,” “You guys are better off without me,” and similar
directed remarks. Talking about death or suicide in person or on social media is an important clue as well. Do not be afraid to bring the subject up. Discussing hopelessness and suicide have not been demonstrated to trigger a suicide attempt. If you are concerned the veteran is contemplating suicide, get immediate help from a qualified professional.

What’s Next: Encouraging Moving Ahead

Meaningful relationships and purposeful work can be healing antidotes. Relationships with others characterized by commitment to conflict resolution and non-judgmental acceptance should be encouraged. Reconnecting with purpose and meaning in work helps restore a sense of value and contribution. Building a personal veteran network, exploring potential employment opportunities as well as opportunities to pursue education can open up other resources for the veteran and move them toward healthy reconnection and purpose in their world.

A key sign of hope is that a veteran is beginning to look forward to the near future optimistically. An interest in opportunities for employment or continuing education are indications of this optimism and should be encouraged. Expanding a personal veteran network and willingness to volunteer to help veterans are other indications of an emerging positive interest in the future. Look for opportunities to suggest these ideas if they do not come up voluntarily and conversationally explore the ideas.

Ultimately, the goal of coaching is to help the veteran reconnect with their self-identity in positive ways; healing of their grief which may include reconnecting emotionally with a deceased loved one or friend; moving away from anger and shame and reconnecting with a positive future and greater community. For everyone, this is a process and not an event. Though peer-to-peer recovery coaching may have moments, turning points, and times when new understanding has visible impact; these are events within the process and don’t necessarily signal all of the unanswered questions that consciously and unconsciously lay behind a veteran’s struggles have been resolved. Coaches are companions on this journey with the veteran. The reality that no one travels alone in this journey helps the veteran experience the discovery of their own restoration faster than if they traveled alone.
INFOGRAPHIC: PEER-TO-PEER COACHING

Peer-to-Peer Recovery Coaching
Restoring and Improving Veteran Connections

Access to Peer Coaching
Monthly in-person updates
Available for weekly phone calls
Comfortable with a wide range of emotions
Maintain appropriate boundaries
Positive reinforcement

Build Growth-Focused Partnership
Build trust
Maintain confidence
Processing experiences
Family dynamics/relationships
Body and mind regulation
Behavioral change

What’s Next
Meaning and purpose
Reconcile relationships
Building your veteran network
Employment
Education
Resources to know about
Volunteering

Peer Coaching Skills
Active listening
Providing psychological safety
Maintaining confidentiality
Starting a conversation
The art of unburdened conversations
Cognitive and emotional processing
Recognizing Burnout and SDV symptoms

Peer Coaching Defined
Coaching is not counseling, mentoring, or facilitating. Coaching is helping someone move from where they are to where they want to be. The root meaning of coach is a conveyance for moving goods and people from one place to another. The word in its origin was used to describe a horse drawn cart or carriage, and over time was simplified to coach. This is the role of a peer coach. Only, in this instance, it is not physically conveying someone from one piece to another. It is helping convey them from one condition to another better state of mind and body. This involves empathy in the context of unburdened conversations characterized by active listening. These conversations begin with the first steps described in Access to Peer Coaching and progressively move into Building Growth-Focused Partnerships. The Peer Coach will need some easily acquired understanding and skills described in Peer Coaching Skills. When you have one optimistic conversations about What’s Next, you will know they are on board and treating with you to a new and healthier place.

Related Research
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OBSERVED OUTCOME

Gill responded well to a suggestion to get involved with a project that encompassed steps of varying complexity. He decided to build furniture, since he liked working with wood. The instructions were detailed, and Gill was encouraged to refer back to the directions often and avoid worrying about forgetting something from one moment to the next. The goal was to engage his mind with complex processes that involve a greater number of neural connections and stimulate a number of areas of his brain promoting memory. In other words, this would result in reconnecting neural pathways and making new ones.

Reconnection is an important part of PTSD therapy and the same structures of the brain involved in learning are also involved in reconnecting with a positive self-identity, healing from lost attachments like the loss of his battle buddy, and reconnecting with friends and community (Springer, 2020). The key to this mind therapy was the repetitive nature of the activity. Finish one step, go on to the next one, consult the directions as often as needed. What we encounter repeatedly shapes us inevitably. The repetition was stimulating the creation of new learning pathways.

The treatment plan called for bi-weekly appointments for six months with monthly appoints potential for another six months. Family support was provided during this time as well. After the initial two months Gill was introduced to a veteran’s group which included a number of volunteer veterans trained in peer-to-peer recovery coaching (Jernigan and Jernigan, 2015). With issues
of perceived burdensomeness and thwarted belongingness resolved between Gill and his wife as a precursor to potential self-directed violence (Gratz et al 2020), Gill was engaged in peer-to-peer coaching from the second month throughout the following ten months. Peer-to-Peer coaching helped sustain the gains made in therapy and provided the needed support for restoring health and hope for Gill and the restoration of family relationships.

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Case Study Example #2:

Suicide Awareness and Education Using Popular Media

CONTRIBUTORS: Duane K. L. France, MA, MBA, LPC and Shauna Springer, Ph.D.

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GENERAL BACKGROUND

In recent years, there has been a surge of interest in using podcasting in higher education and for other learning objectives. Podcasting supports “active, social, and creative aspects of learning, and provides opportunities for reflection, self-paced and independent learning” (Palenque, 2016). The medium can be infinitely scaled and promotes autonomous learning (Hill, Nelson, France, and Woodland, 2012). Moreover, by its nature, podcasting can become a vehicle for increasing connectedness, and creating a sense of community (Van Zanten, Somogy, and Curro, 2012).

In 2020, the authors used popular media and mainstream communication methods to provide education and awareness about suicide prevention in the military affiliated population. In partnership with Military Times, a national independent news source for service members, veterans and their families, the authors produced a limited-series podcast entitled Seeking the Military Suicide Solution. The 52-episode podcast series featured a wide range of guests with expertise in suicide prevention in the military affiliated population.

THEORETICAL BACKGROUND

The show is hosted by Duane France, a combat veteran and clinical mental health counselor, and Dr. Shauna Springer, a nationally recognized expert on suicide prevention in the military affiliated population. Each episode contains an interview with a guest related to suicide prevention, and Dr. Springer and Mr. France explore specific themes that each guest addressed.

STMSS hosted a wide range of guests, including executive leadership at the Department of Veterans Affairs and Department of Defense Suicide Prevention Office; individuals with lived experience of both attempt survival and suicide loss; researchers at the national level addressing suicide prevention, and community members applying research at the local level.

One of the primary goals of the overall project was to identify emergent themes from among the guests. Throughout the series of episodes, nearly 200 quotes were categorized into eleven different areas. These include: identifying risk factors and warning signs, coordination and collaboration, reaching out to support, lethal means safety, and the importance of connectedness in preventing suicide.

INTERVENTION, TOOL, OR LINK TO RESOURCE

The Seeking the Military Suicide Solution Podcast can be found on all major podcast players, to include Apple Podcasts, Google Podcasts, Spotify, and Audible. All of the episodes can be found on the Military Times website, as well as at https://seekingthemilitarysuicidesolution.transistor.fm
The podcast was widely distributed and well received. The show received over 16,000 downloads throughout 2020; the average downloads per episode were 167 within the first seven days and 221 in the first thirty days. According to podcast hosting platform Buzzsprout, a podcast episode that has more than 72 downloads within the first seven days is within the top 25% of all podcasts. As this show is a narrowly defined topic for a narrowly defined audience, the response to the show has been extremely positive.

Throughout the podcast, there was a continuous focus on a public health approach to suicide prevention. Many of the guests shared important perspectives and insights on this topic.

For instance, in the single most downloaded episode in our podcast series, Captain Matt Kleiman, the director of psychological health for the chief of the National Guard Bureau, picked up on the need for collaboration as fundamental to a public health approach to suicide prevention. Kleiman reflects, “The [National] Guard has these silos of excellence…it became really evident to me pretty quickly that we didn’t have a great way to align this and leverage our best practices to inform our broader strategic effort across the National Guard.”

Dr. Harold Kudler, the former assistant deputy undersecretary for patient care services at the Department of Veterans Affairs, emphasizes a similar belief: “We need to do something that was done at the end of world war one. We need the entire nation to develop a national suicide prevention strategy.”

Dr. Matt Miller, the Director of Suicide Prevention Programs for the Department of Veterans Affairs, said this: “I think what’s not working is an over-reliance on clinically based interventions to the exclusion of community-based interventions, and conversely, and over-reliance on community-based interventions to the exclusion of continuing to attend to that which we can do and furthering clinically based intervention.”

Dr. Craig Bryan, a highly regarded suicide prevention researcher and Director of Ohio State University’s trauma and suicide prevention programs, promotes a critical humanistic perspective that gives shape to how a public health approach. As he explains, “Think of the friends that you have that you care about the most...They typically express appreciation to you. They thank you for the little things. They back you up, they support you. They reach out to you in times of need. And even when you’re not in need, they just send you a text message every once-in-a-while and say, ‘Hey, I was thinking about you. Hope you’re doing okay.’ Or ‘Hey, I read this funny article online, it reminded me of you.’ These are the little things that we can actually do on a day-to-day basis that influence and reduce the probability of a person tipping over the edge when they find themselves in that momentary moment of despair.”

And as a fifth example of this common theme, Dr. Rajeev Ramchand, a Senior behavioral scientist at RAND, has similar clarity on this issue as well: “I think that if we were in a society where people just genuinely cared for one another, that might turn the tide on suicide more than mental health treatment or a lot of things.”

As part of this project, to further enhance the connectedness we sought to facilitate, we created a dedicated Facebook page for “Seeking the Military Suicide Solution” which has become a place to share insights, perspectives and resources within the community of those who are working to prevent veteran suicide - whether they are professional healers, peer support specialists, policy makers, or concerned loved ones.

Listeners provided positive feedback throughout the run of the year-long show, to include examples like:
I’ve never written a podcast review but this one deserves a review! I’m a nurse administrator working in Mental Health at a VA. These podcasts gave info in a way I hadn’t thought of so am sharing with lots of people! Thank you thank you thank you!!

This podcast series has been a wealth of information and good dialogue about a very sensitive yet serious issue plaguing our current & veteran military community. I want to thank all of those involved for bringing this to the forefront and providing invaluable resources/guidance for the listeners.

Thank you for this most important information as to how we, as a community, can step up and be an active part of the solution. I lost my son one year ago this month and have been on a mission to create an environment for veterans and active military to workout together strengthening not only physically but mentally and emotionally. My goal is to create an atmosphere of camaraderie that is missed when reintegrating into civilian life. Your information has been of great value as I educate myself as to the problems and possible solutions.

LIMITATIONS

Doing a podcast is a lot of work. Both authors spent considerable time preparing for episodes. Nearly every weekend for a year, we woke early on Saturday mornings since this was the only consistent available overlapping free time in our lives.

Maintaining such a rigorous effort for more than a year was never the intention, but without the support of production assistants, this would have been very challenging. Ultimately, we aimed to create something of tangible value for the advancement of the field.

Like this case series, we came together to accomplish a specific aim, with the accomplishment of that aim set as the natural endpoint for the project. Others may wish to consider the time investment in making a high-quality podcast as a potential limitation.

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SECTION TWO: Reducing Suicide Risk Factors for the Military Affiliated Population

One of the primary goals of suicide prevention is to establish an environment in which a member of the military affiliated population does not experience a suicidal crisis in the first place. Ensuring that service members, veterans, and their family members are connected to each other and their community, that they have economic stability, and that they are aware of and prepared to address warning signs of suicide are critical to making sure that lives are not at risk to begin with.

Unfortunately, however, crises will occur. Regardless of the reasons why a crisis occurs, individuals and organizations in a community should be focused on reducing the risk factors so that the crisis is brief, non-fatal, and non-reoccurring. As is the case with protective factors, there are numerous risk reduction factors that can be applied to the military affiliated population.

The discussion of risk factors in this context does not address cultural or population risk factors for suicide, such as the presence of a mental health diagnoses, exposure to adverse childhood experiences, or the use of substances as a coping mechanism. Instead, the risk reduction factors we are referring to here are those risk factors that will decrease the likelihood that a suicide attempt will occur if someone is in crisis, or if someone is exposed to suicide or a non-fatal attempt, that the risk of future suicide is reduced.

For the purposes of this publication, the following case studies will be focusing on three risk reduction factors: ensuring service members, veterans, and their families have access to culturally competent and responsive care, reducing access to lethal means of suicide for someone in crisis, and supporting those who have lost a loved one to suicide or have experienced a non-fatal suicide attempt. By reducing the risk associated with these factors, it increases the likelihood that a member of the military affiliated population will not die by suicide as a result of a crisis.
Another aspect of preventing suicide is ensuring that the SMVF client has access to responsive care. This also includes, for members of the military affiliated population, access to care by someone who understands the unique nature of military culture. This includes care in the community; suicide screening in primary care settings can significantly reduce deaths by suicide. According to an article in 2016\(^1\), approximately 45% of individuals who took their own life saw a primary care physician within the previous month.

This also means access to care if there are barriers. The Department of Veterans Affairs has made an effort to provide access to emergency mental health treatment for veterans with bad paper; however, the sheer number of veterans requiring and seeking care means that community providers must be ready to provide the same level of care to those veterans who don’t have access to the VA for whatever reasons.

Evidence-based treatment interventions for clients experiencing a suicidal crisis have been proven highly effective. Case studies highlighting programs that have increased access to responsive care demonstrate how other similar programs can be implemented in communities around the country\(^2\).


**Case Study Example #1:**

The HAVEN Study: Challenges to Receiving Mental Health Care among Women Veterans

CONTRIBUTORS: Emily Schmied, MPH, PhD; Judy Dye, PhD, APRN, ANP-BC, GNP; Madisen Ferras MPH(c); San Diego State University

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**BACKGROUND**

Historically, research has not reported, or at least closely examined, sex differences in the rates of military suicide, due in large part to the unequal sex composition of the forces. The research that has stratified by sex has repeatedly concluded that male service members and veterans have higher rates of suicide death than their female counterparts. However, these statistics are misleading because they do not reflect the disparate trajectories in suicide rates between sexes, nor do they reflect the relative risk in service members compared to civilians (Bullman, Hoffmire, Schniederman, & Bossarte, 2015; Department of Veterans Affairs (VA), 2020; Hoffmire, Kemp & Bossarte, 2015). For instance, in some age groups, the rate of suicide among female veterans is higher and increasing faster than in civilians, and the same patterns have not been observed in males (VA, 2020; Hoffmire, Kemp & Bossarte, 2015). Given the differences in suicide patterns between males and females, the need for targeted research on sex differences in risk factors is indisputable. Numerous models of suicide prevention emphasize the importance of receiving timely, evidence-based care to treat suicidality and other mental health symptoms; however, research has also indicated that only about half of suicide decedents have recently received care.

**PROJECT DESCRIPTION**

Researchers from San Diego State University have designed the Healthcare Access in Women Veterans Study (AKA The HAVEN Study) to learn more about the unique healthcare-seeking experiences of women veterans following their separation from service. The mixed-methods study asks participants to describe the health issues for which they sought care, along with challenges that impeded their ability to find care and their satisfaction with the treatment they received. The results will be used to inform the development of public health interventions to improve healthcare access among this at-risk population.

**OUTCOMES**

Data collection is ongoing; 55 women veterans have completed an electronic survey about their experiences, and 23 of them also participated in a one-on-one telephone interview. Preliminary results show several potential points for intervention. **Survey data:** Approximately two-thirds of participants had received care for mental health issues since leaving active duty. Many (66.8%), but not all, participants received their care from the VA or VA-affiliated community clinics. Of those who did not receive care, half reported experiencing clinically meaningful levels of mental health symptoms (as measured by the PHQ-4). Interestingly, many participants (19%) indicated that they wanted care and had tried to meet with a mental health professional but were unable to. The most commonly reported challenges to receiving mental health care were related to insurance—at least half of participants reported they had “moderate” to “very serious” problems with the following: determining if they services were covered by their insurance, finding a
provider who takes their insurance, and the cost of care overall. In addition to these challenges, about a third of participants reported that their decision to seek mental health care was impacted by “moderate” to “great” concern over being prescribed medication and/or that the treatment wouldn’t be helpful. *Interview data:* While several participants described positive experiences receiving mental health treatment after separating from service, many also described their frustration over several challenges they faced when attempting to access care through the VA for either physical or mental health issues. Notably, nearly all described facing long wait times of up to 5 months to receive care. Also, several described instances in which their veteran status was questioned by clinic staff or providers, which they felt was due to their female gender. Relatedly, several participants noted the importance of being seen by female providers and participating in female-only group treatment sessions, as it increased their comfort in talking about sensitive issues.

These preliminary results suggest that women veterans may benefit from public outreach designed to increase knowledge about navigating health insurance and what to expect from mental health treatment (e.g., types of providers and treatment approaches, benefits). Further, healthcare systems should consider the unique needs of female veterans and should offer training to clinic staff and providers about best practices for working with this at-risk population.

**LIMITATIONS**

These results are drawn from a relatively small sample group of veterans that may not represent the experiences of the broader community.

**REFERENCES**


Case Study Example #2:

Virtual Delivery of Mindbody Program through CONNECTED WARRIORS

CONTRIBUTOR: Judy Weaver, C-IAYT, E-RYT 500

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PERSONAL BACKGROUND

David (not his real name) is a 33-year-old Army Medical Officer Veteran who has survived 13 close friends, peers and soldiers’ suicides and his own 3 suicide attempts all as a result of the mental health difficulties that many combat veterans face. David’s coping solution to combat the constant feelings of loneliness, anxiety, depression was alcohol and pharmaceutical drugs. After his third suicide attempt to escape the daily mental and emotional torture, David chose to redirect his journey to health and wellness and discovered Connected Warriors programs. David is one example of many veterans who may benefit from mind-body focused programming. Connected Warriors has offered this programming for many years, in ways that are adapted to the culture of the military and veteran community. Connected Warriors has signed a Memorandum of Agreement with the Department of Veterans Affairs to offer these services as part of a holistic approach engaging community partners to enhance traditional treatment modalities.

Traditionally, such programs have been offered in person. With the advent of COVID-19 restrictions, Connected Warriors has pivoted to offer their programming through a remote, virtual delivery method. This case study provides an illustration of this approach to treatment and remote-delivered intervention that has ensured responsive access to care during this challenging year.

THEORETICAL BACKGROUND

You go to war you do not come back the same. Sebastian Junger wrote in Vanity Fair in 2015, “that our warriors are not killing themselves from the trauma of combat it’s the trauma from coming home”. When you join the military, you start in basic training or “boot camp” beginning your new life with the potential to be “at the ready” 24/7. The military becomes your new family, your friends, your community, your educator, your employer - basically your everything, providing you structure, mission and purpose all laid on top of potential life and death situations. This new reality begins the physiological, psychological, and emotional changes that warriors experience during and after their military service. The civilian gap contributes significantly to the warriors struggles with “reintegration” to civilian life - less than 1% of the households in the USA have anyone actively serving in the military. When our warriors return to the civilian world, they have lost their tribe, structure, purpose, and mission – they can feel alone, without support and unable to relate to the civilian population, which creates anxiety, feeds depression and triggers PTS(D).

According to a study at Fort Carson, Colo, all 72 soldiers chose this answer from 33 choices of why they tried to kill themselves, “It was because of a desire to end intense emotional distress”. The bodymind is a cohesive unit and our health and wellness are interdependent on both mental and physical homeostasis and resiliency. Social isolation is recognized as a primary contributing factor to suicide and with 1 in 3 veterans suffering from a mental health diagnosis, in 2012, suicide among past and present members of the military surpassed combat as a cause of death (Smithsonian-DOD 2012 report).
Connected Warriors is directly battling our current suicide epidemic through work with Trauma-Conscious Yoga therapeutic classes and teacher trainings, community, employment, and behavioral health programs. (TCY) is defined as a methodology that empowers an individual’s journey to well-being through the practice of yoga (postures, breathing and meditation). Trauma Conscious Yoga is taught in a manner that meets the individual where they are physically and mentally in a safe, secure, and predictable environment, minimizing their trigger-ability – learning how to self-regulate. Prior to March 2020, all programs were delivered in-person. We quickly shifted our group classes and trainings to a virtual platform and successfully completed a collaborative pilot program to deliver virtual yoga classes with the West Palm Beach VAMC in December 2021.

A large part of the mental and physical benefits is the release of calming and positive thought producing chemicals which occur in social gatherings with like-minded individuals. Issues are in the tissues - “Yoga offers a way to reprogram automatic physical responses which helps regulate emotional and physiological states. It allows the body to regain its natural movement and teaches the use of breath for self-regulation. For someone to heal from PTSD, one must learn how to control bodily reflexes. PTSD causes memory to be stored at a sensory level—in the body.” Bessel A. van der Kolk, MD, The Body Keeps the Score.

A multi-year study researching the effectiveness of trauma-conscious yoga instruction annotated additional physiological and psychological benefits with participants reporting that one of the most meaningful outcomes was the camaraderie they experienced because of belonging to a group embracing yoga to improve their lives. Engagement in sessions helped participants to no longer feel isolated. (Nova Southeastern University). In July 2017, the American Journal of Preventive Medicine released a study by Dr. Erik J. Groessl and researchers from the VA San Diego Healthcare System on positive outcomes of our program. The study highlighted the improved behavioral-based pain management and a demonstrated decline in opiate use. In addition, a Connected Warriors-partnered scientific study operated in conjunction with the Department of Veterans Affairs found that 62% of participants reported positive reductions in pain, 70% increased levels of flexibility and balance, and 100% reported increased levels of social interaction and stress management behaviors.

Post traumatic Growth or benefit finding is positive psychological change experienced because of adversity and other challenges to rise to a higher level of functioning as defined by Wikipedia. Trauma is isolating and a critical component in healing from trauma is belonging to a community. Dr. Judith Herman states “The core experiences of psychological trauma are disempowerment and disconnection from others. Recovery, therefore, is based upon the empowerment of the survivor and the creation of new connections.” Using technology, we are meeting our warriors’ unique needs for community interaction.

I experienced the power of community as illustrated by this short story. “The Aha moment came for me one day several years ago when I gave away new CW t-shirts to the students in a Connected Warriors class. Up until that time each student would wear their branch of service shirt to practice and would only socialize with other members of the same branch, just like cliques in high school. But that day, once the t-shirts were given out – they immediately removed their branch of service shirts and put on the CW shirt and started to talk to one another regardless of branch of service. It was phenomenal, a new community was formed.”

INTERVENTION, TOOL, OR LINK TO RESOURCE

Trauma-Conscious Yoga is based on the understanding that trauma is held in the cells of the body and mind – it is physiological rather than psychological and that reconnecting the body and mind with the synchronization of conscious breath, movement and concentration in a safe,
secure, and predictable environment supports healing and wellness. The evidence-based protocol manages and eases trauma’s negative consequences occurring in the body mind by reducing potential triggers of stress and providing choices which is the opposite of trauma. Practitioners learn techniques to reconnect and develop awareness of the body mind needs in that moment – self-regulation of the nervous system.

Since May 2020 we offer our several classes virtually and maintain a library of classes and trainings that our warriors and their family members can watch on demand. www.connectedwarriors.org

Example Exercises:

A) Conscious Breathing is the cognitive mental and physical awareness that you are breathing – inhaling and exhaling without effort or control, just observation.

a) Begin either sitting upright with your shoulders aligned above your hips and your weight in front of your sitting bones or reclining on your back with your neck and knees supported.

b) Bring your attention to your next inhale and exhale without effort or control and continue directing your attention to your conscious breathing. Continue if you can maintain your attention to each inhale and exhale. (1-5 minutes)

c) Expand your attention to feel how you consciously breathe, bring one hand to your belly and one hand to your chest and notice your inhale and exhale. During the inhale and exhale notice how your hands move – in or out/ up or down. Continue breathing with this awareness and see if you can inhale so the hand on your belly begins to move up/out when you inhale and in/down when you exhale. (1-5 minutes)

B) Bi-lateral Stimulation is the crossing of your midline or asymmetrical movements which stimulate the corpus callosum that may have been damaged due to trauma.

a. Begin either sitting upright with your shoulders aligned above your hips and your weight in front of your sitting bones.

b. Inhale your arms up over your head and exhale twist to the right, bring your right hand down behind you and your left hand across to your right, look right. Take five conscious breaths here. Inhale as you look forward and exhale there. Inhale your arms back up and twist left to face forward and exhale your arms down. Repeat on the left side.

c. Stand up near a wall if you want support to balance on one foot. Tree pose looks like a Flamingo standing on one foot. Turn your right toes and knee out to the side and place your foot on your left inner leg, above or below your knee. Consider taking both arms up by your head. Take five conscious breaths here then slowly release the right leg down. Repeat on the left side.

OBSERVED OUTCOME

For David, the outcome has been a complete success as he was able to complete the Elevated Warrior Program virtually, moving forward on his post traumatic growth journey. We have had similar outcomes (pre-pandemic) delivering the Elevated Warrior program virtually, and in fact, was able to broaden our reach without geographic and time restrictions.
Read his words about his success with the program and the testament to his continued mental and physical well-being.

“When I came to Connected Warriors, I was homeless and penniless. Through their work, program, and encouragement, I have had the courage to seek benefits for my Mental Health issues and am a 100% disabled veteran today. CW helped me understand that fear was my primary emotion and how to recognize that emotion and work through it in a positive manner and not self-destruct – how to be at peace with the most important relationship of all........with myself. Today, because of CW I am at peace.

As far as relationship to those who are no longer here, there is no relationship to have except for a metaphysical one since they are gone. CW taught me how to properly meditate and build my connection with the individual and channeling their energy when I need their support is always a positive.

Today because of CW, I search out veterans and active duty servicemembers and assist in any way that I can. Because of CW, I was confident enough to walk back onto a military base and make amends to the Colonel & CSM that discharged me from the military and make amends to them. I assist Ft. Knox, KY in their ASAP program and these same individuals play an active part in my life.

The biggest thing that CW taught me was that I did not need to own guns. Through their mindful practices of compassion and love, I have sold all my guns and ammunition. Not that I may not need them or want them, but as a deterrent to keep me from making the ultimate sacrifice. I learned that I was more of threat to myself than my environment. I also went from a $300 a day heroin addiction to being completely sober and not wanting to erase or eradicate the feelings or memories of my past traumas but to embrace them and work through them. Without Connected Warriors and their program, I would not be alive today. I know that I would be dead from suicide. They gave me purpose.

Recently, I became the executive director of a multi-million-dollar organization that treats dual diagnosis (MH and Substance Abuse) and we just expanded to our third facility. I do not make impulse purchases anymore or waste my money on my own destruction. I have a savings account and have even started to invest. I also am a first-time homeowner today. Thankfully, I found Connected Warriors and got the opportunity to share my solution with other veterans trying to achieve both happiness and sobriety.”

LIMITATIONS

No single approach works for all populations or individuals. This program is delivered in multiple ways for the past 10 years with over 1 million visits and zero reported suicides. This writer is not recommending this approach for everyone as it is an individual approach for many of its programs. Readers must use discernment to determine whether this program may be helpful within the context of those they hope to support.
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Chapter 5

RISK REDUCTION FACTOR: Encourage Lethal Means Safety

A discussion about suicide prevention in general, and in the military affiliated population specifically, absolutely must include a conversation around lethal means safety. When this topic is discussed, many jump to the conclusion of, “they’re going to take away my guns.”

The fact is that, if someone is extreme imminent risk to themselves, then \textit{they} should take away their guns. Or, more appropriately, recognize when someone is in crisis and help them take steps to restrict their own access to them. It doesn’t mean giving up guns forever; it only means keeping safe.

This is even more critical, given the fact that firearms are a significant factor in veteran suicides. According to the 2016 VA Veteran Suicide Report\textsuperscript{1}, 67% of all veteran suicides in 2015 were the result of firearm deaths. Not addressing lethal means safety, including firearms safety, is like trying to address the cancer epidemic without mention gin.

And when discussing lethal means, although many jump to the thought of “guns,” it’s not just about that. It’s about controlling access to any form of lethal means. Prescription medications. Known danger zones for suicidal behavior, such as the Golden Gate Bridge. Knives or razor blades.

As with many other aspects of suicide prevention, restricting access to lethal means is a sensitive topic. Having a discussion firearms safety in particular is difficult both politically and personally for many service members, veterans, and their families. This is not a discussion about someone keeping another person safe against their will; it’s a discussion about how individuals can keep themselves and their families safe. When someone is a suicidal crisis, the one thing that is needed the most...clear-headed, rational thinking...is the one thing that someone is least likely to have. Putting protective measures in place before a crisis happens is about saving lives, case studies in the Lethal Means Safety section highlight programs that are doing exactly that\textsuperscript{2}.


Case Study Example #1:

Walk the Talk America (WTAA) Podcast as a practical application of the public health approach to suicide prevention

CONTRIBUTOR: Michael Sodini

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GENERAL BACKGROUND

Walk the Talk America (501-C-3) was started in 2018 to bridge the gap between the firearms industry and the mental health community with a goal of reducing the number of firearm fatalities by suicide. Nearly two-thirds of all gun deaths in the US are suicides, resulting in an average of 64 deaths a day (Centers for Disease Control and Prevention, National Center for Health Statistics). WTTA approached this goal by implementing programs that educate the mental health community about the challenges they may face when talking to the firearms community, as well as educating the firearms community about the misconceptions of seeking help from mental health professionals.

Launching this initiative was about creating a society where the mental health and gun communities could come together to develop innovative programs based on fact and mutual understanding, rather than fear and mistrust – a society where both mental illness and gun ownership are destigmatized. According to the National Shooting Sports Foundation, 21 million background checks were conducted for the sale of a firearm in 2020 (Bartozzi, 2020). Over the past several years, there has been an increase in the prevalence of mental health challenges. Statistics from Mental Health America say that in 2017 to 2019, 19% of adults experienced a mental illness which was an increase of 1.5 million people from the previous year (Mental Health America, 2021). Firearms ownership and mental illness are on the rise, so it is more important to bring the two communities together.

In 2020, two members of WTTA decided to use a podcasting platform to compliment the organization’s mission. Podcasting has become a very popular format of media with more than one-third of Americans age 12 and over (104 Million) consuming podcasts regularly (The Infinite Dial 2020, Edison Research).

By inviting members from different industries and communities while keeping guns and mental health as a topic of discussion, we felt that long form conversation of the subject would open people’s minds and educate them on the challenges both communities face.

THEORETICAL BACKGROUND

Walk the Talk America’s Guns and Mental Health podcast is hosted by Jake Wiskerchen, a licensed clinician and gun owner, and Michael Sodini, a third-generation firearms industry professional and the founder of WTTA. Each episode contains an interview with a guest related to the intersection of firearms and mental health - two topics that have not been previously explored in this format.
Guns and Mental Health has hosted a wide range of guests, including mental health professionals, gun rights activists, first responders, combat veterans, suicide loss survivors, mass shooting survivors, and individuals who work within the space of suicide prevention and mental health awareness.

The primary goal of the show is to have an honest and comprehensive discussion about guns and mental health and to bridge the understanding of two highly stigmatized cultures that have long stood across from each other, refusing to collaborate when tragedy strikes. Our podcast series is designed for clinicians, firearms owners, and the curious public.

**INTERVENTION, TOOL, OR LINK TO RESOURCE**

Guns and Mental Health can be found on all major podcast players, to include Apple Podcasts, Google Podcasts, Spotify, and Audible. All of the episodes can be found on both our website at http://wtta.org/ or http://wtta.buzzsprout.com/

**OBSERVED OUTCOME**

The podcast started in August of 2020 and we have completed 35 episodes. Our show is still fairly new, and we address two topics that historically have never been put together. We have seen more than a 10 percent increase in our audience week over week.

Our goal with each episode is to discuss aspects of mental health and firearms ownership to educate the listener. Regardless of whether our guest is from the firearms industry or the mental health community, they always have stories that overlap the two subjects. We found that the show was the perfect complement to the www.walkthetalkamerica.org website, as the majority of our guests explored the website before coming on the show.

For example, consider the story of Kevin Dixie, a second amendment rights activist and mental health advocate. Mr. Dixie, who is now a professional firearm trainer, reflected on his journey from being suicidal to becoming a well-known instructor on a national level. As he explained on the podcast, “When I got properly introduced to firearms…I realized just how powerful these tools are and what they can do. By that time, I was well past the stage of wanting to hurt myself. I realized, I’m going to grab hold of this thing that everyone is scared of, that we only saw for chaos and violence. If it’s the source of power that everyone is scared of, then I’m going to control it. So the thing that once threatened my life, I grabbed and controlled it to use it to preserve and protect lives. You can literally turn this thing around.”

Sherman Gillums Jr., Chief Strategy & Operations Officer with NAMI shared on his episode these insights: “Suicides by firearms is a problem and we need to address it. The question is how? My position has always been, let’s address lethal means while also talking why those means became lethal in the first place.” He also emphasized the importance of “inviting a diverse swath of the veteran community, not just the people you always have talking about these things.”

Jake Wiskerchen, a mental health clinician and host of the WTFA Podcast said, “We want to stop suicides but we need to start demystifying the counseling process for people too.”

On the topic of firearms and suicide risk, Dr. Shauna Springer said, “The conversation we are having isn’t working…it may be the reason why many firearm owners are dropping out of treatment never to return, or never coming in for treatment that could be life saving for them.
Because our approach to that conversation assumes a level of trust and rank that doesn’t exist.” She also reflected on the cultural knowledge gap, adding that “a lot of clinicians are very uncomfortable with firearms and very uneasy about discussions of firearms.”

Rob Morse, when referring to well-intended laws that ultimately wound up restricting rights, said, “It sounded like a good idea at the time. It was a simple solution and now life is more complex. Now we need to make room in our culture for people to have moments of crisis and recover.”

Brandon Cassinelli, when asked how he balances being a police officer and being a licensed clinician, said, “Some personal relationships have changed because people have certain beliefs both about officers and about therapists.” He mentioned that even though his fellow officers jokingly call him “Sigmund” (referring to Freud, the famous psychiatrist), he sees a benefit. “At the very least,” Cassinelli said, "They are starting the conversation. They are acknowledging there is a therapist among their ranks which I kind of try and use as a way to be like ‘I know right? See, I’m not that scary.’”

Listeners have left us positive feedback after hearing the show. Examples include:

“Some of the earlier podcast episodes explained some of what I’ve experienced and gives me something to work towards. So yeah, I really do appreciate what you are doing”

“Listening to episode 9, I realize now that I have experienced both ASD and PTSD”

“Thank you from the firearm and veteran community”

**LIMITATIONS**

Doing a podcast is very time consuming, especially when the show does not have a budget. Both hosts have to find time to record around their guest’s schedules, write or edit bios, create graphics and produce the show.

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Source: [https://www.mhanational.org/issues/state-mental-health-america](https://www.mhanational.org/issues/state-mental-health-america)
Case Study Example #2:

The Warrior Box Project: A Culturally Grounded Lethal Means Initiative

CONTRIBUTORS: Shauna Springer, Ph.D. and Brian Vargas, MSW

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PERSONAL BACKGROUND

The concept described below comes from many years of work with the warfighter community, in the context of a deep trust I hold with those who fight our nation’s wars. It is also informed by a personal collaboration with USMC Veteran Brian Vargas, who co-developed the WARRIOR BOX Project as part of his personal mission to help keep more of his brothers and sisters in the fight. He is “patient 0” and the story of how this intervention saved his life is shared on the NPR episode “Shrapnel” within the “Snap Judgment” podcast series.

THEORETICAL BACKGROUND

According to the DoD Suicide Event Report (DoDSER), well before the global pandemic, personal firearm use was the most common method of suicide, accounting for 66.5 percent of all 2018 suicides. Since the start of COVID-19, sales of firearms have surged. In the United States, firearms are the method of suicide that is most common, and most lethal. Suicide prevention researchers, including Reger, Stanley, and Joiner (2020), have suggested that the availability of firearms in the context of Coronavirus may be a “perfect storm.” According to other research, one third of a nationally representative sample of Veteran gun owners reported storing their guns loaded and unlocked.

The research and clinical communities have expressed urgent concern about the connection between firearms and veteran suicide.

Yet, to many veterans, asking questions about firearm ownership feels intrusive and disrespectful. A perceived threat that someone may take away their firearm can be a serious barrier to treatment. Sometimes, just asking about firearms can lead a veteran to drop out of treatment entirely.

During his time as a social work student at UC Berkeley, USMC Veteran Brian Vargas asked a group of 70 college enrolled veterans what they really think when mental health providers ask questions about “lethal means.”

When he asked them if they would tell a new clinician the truth about owning firearms, over half said, “probably not” or “definitely not.”

Moreover, over half said they would DROP OUT OF TREATMENT if a clinician they did not know well were to ask them if they own a firearm.

Despite our good intentions, we must acknowledge the very real possibility that asking questions about firearm ownership can increase suicide risk, if this deters veterans from accessing potentially life-saving care.

In the military, taking a firearm away is a power move by someone in a position of authority. Servicemembers often tell me that having a firearm removed is one of the most shaming things that can happen in the military.
Clearly, then, this conversation is not only one that may have life or death consequences, but it is also an emotionally loaded one. It is critical for us to approach this conversation in the right way.

The idea behind what later became the Warrior Box Project came during a restless night, at 3:00 a.m., in the context of asking myself, “When a patient is bent on self-destruction, is there any tool that might be developed to prevent him or her from attempting suicide?”

A Warrior Box is essentially a “war chest” that users build out of a 30- or 50-caliber ammunition can that displays and holds images and objects that represent the tangible, relational protective factors that soldiers will choose to live for, even in times of crisis.

For current and prior service members who own firearms, a Warrior Box offers a strategic storage solution for a firearm lock or firearm safe key, firing pin, ammunition, or an actual firearm. The Warrior Box is thus a mechanism for facilitating safer firearm storage and access practices, but it avoids framing the conversation in a way that is threatening or off-putting to the military community with respect to their choice to own firearms.

The WARRIOR BOX project is a culturally informed way to change the conversation we have with those who own firearms. The intervention gives us a better path than getting into a power struggle about firearms.

The risk of suicide among veterans and active-duty military members has been well-established, and many efforts to address suicide among military populations are underway. The need remains, however, for innovative and culturally competent interventions that are designed for its users.

The Warrior Box is an innovative, theory-informed intervention that can be scaled up to reach and reduce suicide among large numbers of military service members and veterans who are at-risk.

INTERVENTION, TOOL, OR LINK TO RESOURCE

Every Warrior Box is different, but all of them are full of practical tools and objects that have stopping power when they are faced with mental warfare. Brian’s contributions as a Marine Corps veteran and social work graduate student have been critical in making the concept translate to the culture and language of those it is designed to serve. Over the past few years, we have built out and refined the contents into a very practical toolkit (which is copyrighted and available for purchase on the homepage of www.docshaunaspringer.com).

OBSERVED OUTCOME

During development of the Warrior Box Project, Brian polled a sample of seventy college-enrolled veterans. This poll was mentioned in an earlier chapter on firearm safety conversations, and all of the questions were focused on this topic. There was one question about the potential of a Warrior Box to successfully target impulsive firearm suicides. The vast majority of the sample (more than 75%) felt that a Warrior Box could substantially decrease the number of impulsive firearm suicides among their brothers- and sisters-in-arms.

With the donation of a large supply of ammo cans by Kevin Graves, whose son Joey Graves was killed in action in Iraq, more ammo cans donated by a group of Marines, and seed funding from the Kaiser Permanente Veterans Association, we have been able to provide Warrior Boxes
to several groups of veterans, with very promising results. Warrior Box kits have also been ordered by providers in the Department of Veterans Affairs, and by embedded mental health providers at active-duty military bases.

In one group of twenty-three Marines from 2/7, a unit which has been greatly impacted by suicide losses, four out of five felt that it was “very helpful” and “would recommend it to a friend.”

Here is some narrative feedback from 4 veterans to show how the Warrior Box Project has been received by them:

“Dr. Springer and Brian Vargas have brought forward an intervention tool that, unlike so many, is intimately familiar to the culture and life of OIF and OEF veterans. It is powerful, easily accessible, filled with all of the images and their connected emotions that are sometimes the only possible things which can intervene in the horrifically strong cascade and pressure of negative emotions that overtake one’s mind and body when PTS is in full force. This tool is the perfect positive wedge to shove between veterans and their PTS, when it makes the world look like a permanent decision is the only option to stop or escape the pain, during what is really only a temporary event; and save our brothers’ and sisters’ lives. The Warrior Box needs to become part of the main arsenal in the battle against the plague of suicides affecting the veteran community.”

“Having to look at pictures of my beautiful daughters every time I unlock my weapons reminds me what I live for. This is a brilliant intervention, and I believe with the right support this idea could change the statistic of twenty a day.”

“The Warrior Box is on my nightstand . . . it helps me daily. Putting an emotionally charged barrier between yourself and your means of suicide creates an overwhelming choice to grow (post-traumatic strength and growth). More ammo is important in a fight.”

“A tool like this can be a candle in the darkest of caves.”

LIMITATIONS

No single approach works for all populations or individuals. This tool is a culturally adapted approach to supporting warriors that has been directly informed by warriors with lived experience. This approach has been successfully deployed in groups of warriors who have served in the same unit and in different units. It has been very received by active-duty service members and veterans alike.

The application of the materials we’ve developed leaves a wide latitude for individual choice. For some individuals, using these materials in conjunction with professional support may be most helpful. This is how they were originally designed - in the context of a deep trust between a provider and the patient. Others tell us that they have found these materials helpful in conjunction with peer-based support and/or good support from trusted loved ones. But neither of these will necessarily be true for all people in all situations.

It is our hope that those who purchase these materials will find a path to hope and gain an array of very practical ways to get traction for the battles in their lives.
Example of WARRIOR BOX owned by co-developer Brian Vargas. Every WARRIOR BOX is different. Each individual adapts his or her WARRIOR BOX to his or her own values.

Please act with honor and respect our copyright. Our concept and associated materials are copyrighted and can be purchased by organizations and individuals for a reasonable cost. Further, a portion of the funds we generate supports our time and materials needed to keep the project moving forward. Please honor our copyright and contact us through the portal found on: www.docshaunaspringer.com if you wish to purchase materials to deploy this intervention.

REFERENCES


The last area that needs to be addressed is what happens after there is an attempt or a veteran dies by suicide. Postvention are strategies that exist along a continuum. We look to implement prevention strategies...keeping a veteran from getting to the place where suicide is an option for them. We also focus a lot on intervention strategies, where we attempt to intervene with a veteran who is actively in crisis. Postvention, however, is critical to address future suicide after an attempt that does not result in death.

Another aspect of postvention is to prevent more suicides in the immediate social network connected to the veteran who died by suicide. The contagion effect of veteran suicide...in which one suicide in a close network increases the risk of suicide in the other members of that network...is a very real challenge. A study by the National Institute of Health\(^1\) identified that an increase in suicidal behavior by family members is positively associated with suicidal behavior among other members of the family; the same is true for veterans.

Postvention leads to prevention. The cycle starts all over again after a suicide death or attempt. All of the protective factors discussed so far...increasing connectedness, increasing economic stability, and improving education and awareness...are included in the eventual response after an attempt or loss. Just like the sun rises after the darkness of night, there will be a day after an attempt or death by suicide. Each of us individually, and all of us collectively, will have to determine what actions we will take to break the cycle\(^2\). Case studies in postvention will highlight programs and organizations doing exactly that.


Case Study Example #1:

Sibling and Compounded Suicide Loss, Military Service, and the Tragedy Assistance Program for Survivors (TAPS) Postvention Model

CONTRIBUTOR: Christopher D. Jachimiec, MPPA

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GENERAL BACKGROUND

Postvention among the military population is often overlooked and misunderstood. When a military organization experiences a death by suicide, more often than not the response primarily involved has been suicide prevention education that emphasized heightened awareness of risk and warning signs. However, postvention, which refers to well-informed support of those impacted by a suicide loss, helps to stabilize suicide loss survivors and put them on a path to healing (Ruocco, Patton, Burditt, Carroll & Mabe, 2021). Additionally, and through my own personal experience, military helping agencies are often ill-equipped to properly care for those bereaved by suicide loss. Finally, what support is available to those who have gone through multiple suicide losses, to include murder-suicide, in a short span of time? These distinct, sudden losses have the potential to compound trauma and complicated grief. Such is the case for military units and veterans who have experienced the death by suicide of many of their members and battle buddies. Units across the Department of Defense have had more casualties to suicide than that of combat since 9/11. The number of veterans and service members lost to suicide in just one year now surpasses the number of lives lost during the operations in Afghanistan and Iraq to date. The total number lost in the past decade totals more than the number of deaths incurred during the Vietnam War (Tanielian, 2019). This has led to the formation of many military non-profit organizations centered around suicide prevention. Despite this “national security” problem, a relatively small number of organizations are focused on supporting those who have lost a loved one to suicide. Compared to non-military counterparts, there is gratitude in the programming supplied by military connected nonprofit organizations. Support toward the military population often exceeds that of those in the non-military community, especially among the bereaved. From my personal experience, no organization does this better than the Tragedy Assistance Program for Survivors (TAPS).

Suicide after bereavement is a serious yet overlooked problem. Bereavement, in and of itself, can increase suicidal thinking. Other risk factors such as sudden, traumatic death; exposure to trauma related to the death, preexisting mental health and developmental issues; exposure to suicide and history of suicide attempts, as well as the nature of the relationship to the deceased can converge during the agony of separation distress, making the grief seem so unbearable and unrelenting that suicide may be sought as the ultimate form of psychic pain relief (Harrington, Ruocco, Jordan, 2020). Sibling grief is often discounted as well. While recent research and studies have presented themselves, siblings are referred to as the ‘forgotten mourners.’ Through one of their research studies, bereaved siblings therefore must be given ample opportunity to grieve and tell their stories as many feel that this loss is not recognized (Godfrey, 2006). Dyregrov, K., & Dyregrov, A. (2005) found that siblings felt “we are only siblings. I think that is how we feel, because our parents are really suffering. I understand their dreadful situation, because they have lost their child, but I have lost my past, present and future.” This painful expression shows that even siblings can understand that the parents are suffering and therefore do not have the capacity to provide them with the support they require (Dyregrov, K., & Dyregrov, A., 2005). Despite the need for my parents’ support and to be there for them myself I’ve been able to make meaning of these losses through proper postvention support, especially
through other sibling survivors. It has brought meaning and purpose to my brother's loss. For what is grief, but love persevering? (Feige, K. & Schaeffer, J. & Shakman, M., 2021)

AUTHOR BACKGROUND

Christopher Jachimiec is a retired United States Air Force Master Sergeant who served in various capacities in Texas, Nevada, Mississippi, Georgia, Germany and Korea over his twenty plus year career with multiple deployments in support of the wars in Iraq and Afghanistan. During the span of his career, he was named the 2016 Air Combat Command First Sergeant of the Year, 2012 United States Warfare Center Noncommissioned Officer of the Year and was a Distinguished Graduate of all levels of Air Force Enlisted Professional Military Education. Chris holds a Master of Public Policy and Administration Degree from Northwestern University, a Peer Support Specialist certificate from the University of Nevada-Reno, is a Certified Master Resilience Trainer through UPenn and is a Peer Mentor and Care Group Leader for the Tragedy Assistance Program for Survivors. He was medically retired from the United States Air Force in January 2020 through a Medical Evaluation Board for suffering from the Invisible Wounds of War. Chris is currently the communications and social media manager for the Nevada Coalition for Suicide Prevention and is one of the Nevada Ambassadors for PREVENTS Task Force. In his spare time, he is a competitive athlete for the Air Force Wounded Warrior program and integrates sport into his recovery. He currently lives in Las Vegas with his two children.

In 2014, Chris became an Air Force First Sergeant. In this capacity, Chris was responsible for the overall health, morale and welfare of all assigned personnel with the duty to provide the Commander with a "mission ready force". This included providing for the mental health needs of all assigned service and family members which often left him in a capacity to intervene and provide support during suicide ideations, attempts, post-hospitalization treatment teams and deaths by suicide. While serving in this capacity in July 2017, he’d lose his younger brother, Lance Corporal Adam Jachimiec, United States Marine Corps, to suicide. He’d then respond with his unit to three natural disasters, lead through the Route 91 mass shooting in Las Vegas and suffer the suicide loss of two of his peers in a six-month time span. In addition to the loss of his brother and fellow close military members, Chris has experienced multiple losses to suicide in his immediate family to include his grandmother and cousin (murder-suicide).

INTERVENTION, TOOL, OR LINK TO RESOURCE

Tragedy Assistance Program for Survivors Postvention Model – learn more or connect with TAPS Suicide Postvention Team via their website: https://www.taps.org/suicide

DISCUSSION AND OBSERVED OUTCOME

The Tragedy Assistance Program for Survivors Postvention Model is the “gold standard” in suicide postvention. It consists of a three-phase approach to suicide grief that offers a framework for survivors and providers in the aftermath of a suicide. This framework proposes guidance on how to build a foundation for an adaptive grief journey and creates a research-informed, proactive, intentional pathway to posttraumatic growth. The Model follows the Tragedy Assistance Program for Survivors’ peer-based model of care and has supported more than 16,000 military suicide loss survivors over the past decade. The Model is applicable to anyone grieving a suicide loss or coping with any associated trauma. It encapsulates a three phase postvention approach consisting of stabilization, grief work and Post Traumatic Growth (Ruocco, Patton, Burditt, Carroll & Mabe, 2021). While I could elaborate on the Postvention Model, it’s
best to directly connect with their team and reference the recent journal article published in *Death Studies*. Within this construct, TAPS cares for sibling loss survivors perhaps better than any organization by integrating sibling programming into all of their seminars and through sibling specific retreats, webinars, video chats and peer-to-peer mentorship. National organizations supporting suicide postvention should adopt many of these best practices into their programming.

I’d first learn of TAPS through an alcohol and drug abuse counselor within an Air Force Mental Health clinic. She had volunteered her time as a Military Mentor and recommended that I utilize their services due to the loss of my brother Adam. This simple care allowed me to take the first step toward stabilization after his traumatic loss. I’d attend my first TAPS seminar a few months later and it transformed my life. TAPS integrates substance abuse recovery into their seminars and offers safe space for those in recovery. It would be here that I would attend my first group meeting which motivated me to seek further, intensive treatment for my addiction. Coupled with various bereavement counseling within the military and civilian communities, I had launched my path to healing. I’d spend over 60 days in a partial hospitalization and intensive outpatient program in the Las Vegas area that was complimented by continued support through Peer Mentors and various other personnel within TAPS. Perhaps as equally important was the wraparound stabilization programming presented to my children within their Good Grief Camp model. My children, enduring the loss of their uncle, were able to get unique support through their Military Mentors.

This early intervention and stabilization allowed me to properly explore the grief associated with not only my brother’s loss, but the other losses and trauma I experienced from my combat deployments and stateside military service. It allowed me to be transparent with my Command Team and Military Mental Healthcare Professionals. Despite this, the breakthrough in my griefwork came through conversations and companioning by the support of fellow sibling suicide loss survivors. This allowed me to move through my grief into making meaning out of these losses and experiences into Post Traumatic Growth.

Once I hit a “good” spot within my own personal grief journey, I felt it was time to give back. I’d become a certified Peer Mentor and launched the first Las Vegas TAPS Care Group, supporting over 300 individuals in the greater Las Vegas Valley. It led me to seek a certification through the American Foundation for Suicide Prevention to host survivor of suicide loss support groups within the city. TAPS gave me the confidence to share my story in numerous public forums across the United States and transformed my grief into action. In 2020, I’d retire from the United States Air Force through a Medical Evaluation Board, and would find cycling as an outlet thus turning my grief into over 5,000 miles on my road bike in support of TAPS. Lastly, this transformational growth encouraged me to take action in using my voice to prevent suicide among servicemembers, veterans and their families by joining with the SAMHSA Governor’s and Mayor’s Challenge team as well as serving as an ambassador for the PREVENTS Task Force.

**LIMITATIONS**

The observations and outcomes discussed are focused on a single sibling suicide loss survivor who experienced other trauma and challenges over a twenty-year military career starting prior to the events of 9/11 and beyond. The focus may be very narrow as there are a limited number of individuals who fit this demographic. However, similar experiences in Post-Traumatic Growth have been observed within sibling loss survivors who have a connection to military service and or others in the field of suicidology.
Research and data related to sibling suicide loss continues to be limited in scope. However, in my personal experience there are many within the field of suicidology who are fostering change and promotion safe, appropriate research for sibling survivors.

REFERENCES


Case Study Example #2:

Peer Support in the Warrior Community for Suicide-related Emotional Trauma

CONTRIBUTOR: Shauna Springer, Ph.D.

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PERSONAL BACKGROUND

Jake (not his real name) is a 34-year Marine Corps Veteran who attended a private reunion along with several other Marines in the same unit. The Marines in the circle had served together at the same time and knew each other. All of them were emotionally impacted by a recent suicide of a fellow Marine. Jake’s process is used to illustrate a tool that helped many of them address their suicide-loss related distress in a way that promoted healthy grief and the start of a healing journey.

THEORETICAL BACKGROUND

Death is a fact of war but accepting this does not lessen the impact of grief. After losing a battle buddy to combat, my veteran patients were gripped by a sense of helplessness, covered by rage. They wanted to be back in the combat zone. They often expressed that if they had been there, maybe this might not have happened. They wondered aloud whether they could have spotted the enemy’s IED. Survivor’s guilt often took root after combat losses. Several wished they could have been killed in their brother’s or sister’s place. Even among those who were medevac-ed out of the combat zone with terrible injuries, there was often a sense of guilt about not being there with their unit, and a self-directed rage borne of helpless frustration. This kind of “unfinished business” can eat someone from the inside out – over time, it can become lethal. Compared to combat deaths, losses to suicide were even more dangerous.

ARMY STARRS data bears this out – in a study of over 9,000 soldiers, risk of suicide increased in units who had lost members to suicide (Ursano, Kessler, Naifeh, et al, 2017). During my time at the VA, a veteran who was beloved within the local community died by suicide. He left the following note: “It’s not anyone’s fault. I just wasn’t strong enough to fight my demons anymore.” His death rocked the entire community of veterans. His suicide was the focus of many therapy sessions in the weeks following his death. Those sessions had particularly high stakes. Consistent with several research studies (Levi-Belz Y, and Lev-Ari L., 2019.; Mitchell AM, Kim Y, Prigerson HG, and Mortimer-Stephens M. 2004; Young IT, Iglewicz A, Glorioso D, Lanouette N, Seay K, Ilapakurti M, et al., 2012), the mix of emotions in the room was a toxic compound of blinding rage, helplessness, paralyzing fear, hopelessness, and soul-searing grief. In many cases, as in this instance, the suicide of a fellow veteran has not been anticipated by friends and family.

In fact, many times an individual who dies by suicide had appeared to others to be high functioning, perhaps even a leader among his or her peers, prior to the death. To normalize the effect of these sudden traumatic losses for my patients, I developed the concept of the “sniper effect” (Springer, S., 2020; WARRIOR: How to Support Those Who Protect Us). The naming of it as the sniper effect was helpful to my patients because it accurately captured the feeling of losing a fellow veteran to suicide: They had suddenly lost someone to an unknown, unseen enemy.

In the context of what turned out to be a mostly private battle, the demons of their fallen brother or sister seemed to suddenly ambush them. To decrease the risk of self-destructive thoughts
and behaviors, healers – whether licensed professionals or trained peers – must create experiences that RECONNECT warriors with their fallen brothers and sisters in arms. Those grieving need to face off against the storm of emotions that arise – in a safe, and totally non-judgmental space. Social support confers physical and mental health benefits (Cohen, 2004; Reblin and Uchino, 2008).

Multiple studies have shown that peer support is associated with decreased risk of suicide (Bearman and Moody, 2004; Beautrais, 2002; Donald, M., Dower J., Correa-Velez I., and Jones, 2006; Dower, Correa-Velez, and Jones, 2006; Duberstein, Conwell, Conner, Eberly, Evinger and Caine, 2004; Rubenowitz, Waern, Wilhelmsson, and Allebeck, 2001; Ruocco, K. A., Stumpf Patton, C., Burditt, K., Carroll, B., & Mabe, M., 2021; Tulvey, Conwell, Jones, Phillips, Simonsick, Pearson et al, 2002). Approaching grief alongside those in one’s Tribe creates a powerful form of peer support.

Within circles of peers, grief can be processed in a communal way. Addressing grief directly by reconnecting with a fallen brother or sister in arms allows group members to work through a wide array of normal, but potentially isolating, emotions, such as helpless rage, fears about the future, anger at the deceased, an insidious of guilt, and a toxic mix of self-directed blame and shame that may lead to suicidal thoughts.

Aligned with previous research (Castellano, 2012), this peer support confers reciprocal benefit to the peers who lead this exercise and those who participate. While this exercise may be deployed in other contexts – for instance, through a group formed within the VA – it was originally designed for use in circles of warriors who trust each other. In most cases, they have served in the same units and have become “family” to each other. These simple, very inexpensive tools for developing insight have been game-changing in helping those I serve to transform the pain of their loss into a powerful form of post-traumatic growth.
Example Exercise.

Materials needed: 5 x 8” notecard and a pen.

Set-up: This tool is especially powerful when deployed in a circle of service members and veterans that trust each other, and trust the facilitator leading this session.

The notecard has these prompts:

REFLECTION: WARRIORS AND GRIEF INSTRUCTIONS: We must walk through “the valley” to experience relief from suffering. Grief is a valley of suffering that we all walk. Try to avoid it, and it will ambush you, repeatedly. This exercise can help clear the fog of mental warfare and help you move through your grief. Write down any insights. We will discuss whatever you want to share after you’ve had this time to reflect.

1.) What emotions are blocking your grief (anger, guilt, shame, fear, etc.)

2.) How is your relationship now with the person you lost?

3.) If they were here, what would you need to say to them to link up with them again in a healthy way? It is OK to acknowledge this – in words, by writing to them, in prayers.

4.) What do you need to be able to grieve – for example, do you need to forgive someone, to acknowledge that you are angry at God, to forgive yourself? (Figuring this out is often the key to releasing you into healing grief).

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OBSERVED OUTCOME

For many in the group, this simple exercise proved to be a powerful release, and a first step towards healing. When Jake was asked, “What emotions are blocking your grief (anger, guilt, shame, fear, etc.)?”, his response was “Shame. I didn’t know he was going through pain that caused him to take his life.” When he was asked, “How is your relationship now with the person you lost?” he replied, “I feel bad about it. It was not as close as it should have been. We got busy with our jobs and we forgot to connect.”

When he was given an opportunity to put his feelings into words, when asked what he would need to say to link up with [his deceased Marine brother] again in a healthy way, he wrote on his card, and then verbally shared this, “I would say I’m sorry. I wish I had been a better friend. You will always be a brother to me. I miss you brother.” Finally, when asked what he is needing to be able to grieve, he said, “I need to forgive myself! He wouldn’t want me to hurt like this.”

The power of this intervention was felt throughout the group, in the words written on cards and then spoken into the room. Using a notecard and giving time and space for written reflection before any discussion takes the pressure off and creates the conditions for insight. For many of the warriors, it allowed them to “break the seal” on exploring the complicated feelings and emotions they were having in response to the suicide of their fellow Marine. This exercise can ignite a powerful healing journey, when done in an environment that is safe, and with others that are trusted.

LIMITATIONS

No single approach works for all populations or individuals. This tool is a culturally adapted approach to supporting warriors in their grief that has been directly informed by warriors with lived experience. This approach has been successfully deployed in groups of warriors who have served in the same unit. As such, those brothers and sisters that have been lost to suicide are known to all within that circle. This writer is not recommending applying this approach in a blanket manner. Readers must use discernment to determine whether this tool may be helpful within the context of those they hope to support.


Springer, S., 2020; WARRIOR: How to Support Those Who Protect Us.


The goal of this publication is to provide the reader with some tangible examples of how to apply a public health approach to suicide prevention. Moving away from a strictly clinical response, or a solely community-based response to suicide prevention, requires the integration of different efforts to address the many complex and interdependent factors that may lead to suicide in the military affiliated population.

The strategies required to counteract suicide in this population are as complicated as the subject of suicide itself. The examples provided in these case studies show how organizations may apply the concepts of increasing protective factors while reducing risk factors in order to address suicide. Most importantly, everyone who interacts with or supports members of the military affiliated population has a role to play in reducing suicide. It is the responsibility of the mental health provider, local lawmakers, education providers…anyone and everyone in a community has a role to play when it comes to stopping suicide in the military affiliated population.

Those who volunteered to serve our nation, and those who care for them, have sacrificed much on behalf of the country and the people that they serve. The pride and honor that most service members associate with their military service is significant. Service in the military is also inherently dangerous; it is physically and psychologically demanding, both during the course of typical military service and during combat, peacekeeping, or operational deployments. As a nation, we must recognize that collectively and individually we have a responsibility to support those who served, just as they have supported us through their service.

No single individual or organization can stop suicide in the military affiliated population. Collectively, however, we can create an environment in which members of this population are connected, economically stable, and aware of the potential for suicidal thoughts in order to avoid a suicidal crisis. If a crisis does occur, however, we can collectively ensure that the crisis is not fatal by providing access to appropriate care, reducing access to lethal means to those in crisis, and providing support to those who are impacted by suicide.

Collectively, we can make a difference. Together, we can save lives.
The editors would like to acknowledge the contributions of all who participated in the development of this project. The members of the Military and Veteran Suicide Prevention Task Force, as commissioned by the Public Health Committee of the American Association for Suicidology, have generously provided their time and expertise in developing this project. The Public Health Committee, chaired by Dr. Bruce Crow, was instrumental in providing the sponsorship for this project, and Dr. Melissa Brown for her vision in establishing the Task Force.

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Colleen Creighton, AAS Executive Director
Dr. Jonathan Singer, AAS President

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