A Firefighter's Silent Killer: Suicide

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SILENCE OFTEN HIDES THE VERY ISSUE ONE MUST confront. Suicide often occurs because of the silence of society and the silence a person perceives is necessary when contemplating suicide caused by the absence of open and honest communication regarding the reality of suicidal thoughts in response to pain, stress, trauma, and even depression or other mental illnesses. Many people do not like to talk about suicide because of cultural, moral, social, ethical, or religious beliefs. For some, there may be a strong emotional tie to a friend or a family member who has committed suicide. For others, it is a misperception that no one "talks" about suicide. It is this very silence that prevents reduction of suicide among firefighters. If we are serious about decreasing the number of firefighter suicides in this country, we must change that the fire service does not talk about suicide and that it has not embraced any formal suicide training/education awareness/prevention programs. Only in the past year or so have a number of fire service agencies/departments taken a more aggressive approach to educating firefighters on suicide. These agencies serve as a benchmark for others. In this article, we explore the issue of silence surrounding the topic of suicide, risk factors for suicide, the need for additional scientific research on suicides in the fire service, and the development of a national suicide prevention and education program aimed at the fire service (career, call, and volunteer).

THE SCOPE OF THE PROBLEM

Regardless of which problem-solving process you use, generally the steps are identifying the problem, followed by analyzing the problem, and then deciding on the most effective solution. Here is the first challenge: The fire service collectively has not admitted suicide is a problem. Until the fire service identifies suicide as a problem for fire personnel, little time and fiscal resources will be devoted to suicide prevention. Nationally, the fire service does not have a formal tracking mechanism of firefighter suicides, which makes it difficult to analyze how significantly the fire service is impacted by suicides. Overall, the fire service lacks scientific research identifying suicide as a significant cause of death for firefighters. One study that examined North Carolina firefighters found the following: "Compared with professional firefighter line-of-duty deaths (LODDs), suicides occurred more than three times as often."[1] This statistic, along with anecdotal evidence, suggests the fire service indeed has a silent killer that has received very little attention.

Setting up a *firefighter suicide* online search for the past six months has resulted in several news articles of firefighters committing suicide. Some of the titles go like this: "Accused firefighter commits suicide," "Department mourns after chief's apparent suicide," "Tears for firefighter suicide," "Firefighter who attempted suicide recovering," and "Firefighter's suicide stuns colleagues." These articles are only the ones that made it into the news media. The unanswered questions are, How many deaths determined as suicide do not make it into the news, and how many deaths that are suicides are not ruled as suicides?

This brings forward another area of concern. In the past, out of respect for those left behind, the death may not have been classified as a suicide. The stigma when a person commits suicide can be embarrassing for the family. This stigma is very slowly changing, as more and more people in general understand the issue surrounding suicide. However, in the fire service, we still have much more to learn. With a lack of policies or procedures regarding psychological autopsies or attention to suicide as a method of death within the fire service, suicides that occur off duty may not be determined as suicides. The known number of suicides seems less significant as an overall problem. In these situations, only the family may know the method of death, but they do not fully realize the underlying factors contributing to the death.

Suicide takes a toll not only on family, friends, and coworkers but also on organizational productivity and financial perspective. To ensure effective prevention, intervention, and postvention, none of the areas affected can be overlooked. Often, it is the productivity and financial aspects that allow for the provision of services that directly impact the personal aspect. (One of the authors has specifically "exploited" the

financial perspective to garner support for prevention and intervention programs; this approach benefited the company and the employees.)

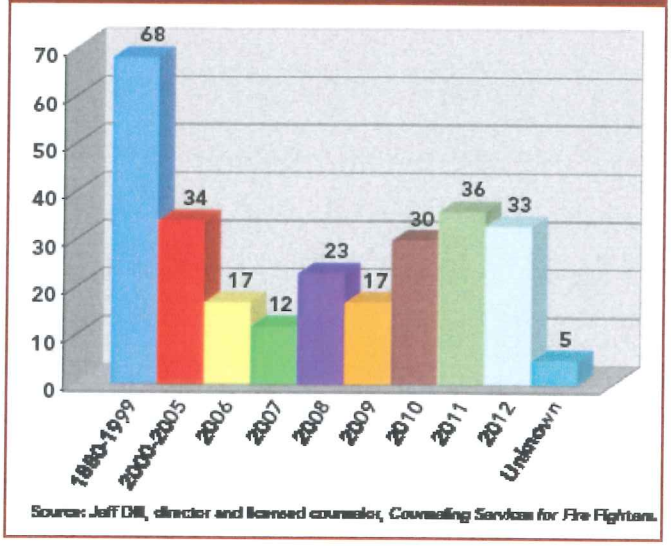
The fire service seems reluctant to openly discuss the issue of suicide within the ranks. The fallacy in this approach may be that openly discussing suicide would be admitting a problem for which there is no known solution. The response to the known suicides has been not to discuss the issue. The topic of suicide often engenders very strong opinions and ideas. These very strong opinions make it uncomfortable to openly talk about suicide. The cognitive and emotional reactions may even prevent some people from talking about and viewing suicide in a rational manner. One way to overcome this challenge is to begin to maintain an open and honest dialog on the topic of suicide and how this silent killer is impacting our fellow firefighters.

To combat the historical lack of discussion, higher education should incorporate this topic in fire science administration programs. National, state, and local fire academies should incorporate suicide awareness in entry-level firefighter training programs, fire line supervisor training, and senior fire officer training. Employee Assistance Programs (EAPs) are equipped to provide training and awareness on suicide to fire department personnel and family members. Fire department chaplains should be trained in how to deal with suicides; they should be given pre-preparation training regarding the risk factors and stress of the fire service and effective support following a death from suicide. Chaplains serve the firefighter, the department, and the families affected regardless of religious or spiritual beliefs. Chaplains' code of ethics requires nonjudgmental support to troubled firefighters and their families. Open and honest discussions of suicide are imperative, as is knowing what action to take if a suicide appears to be planned and imminent. The chaplain's religious beliefs must not preclude the delivery of potential lifesaving service. Some fire department chaplains may have very strong religious beliefs regarding suicide. All personnel and support services should encourage the fire service to be proactive in its approach to suicide.

The question "Is the fire service impacted by suicides?" has been answered by the media. There has been media coverage of several fire departments affected by suicide in the past few years. The Phoenix (AZ) Fire Department lost four firefighters who committed suicide in a seven-month period.[2] The Chicago (IL) Fire Department lost 37 firefighters to suicide since tracking this method of death, and the Montgomery County (MD) Fire Department reported the loss of 17 firefighters to suicide in the past 13 years.[3]

Recent statistics collected by Jeff Dill, director and licensed counselor of the Counseling Services for Fire Fighters, reports that more than 160 firefighters committed suicide since 2000 (Figure 1).[4] Preliminary analysis shows firearms was the most used method, followed by hanging, carbon monoxide poisoning, and overdose. Ongoing data collection may reveal the numbers are even higher once reporting and tracking mechanisms become formalized. We could continue to list the other individual suicides impacting career, call, and volunteer fire departments across the country.

Figure 1. Firefighter Suicides by Year



Source: Jeff Dill, director and licensed counselor, Counseling Services for Fire Fighters.

With the emphasis on suicide prevention since the Surgeon General's Call to Action in 1999, specific occupations are beginning to implement suicide prevention programs designed to address the specific occupational risks that may contribute to personnel suicides. In 1999, the Surgeon General called suicide "a national public health problem," energizing federal, state, and local organizations to address the issue. Agencies outside the purview of the government have not been as proactive. With continued emphasis on suicide prevention across our nation, no agency or organization can ignore the issue. In light of the decisions and recommendations made in 1999, when is the fire service collectively through the national associations going to decide that losing firefighters to suicide, a preventable death, is an emotional, organizational, and financial toll too significant to bear? Collectively, the fire service must stand up and admit that suicide among firefighters is a silent killer and that we need to do more! As you can see, even being reactive to an identified problem of suicide is far better than turning a blind eye to the issue.

It is interesting to note when we step back and look around us that we tend to see "suicide humor" depicted in cartoons, social media, print media, music, and even books. This humor may be similar to "gallows humor" or "macabre humor," common in occupations that deal with situations in which there is a high possibility of death, including first responders, law enforcement, emergency medical personnel, and the military. This humor is not meant to be disrespectful; it decreases the impact or emotionality of a difficult topic. Cartoons depicting suicide, though insensitive to most, may serve the purpose of "demystifying" suicide and making it an approachable topic. The point is that suicide cartoons are a form of humor (some may not agree), yet if they are used at the wrong time, they can be offensive. The use of cartoons can decrease tension regarding the topic and may also decrease resistance to discussing suicide.[5]

Suicide does not discriminate. Attempts and completions can occur in any department, large or small. Suicide involves personnel who are newly hired, in mid-career, and are retir-

ing; it does not discriminate with regard to rank or experience. The bottom line is that it can happen to anyone, and it may be your department that is dealing with the results of an attempted or completed suicide. Knowing how to respond to a suicide of a coworker or how to respond and support a coworker who has made an attempt is critical to the well-being of the organization, the individual firefighter, and the firefighter's family. Compare the operational and administrative response to a member suicide or attempted suicide by a department that has never discussed suicide and whose senior staff holds strong views of the topic with that of a department that has taken a proactive stance on the issue. In which department would you prefer to work?

It is clear there is no standard administrative response to a firefighter who has attempted suicide. Depending on the department, the response may run the full spectrum of not supporting a member to fully supporting the member during the recovery process. Some in the fire service may argue firefighters who attempt suicide should be fired since they are a risk to the department and the community. Many people cannot see the suicide attempt as an indicator of underlying problems or issues that can be resolved and that the person can lead a very productive career with the proper emotional support and professional help. Forcing a firefighter into early retirement or terminating the firefighter for a suicide attempt is wrong. Providing a thorough medical review, a course of treatment, and time to fully recover is necessary. A suicide attempt is not in itself a diagnosis or an indication of a mental illness. If after time and professional mental health care the firefighter is determined to be fit for duty, the firefighter should be returned to duty. Terminating a firefighter who has attempted suicide will only compound the physiological issues the firefighter is currently processing. The bottom line is that a suicide attempt does not have to be career ending; it provides an opportunity to assist the individual in accessing professional care to deal with the underlying reasons for the suicidal thoughts and behaviors. Unresolved medical and mental health conditions may necessitate medical retirement, but specific policies should be in place. The final determination and recommendation should be discussed with the individual firefighter, the mental health provider, and the designated department representative.

We need to act now to put in place suicide prevention and education programs. Moving in the right direction, the National Fallen Firefighters Foundation held a summit in Baltimore, Maryland, last year to bring forward the issue of depression and suicide in the fire service. All of us in the fire service have a responsibility to ensure that this initiative is not just a flash bang; we should demand that more be done.

RISK FACTORS

Are fire service personnel at risk for suicide? To answer this question, it is imperative to look at the research-based risk factors associated with the demographics represented within the fire service. How closely these risk factors mirror fire service personnel provides the answer regarding suicide risk. The higher the number of risk factors, the higher the risk of suicide. It is also important to note that risk factors can be reduced or

mitigated by protective factors, both personal and organizational. Increasing protective factors combats the risk factors and decreases the risk of suicidal thoughts and behaviors.

With regard to national statistics regarding suicide, the Substance Abuse and Mental Health Services Administration (SAMHSA) reports approximately 33,000 deaths are attributed to suicide each year. SAMHSA's Office of Applied Studies (OAS) notes individuals who die from suicide represent a fraction of those who consider or attempt suicide.[6] OAS also notes that in 2003, there were 348,830 nonfatal emergency department (ED) visits by adults ages 18 and older who had harmed themselves. Research suggests that there may be between eight and 25 attempted suicides for every suicide death. (6) As with suicide completions, risk factors for attempted suicide in adults include depression and substance use. It is imperative to understand the magnitude of suicides and the associated suicidal behaviors, both injurious and noninjurious attempts. Though nonfatal attempts do not result in death, these behaviors often have a significant impact on the individuals, their families, and the organizations within which they work.

The number of suicides does not adequately tell the story. To determine the risk for any specific population or occupation, we must look at the rate of suicide. The rate of suicide varies by age, gender, and race. The rate can be broken down by occupation, but the rate within each occupation is dependent on a formal database capturing this information. Suicide rates vary across demographic groups, with some of the highest rates occurring among males, whites, and the elderly. Depending on the specific demographics of a population, there is a need to specifically tailor suicide prevention for those receiving the services. The Department of Defense and law enforcement agencies have recognized suicide is the leading cause of death among their personnel and are making a concentrated effort to capture data of suicides and suicide attempts. Significant research and prevention efforts are also aimed toward children, youth, and college students.

The Institute of Medicine's *Reducing Suicide: A National Imperative*[7] provides a comprehensive look at risk factors contributing to suicide. Risk factors of particular interest to the fire service include the following:

- Gender: Males.
- Age: 18-24 and 40-55.
- Race: Caucasian.
- Effects of acute and chronic stress.
- Impact of trauma.
- Substance or alcohol abuse.
- Childhood trauma.
- Relationship issues.
- Predisposing personality traits such as aggression and impulsivity.

Understanding risk factors enables an organization to incorporate effective prevention and intervention in the organizational culture. Static risk factors of personnel such as gender, race, and age cannot be changed; thus, it is imperative to provide a comprehensive prevention program that addresses static and nonstatic risk factors. Information is key to ensure all personnel are aware of risk factors, are able to identify a person exhibiting or experiencing the risk factors and discuss the issue with him, and that all levels of leadership be able to respond with appropriate intervention. It is interesting to note that the ages above represent the beginning of a career and the end of a career. Difficulty adjusting to increased exposure to stress, trauma, and retirement and loss of identity are significant life transitions that can be risk factors, especially when other risk factors are also present.

It is important to note that anyone can be at risk for suicide; take all warning signs seriously. Warning signs include the following:

- Talking about wanting to die or to kill oneself.
- Looking for a way to kill oneself such as searching online or buying a gun.
- Talking about feeling hopeless or having no reason to live.
- Talking about feeling trapped or being in unbearable pain.
- Talking about being a burden to others.
- Increasing use of alcohol or drugs.
- Acting anxious or agitated or behaving recklessly.
- Sleeping too little or too much.
- Withdrawing or feeling isolated.

- Showing rage or talking about seeking revenge.
- Displaying extreme mood swings.

Protective factors, personally and within an organization, include the following:

- Self-efficacy, a belief in oneself.
- Interpersonal problem solving.
- Positive coping skills.
- Self-esteem.
- Familial and social support.
- Reducing barriers to care.
- Destigmatizing help-seeking behavior.
- Occupational post-trauma support.
- Spirituality, a sense of purpose/belonging.

The fire service, like many other areas of the workforce, is faced with members returning from serving on the front line of a war. How the fire service integrates returning veterans to the department can play a significant role in the veterans' mental health. It is important to note that a majority of military firefighters deployed to Iraq and Afghanistan are reservists and guardsmen and paid and volunteer firefighters when in civilian status, and they return to civilian departments after multiple deployments.

The number of firefighters who have committed suicide or who have attempted to commit suicide is too high to ignore.

In regard to the rate of suicide among veterans, information provided by CBS News is startling. In 2009, CBS News provided information received from the Department of Defense, Department of Veterans Affairs, and then requested information from all 50 states regarding veterans' deaths. CBS News asked all 50 states for their suicide data, based on death records, for veterans and nonveterans, dating back to 1995. Forty-five states responded; the data showed that in 2005 alone, in just those 45 states, there were at least 6,256 suicides among those who served in the armed forces. This equated to 120 suicides each week in just one year.[8] CBS News asked Dr. Steve Rathbun, acting head of the Epidemiology and Biostatistics Department at the University of Georgia, to run a detailed analysis of the raw numbers obtained from state authorities for 2004 and 2005. The analysis showed that in 2005, veterans were more than twice as likely as nonvets to commit suicide.[9] Veterans committed suicide at the rate of between 18.7 and 20.8 per 100,000, compared with other Americans, whose rate was 8.9 per 100,000. One age group stood out: veterans ages 20 through 24 who served during the War on Terror. They had the highest suicide rate among all veterans, estimated to be between two and four times higher than civilians the same age. The suicide rate for nonveterans is 8.3 per 100,000; the rate for veterans was found to be between 22.9 and 31.9 per 100,000. It is estimated that of the 33,000 suicides each year, 20 percent are veterans. (9)

The National Fire Protection Association (NFPA) estimates that there were approximately 1,103,300 firefighters in the United States in 2010.[10] Of the total number of firefighters, 335,150 (30 percent) were career firefighters and 768,150 (70 percent) were volunteer firefighters. Of the 1,103,300 firefighters, the age group accounting for the largest number of firefighters was the 30-39 group, which accounted for 302,250 (27.4 percent) of all firefighters. Many firefighters fell in the 40-49 age group (25.8 percent) and the 20-29 age group (20.9 percent). Firefighters ages 50-59 accounted for a smaller share (16.6 percent) but still more than one-sixth of all firefighters. Few firefighters fell outside this combined range of 20 to 59 years old. Only 3.1 percent of firefighters were in the 16- to 19-year age group; another 6.1 percent were 60 years old and older. (10)

According to the U.S. Department of Labor, Bureau of Labor Statistics, for the 2006-2010 period, there were on average 24,000 African-American career firefighters (8 percent) and 11,800 female career firefighters (4 percent).[11] This indicates a significant majority of fire service personnel are Caucasian males, who in all age groups are at higher risk for suicide than nonwhite males and females. Departments protecting larger communities tend to have a higher proportion of firefighters in the age groups 30-39 and 40-49 than smaller communities. Departments protecting larger communities often have a staff psychologist, a full-time chaplain, an established Employee Assistance Program, and/or a peer support team or a critical incident stress management (CISM) team.

For the fire service whose new recruits are comprised mainly of white males between the ages of 18 and 24 and who will during their first years of service deal with the death of others or may face death themselves, it is self-evident that a number of them may experience increased stress and have difficulty coping and may have thoughts of suicide. Though organizational camaraderie/"being a family" is a protective factor, the historical expectation of "machismo" and "being a hero" inhibits one from coming forward with problems or difficulties.

A TRUE STORY

The following is written by a firefighter who attempted to commit suicide just a few years ago. It is written in the firefighter's own words and demonstrates just some of the internal struggles that some in the fire service may face. As you read the firefighter's description, think back to the prior material you just read and how some of the recommendations might have been helpful in preventing this suicide and assisting in the recovery process.

> By all accounts, at the time of my attempted suicide, I had what anyone in the fire service would call a good life. I was successful at work, owned my own home, and had plenty of money. On the outside, I don't think anyone would have thought I was contemplating suicide, let alone actually going to do it. I appeared happy, outgoing, a regular firefighter. Inside was a different story. I was empty, alone, depressed, and very

sad. Every day, for as long as I could remember, I felt that way. I can remember every day waking up and trying to give myself a reason for being here another day. I abused alcohol, which helped numb most of my feelings. Work seemed to be my bright spot; helping people gave my life a temporary reprieve from my problems, but that would end as soon as my shift was over.

After my attempt, I was committed to a facility for two weeks for treatment. As firefighters, we are conditioned to deal with problems, all kinds of problems, to make sense out of chaos, but these are other people's problems, not our own. While in this facility, I was helped to understand my problems and to deal with them in a healthy, not a self-destructive, way. I still see a counselor regularly, which I think is very helpful. I had to learn that it is OK to ask for help when you need it. Even after my attempt, the department never really knew how to handle it. People in the department went to the chief behind closed doors to tell the chief they didn't trust me and were afraid I might hurt them.

RECOMMENDATIONS

Combating suicide, as shown by the Department of Defense and law enforcement agencies, takes a concentrated and comprehensive effort. Comprehensive programs should incorporate prevention, intervention, and postvention components.[12] No one component can fully address the issue; all three must be included in a comprehensive program.

Prevention includes the following components:

- Signs and signals of stress.
- Static risk factors.
- Nonstatic risk factors.
- Healthy living/stress management.
- Help-seeking behaviors.
- Open communication with leadership.

Intervention includes training all personnel from the new recruit to senior leaders on effectively and genuinely responding to those exhibiting signs and signals of stress. Talking to someone and providing support are the first steps in saving a life. The intervention can be as simple as asking how one is doing to ensuring a warm handing off to the next level of care. There is a continuum of intervention, and each point along the continuum needs to be taught so personnel are comfortable in asking the question "Are you thinking of suicide?" of anyone who may be at risk and responding with lifesaving communication and support when the answer is "yes."

Postvention is actually a continuation of prevention efforts, providing organized support in the aftermath of an attempt or completion. "Effective postvention for suicidally bereaved families may be one of the most important forms of multigenerational prevention available to mental health professionals," notes John R. Jordon, Ph.D.[13] Ensuring policies and procedures are in place to respond to and support personnel affected by a suicide acknowledges the significance and emotionality of a death by suicide and provides a safe environment for those experiencing similar stressors and risks to access services to receive necessary care and treatment.

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Our intent is to bring to light the silent killer of firefighters, suicide. As discussed

in this article, the fire service must collectively admit suicide is a problem. The number of firefighters who have committed suicide or who have attempted to commit suicide is too high to ignore. Once the fire service moves past the fact that we have a problem, only then can we begin to analyze and develop strategies for preventing firefighter suicides. Several larger fire departments in the country already have suicide prevention programs that could serve as a starting point. Open and honest communication about suicide is equally as important. If we can break down the stigma and cultural, ethnic, and religious barriers, we can move forward with a healthy awareness/intervention program for firefighter suicide. Our hope is to stimulate additional research and debate on the importance of preventing firefighter suicide. ●

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