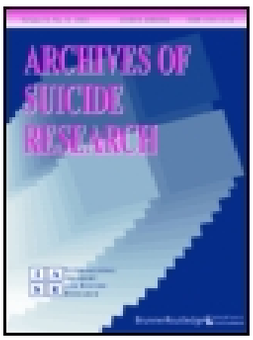

Archives of Suicide Research

ISSN: 1381-1118 (Print) 1543-6136 (Online) Journal homepage: http://www.tandfonline.com/loi/usui20

Spirituality, Religion, and Suicidality Among Veterans: A Qualitative Study

Jaimie Lusk, Steven K. Dobscha, Marek Kopacz, Mary Frances Ritchie & Sarah Ono

To cite this article: Jaimie Lusk, Steven K. Dobscha, Marek Kopacz, Mary Frances Ritchie & Sarah Ono (2017): Spirituality, Religion, and Suicidality Among Veterans: A Qualitative Study, Archives of Suicide Research, DOI: 10.1080/13811118.2017.1340856

To link to this article: http://dx.doi.org/10.1080/13811118.2017.1340856

Accepted author version posted online: 21 Jun 2017.
Published online: 21 Jun 2017.

Archives of Suicide Research, 0:1–16, 2017

ISSN: 1381-1118 print/1543-6136 online
DOI: 10.1080/13811118.2017.1340856

Routledge
Taylor & Francis Group

Spirituality, Religion, and Suicidality Among Veterans: A Qualitative Study

Jaimie Lusk, Steven K. Dobscha, Marek Kopacz, Mary Frances Ritchie, and Sarah Ono

This qualitative study explores the relationship between veterans' spirituality/religion and suicide ideation and attempts. Qualitative semi-structured interviews were conducted with 30 veterans who either endorsed chronic suicidal ideation or had made suicide attempt(s). Interviews explored the bi-directional relationship between spirituality/religion (e.g., beliefs, practices, and experiences), and suicide ideation and behaviors. Interviews were analyzed using thematic analysis. Veterans' responses indicate that spirituality/religion can discourage or permit suicidal ideation, help in coping with ideation, and facilitate meaning making and coping in the presence of self-perceived suffering. Veterans who survived a suicide attempt explored the impact of their spirituality/religion on their recovery. Findings highlight a complex and diverse relationship between spirituality/religion and suicidality. These findings may inform further research on treatment strategies that assess the function of spirituality/religion, and incorporate protective aspects of spirituality/religion into mental health treatment.

Keywords qualitative, religion, spirituality, suicidality, veterans

INTRODUCTION

Different groups of veterans have been recognized as being at increased risk for suicide compared to their civilian counterparts (U.S. Department of Veterans' Affairs, Office of Suicide Prevention, 2016). In a comprehensive Department of Veterans Affairs (VA) Office of Suicide Prevention analysis of suicides from 2001–2014, veterans accounted for 18% of all suicide deaths among U.S. adults, despite representing 8.5% of the U.S. adult population. Since 2001, U.S. adult civilian suicides increased 23%, while veteran suicides increased 32% in the same time period, with increases in suicide rates particularly evident among those who do not use Veterans Health Administration (VHA) services and women (ibid). These findings support the need for a greater understanding of factors contributing to suicidality in the veteran population.

While spirituality and religion are identified as important aspects of wellbeing, their role in understanding suicidality is understudied. Spiritual/religious beliefs, practices, and experiences may act as

protective or risk factors for suicide (Colucci, Hons & Martin, 2008). In a meta-analysis evaluating 2,339 participants who died by suicide, and 5,252 comparison participants, religiosity was shown to have an overall significant protective effect. However, sub-analysis revealed significant variation cross-culturally and intergenerationally (Wu, Wang, & Jia, 2015). Church attendance has been associated with less suicidal ideation and fewer attempts (Colucci, Hons & Martin, 2008; Koenig, King, & Carson, 2012). In contrast, religious doubts, conflicts with church members and church beliefs, as well as fear of God's punishment are associated with poorer mental health, with possible implications for suicidality (Pargament et al., 2003). Such mixed observations underscore the need for developing a fuller understanding of the potential impact of spirituality and religion on suicidality.

Based on emerging research, the spiritual/religious experiences of veterans at increased risk for suicide can easily be described as complex. Veterans with suicidal ideation were found to have a significantly lower mean participation in public and private religious practices compared to those without ideation (Kopacz et al., 2016). In veterans being treated for PTSD, difficulties forgiving and spiritual struggles were associated with suicide ideation, while participation in a spiritual community and spiritual practices were associated with decreased suicidal ideation (Kopacz, Currier, Drescher, & Pigeon, 2016). Difficulty forgiving oneself and others, as well as negative religious coping, have been correlated with depression, anxiety, and PTSD symptom severity (Witvliet, Phipps, Feldman, & Beckham, 2004). Similarly, veterans affected by PTSD have been shown to be more motivated to seek treatment to address weakened religious faith and guilt, than to address PTSD symptom alleviation (Fontana & Rosenheck, 2004). A relationship between moral injury and suicide ideation has also been found (Bryan, Morrow, Etienne, & Ray-Sannerud, 2013; Bryan, Bryan, Morrow, Etienne, & Ray-Sannerud, 2014).

Accordingly, this qualitative study aims to examine the spiritual and/or religious struggles present in a sample of veterans recognized as being at high risk of suicide, who received VA health care services. While the literature has clearly identified a spiritual and/or religious component to suicidality in veteran populations, no published qualitative data exist to either conceptualize or describe these experiences. Effective support for veterans experiencing suicide ideation is essential to the VA mission of supporting veterans and their health.

METHOD

Participants

Participants were recruited between September 2014 and June 2015 from the outpatient mental health (MH) division of a large VA medical center in the Pacific Northwest. The MH division provides mental health care to approximately 16,000 unique patients each year across a variety of services spanning inpatient care to homelessness programs. Outpatient MH providers were informed of the study through email, fliers, and presentations, and in turn, informed their patients of the study. Eligible veterans were those who had a self-reported history of either significant suicidal ideation or a previous suicide attempt, current engagement in MH treatment, and low acute risk for suicidal intent or suicide attempts. Exclusion criteria were as follows: 1) Veterans with significant cognitive impairments that might interfere with their ability to give informed consent or complete the

interview; 2) Veterans who did not have a current outpatient MH provider; 3) Veterans whose MH provider determined they were not clinically stable enough for interview. Once eligibility was confirmed, the study organizer obtained informed consent prior to participation in a semi-structured interview. Participants were reimbursed $20 for time and travel to the VA for interviews. Approval for this project was granted by the medical center's Institutional Review Board.

Measures

A semi-structured interview guide was developed by the study team based on the limited literature, as well as clinical experience of the investigators. The interview was designed to encourage participants to tell their stories in their own words. Questions explored both the role of spirituality and/or religion in contemplating and coping with suicide ideation, as well as how suicide ideation and attempts affected or altered one's sense of spirituality and/or religiosity. Where appropriate, follow-up questions were asked to expand and clarify responses (Chwalisz, Shah, & Hand, 2008). Interviews were conducted by one of the investigators who works as a clinician at the data collection site and had prior qualitative research experience. Interviews lasted from 20 to 96 minutes (mean 50 minutes). All interviews were digitally recorded and transcribed for accuracy. As data were collected we modified the interview guide iteratively to make sure that areas needing clarification were more adequately addressed, and also used a mirroring back of answers to be sure that participants were being understood as intended. See Appendix for full interview guide.

Selected quantitative measures were collected at the time of the interview to help describe the sample. The Beck Scale for Suicidal Ideation (BSS) is a 21-item scale that assesses the severity of suicidal ideation within the previous week. Items 1–19 measure suicidal ideation with each item consisting of three statements ordered in increasing severity (0 = *least severe* to 2 = *most severe*), with score range from 0 to 38. A higher score indicates higher suicidal ideation and higher possible intent. Items 20 and 21 assess past suicide attempts. High levels of internal reliability and concurrent validity have been reported for the BSS (Beck & Steer, 1991). The Meaning in Life Questionnaire (MLQ) is a 10-item measure of two subscales: (1) presence of meaning and (2) search for meaning. Respondents rate each statement on a Likert scale (1 = *absolutely untrue* and 7 = *absolutely true*). The MLQ has shown good internal consistency, temporal stability, and discriminant and convergent validity (Steger, Frazier, Oishi, & Kaler, 2006). The *Brief RCOPE* is a 14-item measure where individuals indicate the extent they use religious coping, and is the most commonly used functional measure of spirituality/religion (Pargament, Feuille, & Burdzy, 2011). Two distinctive subscales, positive religious coping and negative religious coping, contain 7 items rated on a Likert scale (1 = *not at all* and 4 = *a great deal*) (Pargament, Koenig, & Perez, 2000).

Analysis

Suicide prevention remains one of the highest priorities across VA. The findings of this study stand to inform VA suicide prevention efforts and provide a greater understanding of the intersection between spiritual and/or religious beliefs, practices, and experiences, as they relate to suicidality. The need for "increased awareness and integration of spirituality in clinical care, including the assessment and management of risk for suicide" was recently underscored in a Memorandum of Understanding signed between the VA National Chaplain Center and VA Suicide

TABLE 1. **Steps for Collaborative Analysis**

1) Both investigators read through transcripts several times, highlighting noteworthy quotations and paying special attention to participants' stories.
2) Investigators met regularly to discuss frequent and salient themes that emerged from the interviews.
3) A preliminary codebook was generated. Investigators independently coded the first five interviews.
4) Investigators then met again, and finalized a coding sheet. Conceptual memos were used to track emerging themes.
5) One of the investigators coded transcripts using Atlas.ti qualitative software.
6) The investigators reconvened to share relevant quotes, focusing on themes of impact of spirituality/religion on suicidality, and identifying emerging themes.

Prevention Office (Department of Veterans Affairs, 2016, not publicly available). To this end, a qualitative methodology was deemed to be most appropriate for this exploratory study.

Qualitative studies have been recommended in the field of suicidology to better understand suicide risk (Hjelmeland & Knizek, 2010). Qualitative methodology provides a contextual understanding of the relationship between spirituality and/or religion and suicidality (Colucci, Hons & Martin, 2008). As Hall, Meador, and Koenig (2008) note, quantitative results related to spirituality and/or religion are difficult to compare, because researchers have operationalized these constructs in a variety of ways. There are currently over 100 psychometric instruments to assess spirituality and religion in the literature, yet no single measure has emerged as a gold standard. In fact, it has been argued "context free" measures of spirituality and religion are neither possible nor useful. The terms, "spirituality" and "religion" are commonly perceived as distinct but overlapping constructs with diverse meanings dependent on the individual (Zinnbauer et al., 1997; Zinnbauer, Pargament, & Scott, 1999). For this reason, care was taken to include both terms throughout the study.

Interviews were analyzed using a qualitative, thematic analysis method. This method seeks to explore experiences, associated meanings, and the context from which meaning is created, without applying a theoretical lens for data interpretation (Braun & Clarke, 2006). Thematic analysis allows researchers to deductively explore pre-existing research questions, as well as inductively identify and explore unanticipated themes.

All interviews were transcribed *verbatim*, after which linguistic "fillers" (e.g., "like," "you know") were removed. Each participant was assigned a letter code not related to their name or to other identifying information. Study team members read transcripts as they were completed and met every 3 months between October 2014 and December 2015 to discuss emerging themes and identify emergent codes. Transcriptions were entered into Atlas.ti®, qualitative data management software to facilitate coding and aid in analysis. The rigor of this study was ensured through collaborative analysis conducted by two investigators (Table 1; Chwalisz et al., 2008). One investigator is a cultural anthropologist who specializes in health services research and qualitative methodology. The second investigator is a full-time mental health clinician on the VA Portland Health Care System's PTSD clinical team. Data analysis involved a six-stage stepwise replication, including individual and collective attending to the unique experiences of participants (Table 1; Chwalisz et al., 2008; Giorgi & Giorgi, 2003). Refinement of

TABLE 2. **Demographic Characteristics of Veteran Participants**

Characteristic	Subtotal ($n = 30$)		%
Age at post-deployment health assessment (Mean age: 53)	30–39:	3	10
	40–54:	13	43
	55–64:	10	33
	65+	4	13
Education	GED/High school diploma:	2	7
	Some college:	14	47
	AA/Technical degree:	6	20
	Bachelor's degree:	4	13
	Advanced degree:	2	7
Gender	Male:	19	63
	Female:	10	33
	Unique gender identity:	1	3
Ethnicity	Hispanic/Latino(a):	3	10
	Asian/Pacific Islander	0	0
	Black/African American:	2	7
	American Indian/Alaska Native:	2	7
	White/Caucasian:	22	73
	Other:	1	3
Years military service (Mean: 5.3)	0–4:	21	70
	4–10:	4	13
	10–20:	4	13
	20+	1	3
Branch of military	Active duty Air Force	5	17
	Active duty Army	12	40
	Army National Guard	1	3
	Active duty Navy	8	27
	Active duty Marine Corps	2	7
	Marine Corps Reserves	1	3
Rank at separation	E1–E4	17	57
	E5–E6	5	17
	E7–E9	1	3
	O1–O10	7	23
Current employment status	Employed full time	2	7
	Reserves	1	3
	Retired	6	20
	Disabled	13	43
	Employed part time	1	3
	Unemployed, not looking for work	4	13
	Looking for work	2	7
	Mean	.66	

(Continued)

TABLE 2. Continued

Characteristic	Subtotal ($n = 30$)		%
Number of service connected MH Diagnosis			
Service connected disability (Mean: 43%)	0%	10	33
	1–30%	4	13
	31–70%	8	27
	71–100%	7	23
Combat Deployment	Yes	11	37
	No	18	60
	Vietnam:	5	45
	Iraq:	1	9
	Afghanistan:	2	18
	Persian Gulf:	3	27
Annual household income	Less than $10,000	6	20
	$10,000–$24,999	13	43
	$25,000–$40,00	7	23
	$40,000–$74,999	3	10
	$75,000 or more	0	0
Relationship status	Single	7	23
	Partnered	2	7
	Married—1st marriage	1	3
	Married—2nd marriage +	2	7
	Divorced _____ (year)	14	47
	Widowed _____ (year)	2	7
	Prefer not to answer	2	7
Religious affiliation	Protestant	10	33
	Catholicism	4	13
	Judaism	2	7
	Muslim/Hindu/Buddhist/Mormon	0	0
	Agnostic/Atheist/None	0	0
	Prefer not to answer	1	3
	Non-Denominational/"Born Again" Other *(Asatru, Pagan, Former Mormon, Vedanta, Taoism/Shintoism, Jehovah Witness)*	2 9	7 30
Frequency of religious meetings	One or more times per week	7	23
	One or more times per month	3	10
	One or more times per year	5	17
	Less than once per year	14	47

themes and organizational structure continued until the investigators achieved consensus on essential themes, concepts and ideas reflected in the data, and no new categories emerged (Creswell, 2006). This informational redundancy indicates sample size

was sufficient (Onwuegbuzie & Leech, 2007).

Description of the Sample

A total of $n = 30$ veteran participants were recruited for this study. Respondents were aged 36–72 years (mean age of 53, SD = 10.15). Respondents were primarily male (63%), Caucasian (73%), with 0–4 years of military service (70%). Veterans self-identified as Protestant (33%) Catholic (13%), Jewish (7%), prefer not to answer (10%) and Other (30%; including "Born Again," Asatru, Pagan, Mormon, Vedanta, Taoism/Shintoism, Jehovah Witness). Table 2 shows demographic information.

Mean score on the Beck Scale for Suicidal Ideation was 11.1 (SD = 8.7). A total of $n = 10$ (33%) self-reported never having attempted suicide, $n = 4$ (13%) reported one lifetime attempt, and $n = 16$ (57%) reported two or more lifetime attempts. The percentage of participants reporting some level of suicidal ideation in the past week (i.e., scores greater than 0 on the BSS) was high ($n = 27$, 90%). The mean score on the Presence of Meaning subscale was 20.9 (SD = 5.5), indicating that overall individuals in this study did not feel his or her life has valued meaning or purpose (Steger et al., 2006). The mean score on the search for meaning subscale was 25.9 (SD = 6.3), indicating high distress, depression, neuroticism and rumination about purpose/meaning of life (ibid). Using the Brief RCOPE, the mean positive religious coping subscale score was moderate at 18.79 (SD = 6.9) (K.I. Pargament, personal communication regarding interpretation of result, October 28, 2016). The mean negative religious coping subscale score was relatively high at 12.66 (SD = 5.4) (Pargament, 2016). Of note, four veterans communicated that they found the use of "God" in this measure problematic, as they did not believe in existence of a higher power.

RESULTS

The themes identified in the course of this study include veterans' spiritual/religious beliefs discouraging or permitting suicide behaviors, veterans' experience of spirituality/religion helping them make meaning of, or cope with suffering, and the role of spirituality/religion in surviving a suicide attempt and moving forward.

Spiritual/Religious Beliefs Discouraging Suicide Behaviors

Spiritual/religious beliefs discouraging suicide were described by $n = 10$ respondents. For example, one veteran explained that it disrespected God; "committing suicide is like slapping God in the face and saying, 'Here, I don't want your life after all.'" Others cited violations of religious tenants; "It's contrary to Jewish law to commit suicide—not killing yourself is a mitzvah … [suicide is] the equivalent to committing murder." Of the ten veterans whose beliefs discouraged suicide, six discussed fear of spiritual/religious consequences. For instance, four of the ten veterans stated they would go to hell if they died by suicide, and one remarked, "I believe in reincarnation, and that there are certain things that we're here to experience and to work through. To commit suicide would create unfinished business, and I would have to do it all over again." Another veteran explained that killing herself prevented her from further experience, "Your body is your temple. And without that temple, you can't do the things that you want to do. You can't work through the things you want to work through. You can't see the Higher Being. … You can't see the things that you want to see spiritually."

Spiritual/Religious Beliefs Permitting Suicide Behaviors

Several veterans in this study ($n = 10$) explained that suicide was permitted in the context of their spirituality/religion. Of these ten veterans, three explained that there was no difference between this life and afterlife; "What's the difference between life and death? There isn't any, because you have a body here, you'll have a body there, because of the resurrection. You have pains and troubles here, you will have pains and troubles there. You will have joy here, and you will have joy there. It's just the . . . . continuation of a journey." Another described suicide as altruism, "When [Scripture] was written there weren't very many people on the planet, and we needed every one of them. And now we are over-populated and perhaps it wouldn't be a sin; perhaps if the scriptures were written today it might be considered, 'Oh, good for you.'" Some veterans ($n = 6$) believed the afterlife would be significantly better than this life. One veteran reported, "God puts in my head, 'you need to do what's right for you this time. … If you want to die, just go and do it'… I love God so much and I don't want anything to do with this world no more."

Spiritual/Religious Beliefs That Both Discourage and Permit Suicide Behaviors

Spiritual/religious beliefs both discouraged and permitted suicide were noted by two respondents. One veteran explained that if he died by suicide, "My (deceased) wife would be very pissed at me," but that he wanted to die to be with his deceased wife. Another veteran explained that while she feared that if she killed herself she would have to repeat life all over again, she felt her Higher Power saying, "yeah, if you really feel like that's what you need to do, I'm OK with that." Some veterans ($n = 5$) explained that while they believed suicide was wrong, they also believed God would understand; "What kind of loving God doesn't forgive [suicide]?"

Spiritual Beliefs That Help Cope with Suicidal Ideation

Spiritual/religious beliefs that decreased suicide ideation were discussed by seven respondents, who reported how such beliefs helped them think more optimistically and hopefully. One of these veterans understood suicidal ideation as a spiritual force to be resisted; "I think I'll always be suicidal. I think it'll always enter into my mind. I just say, 'No, I'm not going there. … Satan wants to take us by the hand and take us down that road … the devil is roaming about seeking those who he can slay." Another veteran described balancing suicidal ideation with other perspectives learned from his spiritual practice, "When I have my suicide ideations now, usually you can trace it back to I have become imbalanced somewhere. … I find balance. And the balance is being able to come back where that part of me is accepted, is embraced, but not in control." Another veteran stated, "I think that it's very positive to have a spiritual life. It helps that grounding and the balance. Because if I didn't have it, not only would I be dead, but probably several others would be, too, at my hands. … Spirituality for service members is probably even more important than it is for the average Joe on the street, because you have such a strong influence over here, you really need a strong influence over here to balance. That whole, 'We kill people,' oh, no, 'We pray for people and save people.'" Another veteran explained, "There's ways I can manage my pain. Ways I can manage my moods. I am still important to my spiritual family. I still have things to give them. I still have wisdom I can give my community. I am not useless."

Spirituality/Religion Increasing Suffering

While interview questions were designed to explore spirituality/religion and suicide ideation and attempts more directly, several veterans reported that spirituality/religion increased suffering, and suffering contributed to suicidality. For instance, five veterans described suffering related to failure to live up to spiritual/religious standards. One explained, "I felt like I had sinned so bad … there's this constant, barrage of, 'You're not any good. You've done bad things. You've hurt people.'" Another veteran described feeling judged by God after a suicide attempt, which then contributed to more suicidal ideation. Still another directly attributed rejection from a religious community to a suicide attempt. Suffering related to difficulties participating in spiritual/religious community were discussed by seven participants. Lack of belonging in faith-based communities related to sexual orientation was described by three veterans. Mental health problems contributing to difficulties participating in spiritual/religious communities were described by three respondents. For instance, "Fellowship is important—to be around other believers. But my PTSD makes it challenging. The kind of meetings I go to, people like to pray over people and lay their hands on them, and I freak out when people start putting their hands on me … I can tolerate it for a while, but I am just sitting there being miserable, and I can't hear what they say because my brain's gone somewhere else." Three participants described their faith-based communities themselves as under-resourced or marginalized.

Failing to make sense of suffering through spiritual/religious beliefs was reported by nine participants. For instance, three participants described feeling abandoned by their higher power during trauma, and three veterans discussed an unmet expectation that spirituality/religion would contribute to one's life purpose. One veteran described losing faith after a trauma, "I thought God was supposed to be there, at least to guide you in a way to be able to have to help guide you with strength to get through this. Bull! Didn't happen."

Making Meaning of Suffering

Believing that God has purpose in suffering was reported by two participants. One of these veterans said, "All the horror that I went through, and some of the problems I even go through now, it's like I take it and reprocess it, instead of playing the old tapes, 'Oh somebody is punishing me for this.' Nope. No he is making me stronger. And it really has been a blessing and it really does work for me." Spiritual/religious beliefs contributing to hope or feelings of purpose in the midst of suffering were reported by seven respondents. For example, "Life is great, but the world is Hell, you know what I'm saying? But you can separate living on the beautiful earth, being a child of God. You can separate that from that evil world which is Satan's. So life is good." One veteran stated the question of purpose kept her alive; "The part that keeps me alive is I need to know for sure. Have I traveled all avenues to come to the final understanding of what the heck I'm doing here?"

Coping with Suffering

Veterans discussed spiritual/religious practices as helpful for coping with suffering—broadly defined. This included any combination of self-perceived physical, psychological, and/or spiritual suffering. One veteran explained, "There is a strong connection between the idea of continuously practicing any form of spirituality religion—or any other concept of doing something over enough to where it becomes healthy mentally. I'm just realizing that.

I will stop, sit, listen—to me and others—and be just now. And I am finding that the strength in that strongly disables the idea of any suicidal ideations." Another individual described the value of being "spiritually centered"—"It's not that people who are spiritually centered don't want to kill themselves, people [who] are spiritually centered may want to kill themselves but choose not to."

Specific practices veterans perceived as helpful for coping with suffering included reading spiritual/religious texts, serving others, meditation, prayer, time in nature, vows, and participation in a spiritual/religious community. Using spiritual/religious texts to better cope with suffering was reported by eight respondents. One explained, "When I am trying to turn my mind from suicide, I will often think of one of the tales of the gods. Or I will look at the Havamal. The Havamal is sort of the —our book of proverbs. It's wisdom that Odin gave to a traveler … I read, I go through it, it gives me something else to put my mind on." Four veterans described the efficacy of service to others; one said, "The more I try to help other people it helps me to realize that that's part of my purpose," and another explained, "I work to find reasons. … holding the sick babies [at hospital] … teaching people to meditate and have conversations. … also I started painting. And it turns out I am very good."

The importance of using meditation to cope with suffering was reported by four respondents. For example, "If I didn't meditate, I wouldn't be here. It was my anchor. And how it helps is that I do not have to engage in conversations with my mind. And as I put it, I put a guard at the gate. I cannot change what has happened. So to ruminate over it and get upset, who suffers? I do. And I don't need to suffer … When I was [in psych ward after suicide attempt], it was a crisis. And how do I get out of it? How do I resolve this? I have no idea. I just sat down and I meditated and I meditated all night. And the next day I felt better and started working my way out." Prayer was cited as helpful by three respondents, with one describing having asked his friend to bring his "tallit, teffilin and sedur" to the inpatient psychiatric ward after a suicide attempt so he could say prayers. Enjoying nature as a spiritual/religious practice was reported by one respondent; "It's all about Mother Earth, it's what's around you. It's the beauty of life … it's about the plants and the flowers and the beautiful trees and the animals … [these] bring me to reality and realize that, there really is beauty in life. That life is worth living." Taking vows was reported by two respondents as keeping them from acting on suicidal ideation. Of note, only two veterans in the study explicitly discussed belonging and participation in a spiritual/religious community as a deterrent to committing suicide.

Integrating Spirituality/Religion with Mental Health Care and Suicidal Ideation

Integrating spirituality/religion with MH care was only reported by two respondents. For example, one veteran's MH provider integrated the veteran's vow to her community into her safety plan, "I made a troth. A pledge with my family that before I take any action to seriously harm or kill myself, I will speak with them about it. I can't promise not to, because it is my life, and I have that right. But in pledging to speak with them, I also know they are going to call for an ambulance, they are going to get me down to the VA and get help. If I don't speak with them, dying an oath-breaker is a really bad thing … if you die with a broken pledge on your lips, you go to the realm of the dishonored dead —nothing that even in my darkest times I think would be better than what I am going through now." Another veteran cited her psychiatrist's willingness to talk about spirituality as a key factor in her recovery

—the psychiatrist "would talk about religion in our sessions. It was very helpful. Because he was like, 'You feel ashamed because you tried to commit suicide, but, God's not looking down on you.' He would tell me stuff like that all the time, he'd be like, 'God's not looking down on you just because you're sick' … it helped me a lot with the shame."

Surviving an Attempt and the Role of Spirituality/Religion

A history of at least one suicide attempt was reported by the majority of respondents ($n = 20$), of which 12 posited a relationship between spirituality/religion and surviving an attempt. Surviving a suicide attempt was attributed to "Divine intervention" by seven respondents. For example, one veteran said, "He saved me for a reason; maybe I need to talk to somebody." Another mused, "If God don't want you out of here, you ain't going nowhere. And if he wants you out of here, ain't nothing you can do about it." Feeling some deeper reason/purpose to remaining alive was reported by two respondents. For example, "there must be a reason that I'm still here. Because I gave it a really good shot." Feeling their survival as leading to spiritual/religious seeking was reported by three respondents. For example, "Am I really meant for something that I haven't accomplished yet? … I really began to question and explore." Another noticed that prior to her attempt, she was not observing her spiritual/religious practices, "I realized that's part of what gives my life—and my way of living—meaning, so I started seeking understanding again."

DISCUSSION

The aim of this qualitative study was to examine individual experiences of spirituality and/or religion in a sample of veterans recognized as being at increased risk of suicide. The thematic findings suggest a broad range of experiences. Though no single, universal, or unifying theme emerged, what was clearly evident was that issues related to spirituality and/or religion figured prominently in the lives of these veterans and specifically in their struggles with suicide ideation and attempts. This is the first time that a qualitative framework has been proposed for understanding spirituality and/or religion in the context of veteran experiences with suicidality. Findings underscore the clinical importance of discussing and exploring an individual's spiritual and/or religious beliefs when assessing suicide risk. Spirituality/religiosity plays adaptive and maladatpive roles for patients in terms of evaluating suicide as a possible action, understanding and coping with suffering, as well as recovery from a suicide attempt. Clinicians need to be aware of this and not make assumptions.

The themes uncovered in this study suggest that spirituality and/or religion figured prominently in the existential suffering of respondents and their experiences with suicide ideation. While participants were not directly asked about this connection, it was something consistently alluded to throughout each of the thirty interviews. This aligns with Chiles and Strosahl's (1995) conceptualization of suicide as experiential avoidance, where suffering is perceived as "intolerable, interminable, and inescapable." What follows from this theory is that spiritual and/or religious beliefs, practices, and experiences that add to suffering may potentially lower the threshold for suicidal behavior. In this study, suffering attributed to spirituality and/or religion included failure to live up to preset standards, rejection from one's faith-based community, lack of resources in one's faith-based community, or failure to make sense of suffering using one's spiritual and/or religious beliefs. Conversely, spiritual and/or religious beliefs that

supported making meaning of suffering included the belief that God has purpose in suffering, ability to separate suffering from enjoyable aspects of life, and finding purpose in suffering. These findings underscore the importance of exploring the impact of spirituality and/or religiosity on veteran experiences of suffering, including the ability to make meaning of or cope with suffering.

What warrants mention is that out of 30 participants, while only two identified MH providers as actively incorporating spirituality/religion into their therapeutic regimen, both of these veterans described these interventions as vital to their ongoing management of suicidal ideation. The findings presented here suggest that considering spiritual and/or religious experiences in the therapeutic regimen may be a useful component in mitigating suicide risk. For example, where deemed appropriate, greater collaboration with spiritual and pastoral care providers (e.g., chaplains) could help veterans uncover a measure of spiritual and/or religious meaning in their suffering, facilitating mental health recovery. As one suicidologist suggested, "when considering veterans and/or service members who appraise their life experiences via a lens of a specific spiritual/religious tradition, assuming a nonreductionistic approach that attempts to understand/contextualize the therapeutic procedures in their faith system might engender greater collaboration and productivity in minimizing suicide risk" (Currier, Kuhlman, & Smith, 2015, p. 68).

Finally, 12 of the 20 veterans with a history of a suicide attempt attributed their survival to spirituality and/or religion. This included viewing their survival as evidence of Divine intervention, proof that their life had purpose, or uncovering other facets of spiritual significance. This points to the potential importance of spirituality and/or religion in post-vention. The period following a suicide attempt potentially represents a time of significant meaning making. Approximately 33% of veterans who sought health care at a VA medical center in the month following a suicide attempt met with a chaplain at least once (Kopacz, Kane, Pigeon, & Nieuwsma, 2017). Another study found that approximately 10% of veterans who survived a suicide attempt received supportive services for "other psychological or physical stress, not elsewhere classified," a diagnosis which captures four chief complaints, including religious or spiritual problems (Kopacz, Kane, Stephens, & Pigeon, 2016).

Strengths

The sample included a diverse sample of veterans, from many different spiritual and/or religious backgrounds and demographic groups. This study also contained a good representation of both suicidal ideates and attempters.

Limitations

The findings of this study should be interpreted in the context of limitations which prohibit any generalizations to the larger veteran population. This study was conducted at a large VA medical center in the northwest, a region that may have a different faith-based profile as compared to other parts of the country. Also, veterans volunteered to participate in the study, and thus, may not represent the at-risk population as a whole. Self-selection bias may have limited the volunteers for this study to veterans who had a more developed sense and awareness of spirituality and/or religion. Furthermore, this study included only veterans who currently utilize MH services at the VHA. It was beyond the scope of this study to control for each individual's mental health treatment plan or what mental health service provider they may have been referred by to the study.

CONCLUSION

Findings from this qualitative study highlight the importance of spirituality and/or religion in veteran experiences of dealing with suicide ideation. Future research might include developing validated assessment tools, unique to veterans, which could allow for better exploring possible relationships between spirituality and/or religion and suicidality. This study supports the development and evaluation of interventions that help veterans integrate functional aspects of their spirituality /religion into suicide safety plans and mental health recovery, while addressing aspects of spirituality/religion that might contribute to suicidality and suffering.

AUTHOR NOTE

The authors would like to thank the veterans who participated, and their willingness to describe their lived experiences.

Jaimie Lusk, Center to Improve Veteran Involvement in Care (CIVIC), VA Portland Health Care System, Portland, Oregon, USA and Mental Health Services, VA Portland Health Care System, Portland, Oregon, USA.

Steven K. Dobscha, Center to Improve Veteran Involvement in Care (CIVIC), VA Portland Health Care System, Portland, Oregon, USA and Department of Psychiatry, Oregon Health & Science University, Portland, Oregon, USA.

Marek Kopacz, U.S. Department of Veterans Affairs, VISN 2 Center of Excellence for Suicide Prevention, Canandaigua, New York, USA.

Mary Frances Ritchie, Center to Improve Veteran Involvement in Care (CIVIC), VA Portland Health Care System, Portland, Oregon, USA.

Sarah Ono, Center to Improve Veteran Involvement in Care (CIVIC), VA Portland Health Care System

Department of Psychiatry, Oregon Health & Science University, Portland, Oregon, USA.

Correspondence concerning this article should be addressed to Jaimie Lusk, VA Portland Healthcare System, P3MHDC, 3710 SW US Veterans Hospital Road, Portland, OR 97239. E-mail: jaimie.lusk@va.gov

REFERENCES

Beck, A. T., & Steer, R. A. (1991). *Manual for Beck scale for suicidal ideation*. San Antonio, TX: Psychological Corporation.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. doi:10.1191/1478088706qp063oa

Bryan, A., Bryan, C. J., Morrow, C. E., Etienne, N., & Ray-Sannerud, B. (2014). Moral injury, suicidal ideation, and suicide attempts in a military sample. *Traumatology*, *20*(3), 154–160. doi:10.1037/h0099852

Bryan, C. J., Morrow, C. E., Etienne, N., & Ray-Sannerud, B. (2013). Guilt, shame and suicidal ideation in a military outpatient clinical sample. *Depression and Anxiety*, *30*, 55–60. doi:10.1002/da.22002

Chiles, J. A., & Strosahl, K. D. (1995). *The suicide patient: Principles of assessment, treatment, and case management*. Washington, DC: American Psychiatric Press.

Chwalisz, K., Shah, S. R., & Hand, K. M. (2008). Facilitating rigorous qualitative research in rehabilitation psychology. *Rehabilitation Psychology*, *53*(3), 387–399. doi:10.1037/a0012998

Colucci, E., & Martin, G. (2008). Religion and spirituality along the suicidal path. *Suicide and Life-Threatening Behavior*, *38*(2), 229–244. doi:10.1521/suli.2008.38.2.229

Creswell, J. (2006). *Qualitative inquiry and research design: Choosing among five approaches* (2nd ed.). Thousand Oaks, CA: Sage.

Currier, J. M., Kuhlman, S., & Smith, P. N. (2015). Empirical and ethical considerations for addressing spirituality among veterans and other military populations at risk for suicide. *Spirituality in Clinical Practice*, *2*(1), 68.

Department of Veterans Affairs. (2016). Memorandum of understanding between

Fontana, A., & Rosenheck, R. (2004). Trauma, change in strength of religious faith, and mental health service use among veterans treated for PTSD. *Journal of Nervous & Mental Disease*, *192* (9), 579–584. doi:10.1097/01.nmd.0000138224.17375.55

Giorgi, A. P., & Giorgi, B. M. (2003). The descriptive phenomenological psychological method. In P. M. Camic J. E. Rhodes, & L. Yardley (Eds.), *Qualitative research in psychology: Expanding perspectives in methodology and design*. Washington, DC, USA: American Psychological Association.

Hall, D. E., Meador, K. G., & Koenig, H. G. (2008). Measuring religiousness in health research: Review and critique. *Journal of Religion and Health*, *47*, 134–163. doi:10.1007/s10943-008-9165-2

Hill, P. C., & Pargament, K. I. (2003). Advances in the conceptualization and measurement of religion and spirituality: Implications for physical and mental health research. *American Psychologist*, *58* (1), 64–74. doi:10.1037/0003-066x.58.1.64

Hjelmeland, H., & Knizek, B. L. (2010). Why we need qualitative research in suicidology. *Suicide and Life-Threatening Behavior*, *40*(1), 74–80. doi:10.1521/suli.2010.40.1.74

Koenig, H. G., King, D. E., & Carson, V. B. (2012). *Handbook of religion and health*. New York, NY: Oxford University Press.

Kopacz, M. S., Currier, J. M., Drescher, K. D., & Pigeon, W. R. (2016). Suicidal behavior and spiritual functioning in a sample of veterans diagnosed with PTSD. *Journal of Injury and Violence Research*, *8*(1), 6–14. doi:10.5249/jivr.v8i1.728

Kopacz, M. S., Kane, C. P., Pigeon, W. R., & Nieuwsma, J. A. (2017). Chaplaincy encounters following a suicide attempt. *Journal of Health Care Chaplaincy*, 1–7.

Kopacz, M. S., Kane, C. P., Stephens, B., & Pigeon, W. R. (2016). Use of ICD-9-CM Diagnosis Code V62.89 (other psychological or physical stress, not elsewhere classified) following a suicide attempt. *Psychiatric Services*, *67*, 807–810. doi:10.1176/appi.ps.201500302

Kopacz, M. S., Morley, S. W., Woźniak, B. M., Simons, K. V., Bishop, T. M., & Vance, C. G. (2016). Religious well-being and suicide ideation in veterans—An exploratory study. *Pastoral Psychology*, *65*, 481–491. doi:10.1007/s11089-016-0699-z

Onwuegbuzie, A. J., & Leech, N. L. (2007). Sampling designs in qualitative research: Making the sampling process more public. *The Qualitative Report*, *12*(2), 238–254. Retrieved from http://www.nova.edu/ssss/QR/QR12-2/onwuegbuzie1.pdf

Pargament, K. I., Feuille, M., & Burdzy, D. (2011). The Brief RCOPE: Current psychometric status of a short measure of religious coping. *Religions*, *2*, 51–76. doi:10.3390/rel2010051

Pargament, K. I., Koenig, H. G., & Perez, L. M. (2000). The many methods of religious coping: Development and initial validation of the RCOPE. *Journal of Clinical Psychology*, *56*, 519–543. doi:10.1002/(sici)1097-4679(200004)56:4<519::aid-jclp6>3.0.co;2-1

Pargament, K. I., Zinnbauer, B. J., Scott, A. B., Butter, E. M., Zerowin, J., & Stanik, P. (2003). Red flags and religious coping: Identifying some religious warning signs among people in crisis. *Journal of Clinical Psychology*, *59*(12), 1335–1348. doi:10.1002/jclp.10225

Steger, M. F., Frazier, P., Oishi, S., & Kaler, M. (2006). The meaning in life Questionnaire: Assessing the presence of and search for meaning in life. *Journal of Counseling Psychology*, *53*(1), 80–93. doi:10.1037/0022-0167.53.1.80

U.S. Department of Veterans' Affairs, Office of Suicide Prevention. (2016). *Suicide among veterans and other Americans, 2001–2014*. Retrieved from http://www.mentalhealth.va.gov/docs/2016suicidedatareport.pdf

Witvliet, C. V., Phipps, K. A., Feldman, M. E., & Beckham, J. C. (2004). Posttraumatic mental and physical health correlates of forgiveness and religious coping in military veterans. *Journal of Traumatic Stress*, *17*(3), 269–273. doi:10.1023/b:jots.0000029270.47848.e5

Wu, A., Wang, J. Y., & Jia, C. X. (2015). Religion and completed suicide: A meta-analysis. *PLoS ONE*, *10*(6), e0131715. doi:10.1371/journal.pone.0131715

Zinnbauer, B. J., Pargament, K. I., Cole, B., Rye, M. S., Butter, E. M., Belavich, T. G., … Kadar, J. L. (1997). Religion and spirituality: Unfuzzying the fuzzy. *Journal for the Scientific Study of Religion*, *36*(4), 549–564. doi:10.2307/1387689

Zinnbauer, B. J., Pargament, K. I., & Scott, A. B. (1999). The emerging meanings of religiousness and spirituality: Problems and prospects. *Journal of Personality*, *67*(6), 889–919. doi:10.1111/1467-6494.00077

APPENDIX: INTERVIEW GUIDE

Interview Guide—Veterans

Thank you for taking time to meet with me today. My name is Jaimie Lusk, date, participant #. Are you aware that you are being tape recorded? I am a psychology intern and a member of the research team investigating relationships among religion, spirituality, and suicidal thoughts and behaviors. Your participation is entirely voluntary and if there is any question you prefer not to answer that is fine. Also, if at any point you have questions for me, please let me know. This interview talks about things that usually aren't talked about, like religion and suicide. Are you willing to have a conversation about these topics?

A: Introduction: Let's begin with some general questions about religion/spirituality

- What is your history with religion/spirituality?
- Do you consider yourself religious or spiritual? If so, in what ways?
- If veteran is not religious or spiritual, skip to B.
- Describe your current religious/spiritual practice. *Formal or informal? Daily, weekly?*
- Describe times in your life where your (religion/spirituality/word in part B) dramatically shifted.
- What does your (religion/spirituality/word in part B) say about who you are?
- What communities do you consider yourself a member of?

B: Meaning/Purpose

- Do you have a personal or moral code that guides your life? Tell me about this.
- *What do you do that matters to you? What do you wish you could do with your life? What's your code? What do you live by? What's your deal? What are you about?*
- Something else that guides your life? Rules for living, values, desired life, vision, etc.

C: Relationship between religion/spirituality and distress

Some people experience comfort and help from (religion/spirituality/word in part B) and some people experience problems with (religion/spirituality/word in part B). I am curious about your experience.

- How does your (religion/spirituality/word in part B) help you?
- What (religion/spirituality/word in part B) concerns or needs do you currently have?
- Can you think of a time when (religion/spirituality/word in part B) increased your stress level?

D: Relationship between religion/spirituality and suicidality

- Tell me about your experiences with suicidal thinking or behavior.
- What part did (religion/spirituality/word in part B) play in your suicidal thinking/behavior?
- Has (religion/spirituality/word in part B) affected your reasons for living? Reasons for dying?
- What if any (religion/spirituality/word in part B) do you draw from when you are having thoughts about suicide?
- Has a suicidal crisis affected/altered your (religion/spirituality/word in part B)?
- If you were having a suicide crisis in the future, would you draw on your (religion/spirituality/word in part B)? If so, how and why?
- In general, how do you think someone's beliefs or practices influence suicide?

E: Final thoughts

- Are there questions I should be asking that I haven't? (Alt: Is there

anything I haven't asked you that you would like to share before we wrap up?)
- What inspired you to participate in this study?

Risk Assessment

- How are you doing after this interview?
- Do risk assessment if necessary.

Refer to suicide hotline/MH providers.