

PREVENTION OF SUICIDAL BEHAVIOUR AMONG ARMY PERSONNEL: A QUALITATIVE STUDY

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Abstract

Objectives: To examine the context of suicidal behaviour among soldiers in the United Kingdom and identify factors that could reduce the risk of such behaviour.

Method: A series of in-depth interviews with service providers involved in treating soldiers following deliberate self harm. Their responses were compared with those of a small sub-sample of soldiers who presented to Army medical services following self harm.

Results: We interviewed 21 service providers with a range of experience and professional backgrounds and 10 soldiers. Service providers told us that the rarity of suicide among soldiers together with lower levels of mental illness amongst those who end their lives made suicide prevention in the Army a difficult task. However they highlighted concerns about recruitment and retention of young soldiers, and stated that stigmatisation of mental illness in the Army sometimes prevented those with suicidal ideation seeking help. They also highlighted the role of alcohol use in precipitating self-harm. Soldiers who had self-harmed told us that they struggled to balance the demands of work and family life and described harming themselves impulsively often while intoxicated with alcohol. Soldiers look to sources of support outside the Army, and see commanding officers, rather than healthcare professionals, as helping resolve their problems. Neither service providers nor soldiers mentioned helplines and other 'independent' sources of confidential advice and support which are available to soldiers serving with the British Army.

Conclusion: Our findings highlight problems associated with efforts to reduce suicide among soldiers but suggest that these should focus continuing to try to reduce stigmatisation of mental distress and specifically on the role of commanding officers. Greater efforts should also be made to publicise existing sources of help and reduce levels of alcohol misuse.

Introduction

Levels of suicide among military personnel are generally lower than among the general public. Despite this, it is estimated that there were 672 suicides among members of British armed forces between 1984 and 2006 and that the rate of suicide among male soldiers aged 16 to 20 during this period was 50% higher than that in the general population [1].

Risk factors for suicide among soldiers have been explored using psychological autopsy studies [2]. Such studies have demonstrated that as many as half of suicides by soldiers involve firearms; that mental disorder is more prevalent among soldiers that commit suicide than those that do not; and that alcohol is often consumed prior to the incident [3,4]. Data collected retrospectively are inevitably limited to those obtained from routine records and other secondary sources. While they can help to quantify the strength of association between risk factors and suicide they are not able to provide a complete picture of the context in which suicidal behaviour occurs.

In civilian settings, qualitative research methods have been used to deepen our understanding of the aetiology of suicidal behaviour and help shape strategies for suicide prevention [5, 6]. Healthcare professionals who are involved in the assessment and treatment of people following episodes of suicidal behaviour are particularly well

placed to identify factors which give rise to suicidal behaviour and interventions that may help to prevent suicide [7].

Concerns about suicidal behaviour among soldiers have recently increased following a number of high profile deaths among military personnel [8]. In the light of these concerns we set out to examine factors that may be important in the aetiology of suicidal behaviour among soldiers and to try to identify steps that might be taken to prevent suicidal behaviour among soldiers. We also sought to explore the extent and type of help seeking behaviour prior to and following an episode of self-harm and consider factors that promote and inhibit contact with support services during this period.

Methods

The Army provides mental health services for soldiers based in the UK via nine Departments of Community Mental Health (DCMH). In collaboration with Army personnel we identified a 'link worker' at each of the nine DCMHs who we asked to help us collect data from service providers at each site. We set out to interview at least two healthcare professionals involved in the management of soldiers who self-harm at each of the DCMHs. We sought to involve those with a range of different professional backgrounds or levels of experience. Data were collected using a topic guide that was based on a review of previous research on suicidal behaviour in civilian and military settings and in consultation with a project advisory group. The topic guide comprised a series of closed questions on the person's professional background followed by open-ended questions on:

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- Factors that predispose and precipitate suicidal behaviour among soldiers;
- Information on methods used for deliberate self-harm;
- The extent and type of help seeking behaviour prior to and following an episode of deliberate self-harm; and
- Factors that promote and hinder contact with support services during this period.

Interviews lasted between 45 and 60 minutes, were conducted in private and were recorded on an audio digital recorder. Verbatim transcripts were then made of all recordings.

Interviews with soldiers

In order to examine the validity of data collected from service providers we set out to collect data from a sub-sample of soldiers who had been treated by staff at DCMHs following an episode of deliberate self-harm. These interviews were conducted by link workers. Each link worker was invited to attend a one-day training session which provided a general introduction to the aims of the study, and a detailed description of how to recruit participants and collect qualitative data from them using a semi-structured topic guide designed by the study team. The topic guide reflected the structure of that used for interviews with service providers and was designed to explore the study aims. Audio digital recordings of study interviews were then sent to Imperial College for data analysis. Participation in the study was restricted to those willing to provide written informed consent. Ethical committee approval was obtained prior to the start of data collection.

Data analysis

Interviews with service providers and soldiers were analysed thematically by hand. A framework was developed using analytic induction from early interviews and iteratively added to and amended as further data emerged [9]. The coding framework was derived from the aims of the study and topic guides and developed to ensure that all aspects of the data were included. Data was pasted into the coding framework, and triangulation of data from services providers and soldiers was noted. Validation of the analytic approach was carried out on an ongoing basis through individual and group supervision.

Results

Interviews with service providers

Twenty one interviews with service providers were completed comprising 12 Community Psychiatric Nurses, 6 Medical Officers, 2 psychiatrists and a social worker. Sixteen were serving in the Army (from Corporal to Colonel) and 5 were civilians, with between 2 and 25 years experience of working in health care services. Service providers gave a consistent account of the context in which suicidal behaviour arose: young male recruits who experienced stress or crisis in the context of feeling unhappy about being in the Army. We were told that incidents were impulsive with low levels of suicidal intent. Participants told us that soldiers, and particularly young male soldiers are 'not good at seeking help' and that the culture of the Army exacerbated this problem.

"... a young, probably male, soldier who realized soon after enlisting that he had made a mistake, was unhappy, expressed that unhappiness but was frustrated in his attempts to leave. Continued to be unhappy, continued to be reassured that he would settle into it, that things would improve and then eventually became so desperate that that was the only thing he could think of to express his unhappiness further"

(Community Psychiatric Nurse)

Participants stated that alcohol use was strongly associated with self-harming behaviour, and several implied that the incidence of self-harm would be lowered if soldiers drank less.

"Almost all the people I see who take an overdose are people who have gone out and got drunk"

(Community Psychiatric Nurse)

Service providers told us that soldiers used alcohol, violence, physical activity, avoidance and a minority used self-harm as a means of coping with distress. We were told that some incidents of suicidal behaviour were a 'last resort' used to influence the chain of command to allow them to leave the Army. For others, they were evidence of long-term failures of coping strategies. Other precipitants that were frequently mentioned included relationship or work problems, an imminent return to unit following leave, and distance from family. In the latter context service providers told us that self-harm may be used by soldiers to try to increase the amount of contact they are able to have with their family.

Participants reported that the most commonly used method for self-harm was self-poisoning. This was usually with non-prescription analgesics such as ibuprofen and paracetamol. Several participants commented that these drugs are very easy to obtain as soft-tissue injuries are common amongst soldiers. The other main method for self-harm was self-cutting; we were told that wounds were generally superficial. In completed suicides, hanging was considered to be a common method. The use of firearms in self-harm was reported to be very rare.

Participants generally described feeling sympathetic towards soldiers who self-harm, and that they felt they provided a non-judgemental service. It was considered that punishment was more likely to come from the soldier's peers than from higher ranking officers, and in the form of stigma, ostracism and occasional bullying.

"Well, a lot of them I would say get stigmatised, called names"

(Consultant Psychiatrist)

"If their peers get to know about it then it can generate anger and serve to stigmatise them, which is a form of punishment, but in terms of getting them a beating or something I've not heard of that but I wouldn't necessarily get to hear of it"

(Community Psychiatric Nurse)

While all clinical information is considered confidential, several informants said there is an overriding occupational component to medical, nursing and welfare support in the Army, as it is philosophically linked to the maintenance of a fighting force. This reduces the priority attached to confidentiality. Although efforts are made to maximise confidentiality, soldiers can not hide the fact they have an appointment with a Community Psychiatric Nurse as appointment details may be put in Routine Standing Orders, information that all soldiers read everyday.

Suggestions made by service providers for reducing the incidence of suicidal behaviour are listed in Table 1. Foremost among these were issues of recruitment and retention. Participants told us that pressures to retain soldiers within armed services combined with Terms of Service under which soldiers serve meant that some felt 'trapped', and that this in turn made self-harm more likely. While participants differed in their opinion about the adequacy of welfare services, there was a general consensus that reduction of stigma associated with mental distress was a constant and necessary challenge for Army medical and welfare services.

Responses of service providers

To change soldier's terms of service - to make it easier for those who are set on leaving the Army to leave.

"You have an 18 year old lad who is missing home, maybe has a history of self-harm and his girl friend has left him, at least he knows that if he wants to leave he's got that get out. And it maybe in some circumstances it could be quicker. There needs to be more flexibility in the system to help these people" (Community Psychiatric Nurse)

"You don't want someone who is that grossly unhappy in the organisation, they affect the dynamic of the unit, and...they won't perform well anyway, so why keep them?" (Community Psychiatric Nurse)

To make mental health services less stigmatising by raising the profile of mental health at a unit level, and integrating CPNs into medical centres.

"Give mental health a more regimental flavour" (Community Psychiatric Nurse)

"in an ideal world you would have a CPN based at every Medical Centre so that referral would be facilitated and less stigmatised. It's a lot easier for someone to say "I have to go to the medical centre" and when the commander asks why then they can say, "well that's between me and the doc" (Consultant Psychiatrist)

To avoid recruitment of people unsuited to army life into the Army, and make it easier for trainees to leave prior to completion of training, or to transfer to different career pathways.

"the guy [at the careers office] will do everything in his power to recruit you to those corps. That's why we have loads of unhappy soldiers; they are in the wrong jobs" (Community Psychiatric Nurse)

To improve communication between agencies working for the welfare of soldiers and senior officers, to avoid situations where care plans are not implemented by a soldier's Commanding Officer.

"I don't think that communication takes place as much as it should. Therefore it is often left to us to surprise the CO that we are seeing one of his soldiers" (Community Psychiatric Nurse)

"Sometimes they do not appear because the sergeant has cancelled the appointment because they were on exercise, or similar excuse. That drives me mad" (Community Psychiatric Nurse)

Tackling stigma associated with help seeking.

"That's the way the 'big Army' perceives somebody when they come to us for help, they are seen as weak" (Community Psychiatric Nurse)

Table 1. Factors that may reduce the incidence of suicidal behaviour among soldiers: responses of 21 service providers

Interviews with soldiers

Eight of nine possible link workers attended the training day. Link workers attempted to collect data from 14 soldiers who presented to DCMHs following self harm, of whom 10 (71%) consented to take part in the study. All soldiers were male, their ages ranged from 18 to 29 (median - 22 years). They had served in the Army for between 1.5 to 9 years prior to the index episode of deliberate self-harm. Six were under 18 when they joined the Army (range - 16 to 25). Four episodes involved overdose, 4 deliberate self-injury and 2 both overdose and self-injury. All but one overdose involved analgesics. Incidents of self injury ranged from cuts to wrist to fracture of the forearm. Six had a past history of self harm and 6 reported being intoxicated with alcohol at the time of the incident. When asked about what motivated them to harm themselves: one stated that they had wanted to die, five that they had not wanted to die, and four that they wanted to hurt themselves and would not have cared if they had died following the incident.

When asked about factors that led to self harm, most soldiers described tensions between work and family life. Soldiers said that they were not free to address or even influence marital problems while spending long periods away from home. This left them feeling powerless to resolve personal or domestic difficulties. Several soldiers commented that absence from home life had contributed to the breakdown of domestic relationships. Two soldiers told us that they had never felt happy in the Army. One of these stated that he had thought self-harming could speed his leaving the Army.

Regarding management following self harm, three soldiers felt the response of the Army to the incident had been supportive, while four told us they had not been treated sympathetically. Soldiers suggested that attitudes and responses to self-harming or to mental disorders were dependent on the culture

encouraged by the Commanding Officer. Five of the nine soldiers interviewed felt that their Army records and careers had been blighted by the self-harming incident. When asked about changes that could be made to reduce the incidence of suicidal behaviour soldiers had few spontaneous suggestions. Responses of three soldiers, following prompts are listed in Table 2.

Responses of soldiers

A more supportive stance from Senior Officers

'Listen to them. The way it [relationships with Senior Officers] works you have to keep asking and asking for it. And they keep fobbing you off.' (Soldier 5)

Access to confidential advice and support 24 hours a day

'Having someone I could sit down with and talk all the problems through.' (Soldier 4)

'I think there should be someone there 24/7 to speak to someone if they need to.' (Soldier 3)

Access to peer-support (from soldiers who had experienced and coped with emotional problems in the Army)

'It would be good to talk to other soldiers who've gone through the same, a support group.' (Soldier 10)

Table 2. Factors that may reduce the incidence of suicidal behaviour among soldiers: responses of 10 soldiers

Discussion

In depth interviews with staff involved the management of soldiers who self harm highlighted several issues thought to be important in the aetiology and prevention of suicidal behaviour among soldiers. Service providers told us that incidents of self harm were generally impulsive involving little planning and unlikely to be preceded by contact with medical or welfare

services. This account was supported by data collected from our sub-sample of soldiers who had self harmed. Staff told us that alcohol use often precipitated self harm and over half the soldiers we interviewed were intoxicated with alcohol when incidents took place. Both groups also highlighted the problem of stigmatisation of mental illness within the Army, and told us that methods needed to be found to make access to mental health and welfare services more acceptable to all ranks. Concerns were raised about the response that Commanding Officers have towards self harm. Soldiers told us that they look to their Officers rather than to support services to help them find solutions to their problems.

While we were able to complete collection of data from a purposive sample of service providers we wanted to interview, we were only able to collect data from 10 soldiers who self harmed during the 10 month study period. 71% of soldiers who were approached to take part in the study agreed to participate. While the incidence of DSH among soldiers is far higher than this, service providers told us that most soldiers who self-harm are treated in civilian settings, and may actively avoid the attention of staff at DCMHs. We do not know if our findings can be generalised to soldiers who do not make contact with DCMHs following an episode of self-harm. Another limitation of an interview based study is the possibility of response bias, especially in the responses of soldiers who were interviewed by trained Army personnel. We believe that by emphasising the independence of the research team we were able to persuade most participants to speak candidly about their experiences. Indeed several soldiers and service providers were critical of aspects of Army life. Finally, most of the information that we collected related to non-fatal deliberate self-harm. While service providers were also asked about suicide, most said that they had had very little first-hand knowledge of such incidents. Research conducted in civilian settings has demonstrated that risk factors for suicide and non-fatal self harm have much in common, however important differences do exist. For instance 35% of suicides in the Army involve use of guns [10], and none of the episodes of self harm we enquired about involved this method. Efforts to reduce access to means of self harm provide an important means of reducing suicide rates [11] and methods used in suicides in the Army require further investigation.

Service providers made a series of suggestions for changes in policy and practice aimed at preventing suicidal behaviour among soldiers. Foremost among these were issues of recruitment and retention. We were told that pressures placed on soldiers to stick with the Army during their basic training meant that some people unsuited to Army life felt trapped within the service. Staff told us that not all those that started basic training were suited to being soldiers, and that by ensuring that those who felt they had made a mistake were allowed to leave, the incidence of self-harm in the Army could be reduced. These views were supported by accounts of recruitment given by soldiers, some of whom described being persuaded to join the Army during a time of uncertainty when they may not have given the matter sufficient informed consideration. Terms of service specifying that once a soldier has completed his/her basic training, s/he cannot leave the Army for a four-year period were also highlighted as a factor which contributed to soldiers' self-harming. While changes to terms and conditions for soldiers may have important wider implications for the Army, healthcare professionals involved in the assessment of soldiers who self-harm told us that soldiers who consistently expressed the view that they wanted to leave the Army should be provided with a means of doing so.

Efforts made to prevent suicide among members of the US Air Force focussed on promoting mental health awareness throughout the service [12]. Soldiers told us that they look to

their Officers rather than to those providing welfare services for help in dealing with emotional distress. Given low levels of help seeking prior to self harm, our findings support the notion that efforts aimed at preventing suicidal behaviour need to involve a whole Army approach to mental health awareness.

The strong link between alcohol misuse and self harm among soldiers is noteworthy. This association was also found in a retrospective audit of case notes of Naval personnel who were treated following deliberate self harm treated, which reported that alcohol misuse was associated with 70 (66%) of 107 episodes of self harm [13]. High levels of alcohol misuse have also been found in retrospective studies of suicide among military personnel [14]. People who have successfully stopped self harming have highlighted resolution of alcohol problems as an important step in their recovery [6]. The efficacy of brief interventions aimed at helping people who misuse alcohol reduce their level of consumption has been established [15, 16], and efforts to tackle high levels of alcohol misuse among soldiers deserve further consideration. However data collected from service providers suggested that this may not be an easy task. They told us that alcohol consumption was one of the methods that soldiers often used to try to help them cope with emotional problems and previous research has also emphasised the central role that alcohol plays in the social fabric of Army life [17].

Given requests of soldiers for access to support at times of crisis we were surprised that none of the soldiers or service providers who participated in the study mentioned one of the 24hr help-lines that are provided for military personnel. Providing people with such information is commonplace in civilian settings [18] and further steps should be taken to publicise such resources to both soldiers and healthcare professionals involved in the management of soldiers who self-harm.

Following completion of this study and discussion of study findings, the Army Medical Directorate issued revised and improved guidance to unit medical officers on how to manage self-harm cases. This makes it clear that appointments with mental health services are not cancelled for operational or training reasons and that specifies steps that should be taken to ensure confidentiality. Revisions to the Army's Substance Misuse Policy paper has taken account of the recommendations to improve awareness of the risks associated with alcohol misuse and the link to DSH, and will shortly introduce an Early Intervention for Alcohol Misuse programme.

The Army's continuing commitment to recruiting young men and women as soldiers, and to providing a source of employment and training to people from diverse backgrounds requires the service to ensure that efforts are made to provide high quality welfare services and ensure that those who self-harm receive appropriate treatment. Our findings suggest that greater efforts need to be made to provide and publicise sources of independent and confidential advice and support. Challenging attitudes to mental health problems and their management in the Army will be a difficult task, but efforts that are being made to improve welfare services, inform Army personnel about mental health issues and mainstream mental health services within existing healthcare are an important part of continuing efforts that are being made to prevent suicidal behavior in the Army.

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