Recognizing and Responding to Suicide Risk with Veterans in Non-Clinical Settings and Communities of Faith: Using the 4-E's Checklist

Family and Community Ministries, 25(1), 68-80

CHRISTIAN LEADERS SUMMARY

M. David Rudd

Many veterans report significant problems readjusting to civilian life and often feel isolated and without adequate support. Surprisingly large numbers are struggling with persistent emotional distress and suicide risk. Veterans identified church attendance as the single most important variable to help ease a problematic transition. The social connections and unique support provided by clergy and religious institutions are essential for returning veterans. Clergy are uniquely positioned to hear from a veteran at risk for suicide. It is likely that clergy will be faced with opportunities to intervene and assist in facilitating appropriate clinical intervention and ongoing treatment for these veterans.

Suicide warning signs wallet cards are readily available. It is critical to be aware of several particularly toxic warning signs: sleep disturbance, burdensomeness, and unmanageable anxiety and agitation. The 4-E's checklist offers steps to follow to engage and intervene with a veteran at risk for suicide.

The first step is to engage the individual. Ask the individual to tell his or her story. It is important to reinforce that in the context of the individual's current stressors, it is not "unusual" to have thoughts of suicide. Suicidal individuals tend not to recognize that "a part" of who they are very much wants to live. Label and reinforce this ambivalence. Do not engage in a discussion about the individual's right to die by suicide as doing so can create an unnecessary power struggle. Identify a common goal for eventual treatment (e.g., reduce emotional suffering, improve day to day living, and find a more fulfilling life).

The second step is to evaluate risk. It is important to talk about suicide in a matter-of-fact manner. Ask questions about the nature of current suicidal thinking. Identify the presence of active suicide intent. Identify the presence of any suicide-related behaviors, including preparation and rehearsal (e.g., writing letters to loved ones, developing financial plans for surviving family, or going through the steps needed to make a suicide attempt). Identify any access to method(s).

The third step is to educate the individual and prepare him or her for clinical care. Effective models describe suicidality as a function of limited individual skills. Treatment will help build the necessary skill set to effectively relieve the emotional suffering.

The final step is to equip the individual in crisis for clinical care by generating a safety plan and facilitating a referral. Safety plans need to be written on a card the individual can carry with him or her and should include the following points: a phone number to call in crisis (1-800-273-TALK can be used if there is not a local number available), a commitment to remove access to the suicide method(s), reasons for living, a supportive contact with a phone number to call, and a referral to a clinical provider (the name of the provider and a day and time for an appointment). Clergy members need to have a referral list handy and already prepared (with an identified set of clinicians willing to take emergency referrals).