

RESEARCH

A Qualitative Study of Potential Suicide Risk Factors in Returning Combat Veterans

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According to the interpersonal-psychological theory of attempted and completed suicide (Joiner, 2005) suicide-related behavior is contingent upon three factors: acquired ability, burdensomeness, and failed belongingness. Qualitative research methodology was employed to explore these concepts among a group of returning Operation Enduring Freedom (OEF)/Operation Iraqi Freedom (OIF) combat veterans. A sample of 16 individuals participated in interviews. Themes emerged regarding combat as a context for exposure to pain, subsequent coping strategies, and perceptions of burdensomeness, failed belongingness, and increased pain tolerance. Suicidal behavior was also articulated as a means of coping with risk factors outlined by Joiner. These results highlight the potential utility of this theory for OEF/OIF veterans. Interventions aimed at decreasing emotional dysregulation, and lessening perceptions of burdensomeness and failed belongingness may reduce risk for suicidal behavior.

While the ability to identify factors that make an individual more or less likely to engage in suicidal behavior has significant clinical utility (Beck, Steer, Kovacs, & Garrison, 1985; Jobes & Mann, 1999), such knowledge does not allow us to predict who will die by suicide. Recent work by Joiner (2005) represents years of theory building, refinement, and empirical validation aimed

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at increasing understanding about how and why people become suicidal. The foundation of Joiner's (2005) theory, the interpersonal-psychological theory of attempted and completed suicide, is that lethally suicidal individuals perceive that they are an unbearable burden on their family, friends, and/or society (burdensomeness); their efforts at establishing and maintaining social connections have repeatedly been thwarted or have failed (failed belongingness); and through multiple experiences they have acquired the ability to engage in suicidal behavior. When all three elements are present, suicidal behavior with lethal intent is likely and imminent.

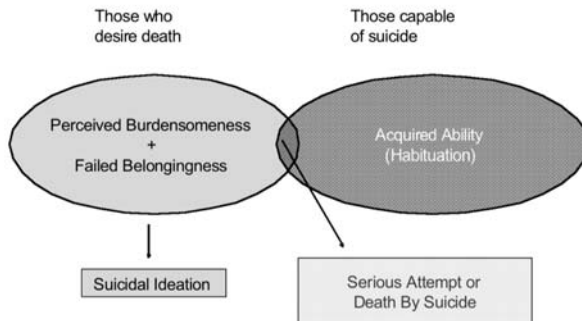
Components of the theory have been tested in adults (Joiner, Pettit, Walker, Voelz, Cruz, & Rudd, 2002; Joiner & Rudd, 2000), college students, and adolescents (Joiner, Rudd, Rouleau, & Wagner, 2000). However, research has only begun to explore whether the theory applies to veterans (Cornette, Deboard, Clark, Holloway, Brenner, Gutierrez, et al., 2007; Cornette, deRoos-Cassini, Joiner, & Proescher, 2006). The importance of identifying means of assessing risk in this population is highlighted by a recent study of U.S. male military veterans aged 18 and older (Kaplan, Huguet, McFarland, & Newsom, 2007). Such individuals were twice as likely to die by suicide when compared with nonveteran males. Those who were white, had ≥ 12 years of education, or activity limitations were at greater risk (Kaplan, Huguet, McFarland, & Newsom, 2007). Previous research has demonstrated that combat-related experiences also place veterans at risk (Bullman & Kang, 1996). Demographically, those aged 20–29 represent the majority of returning Operation Enduring Freedom (OEF)/Operation Iraqi Freedom (OIF) veterans who seek care within the Veterans Administration (VA) system (VHA Office of Public Health, 2006); in the U.S. general population, young people aged 15–24 make the largest number of suicide attempts each year (Centers for Disease Control and Prevention [CDC], 2006). Suicide is also on the rise among soldiers, with 2006 having the highest number of confirmed cases since 1990 (Lorge, 2008). To facilitate treatment and prevent future OEF/OIF suicides, increased understanding of risk factors for veteran suicidal behavior is needed.

Acquiring the ability to engage in suicidal behavior may be related to “hav[ing] witnessed, experienced, or engaged in more violence than others, because violence exposure would be one way to habituate—either directly or vicariously—to pain and provocation” (Joiner, 2005, p. 70). Hoge, Auchterlonie, and Milliken (2006) found that 65.1% of OIF soldiers and 46% of OEF soldiers reported a history of combat. Habituation to pain and subsequent acquired ability secondary to combat exposure, coupled with a post-deployment sense of failed/thwarted belongingness and/or burdensomeness would, according to Joiner's theory, place veterans at increased risk for suicidal behavior.

Perceived burdensomeness and failed belongingness contribute to the desire

to die, and habituation to pain impacts an individual's ability for engaging in suicidal behavior (Joiner, 2005). Figure 1 outlines the spheres of suicide risk, with those individuals at highest risk being represented by the area where the spheres overlap. Although all three components are believed to be relevant to understanding veteran suicide, habituation to pain is the most complex concept to apply, so it will be given the most attention in this paper.

Figure 1. Interpersonal-Psychological Theory of Suicide Risk



Adapted from *Why people die by suicide* by T. E. Joiner, 2005, p. 138. Cambridge, MA: Harvard University Press.

Qualitative research can be particularly useful in clarifying less-understood phenomena (Strauss & Corbin, 1990). As the concepts introduced in the theory are not well-understood in this population, we employed this methodology. In particular, our goal was to elucidate the complex details regarding OEF/OIF veterans' perceptions about potential suicide risk factors, habituation to pain, burdensomeness, and belongingness. This study was also intended as the first in a series leading to the development of new measures to assess the constructs in veterans. Work of this type often begins with a qualitative study from which initial items can be generated (Haynes, Richard, & Kubany, 1995).

To elicit OEF/OIF-specific information about concepts hypothesized to increase risk for suicidal behavior, questions were posed about habituation to pain, perceived burdensomeness, and failed belongingness. We paid particular attention to whether combat was a context for exposure to pain and thus resulted in habituation to pain. Other questions dealt with burdensomeness and belongingness in the context of past military experiences and reintegration into civilian life. The final question in each section of the interview asked about "the most extreme" way the respondent might cope with the issue raised. Although no specific questions regarding suicide were asked and the word suicide was intentionally not included in interview questions, we were interested in whether themes related to suicide would emerge spontaneously in response to all three constructs.

METHODS

Participants

With the approval of the local Institutional Review Board, research participants were recruited from the population OEF/OIF veterans within a western VA health care system. All had sought care within the mental health system between 2004 and 2007 and had open cases at the time of recruitment. The sample consisted of 16 OEF/OIF veterans with combat experience, ages 18–55. Those selected had been deployed to Iraq and/or Afghanistan. At the time of their consent, participants were neither experiencing active psychosis nor demonstrating imminent suicidality. All those recruited were interviewed (see Table 1 for participant demographics.)

Table 1
Participant Demographics

	Total	%
Age at post-deployment health assessment		
18–24	9	56.25
25–29	1	6.25
30–39	0	0
40+	6	37.5
Age at interview		
18–24	3	18.75
25–29	7	43.75
30–39	1	6.25
40+	5	31.25
Gender		
Male	15	93.75
Female	1	6.25
Military branch		
Army	12	75.0
Marine	4	25.0
Military occupational specialty		
Combat arms	6	37.5
Combat support	5	31.25
Combat support services	3	18.75
Unknown	2	12.5
Number of combat tours		
One	9	56.25
Two	6	37.5
Three	1	6.25
Theaters ¹		
Iraq/Afghanistan	20	83.3
Other ²	4	16.7

¹Because some served in multiple theaters, total number of deployments is greater than the number of participants. ²Included the Persian Gulf, Bosnia, and Kosovo.

Measure

A series of structured, open-ended questions were drafted to elicit information about Joiner's (2005) three main constructs. Some were designed to

identify the most extreme way someone might respond to chronic emotional or physical pain, being a burden on others, or having all or most of their significant interpersonal relationships fail. One researcher began the design process by drafting questions based on the interpersonal-psychological theory of attempted and completed suicide: 18 questions on habituation to pain, 17 on burdensomeness, 11 on failed belongingness, and 2 broad questions on suicide. Three other members of the research team commented on the questions, and they were accordingly revised. The revised questions were then reviewed for clarity and redundancy, final edits were completed, and 26 questions were omitted. The final interview contained 7 questions on pain, 8 on burdensomeness, and 7 on belongingness. Within each section one to three follow-up questions were added as part of the formal interview. The total number of questions in the interview protocol was 36. Sample questions on each concept are as follows: (1) habituation—"Would you describe how emotional pain feels? Physical pain feels? How do you cope with being in pain?" (2) burdensomeness—"What's the difference between needing help with a problem and being seen as weak or a burden?" and (3) failed belongingness—"Is it really necessary to have social connections with others, or are some people just fine completely on their own?" The complete interview protocol is available upon request.

Procedures

Informed consent was obtained. Three members of the team were individually paired with participants. Interviews were audiotaped and lasted approximately 15 to 65 minutes. Following the interviews, the audiotapes were transcribed. Transcripts were independently reviewed by another member of the team who listened to the audiotapes while reading the transcripts. Significant discrepancies identified through this process were discussed with the original transcribers and interviewers, and consensus was obtained regarding suggested changes. Corrections were made and saved as alternate documents. Original transcripts were maintained.

Four members of the team independently reviewed the revised transcripts to begin identifying unique and universal themes. Next, they independently coded the transcripts using colored cards to track language and themes. During independent coding, the reviewers also utilized a template created by the research team to organize veteran interview responses according to Joiner's (2005) constructs and to track whether or not the concept of suicide spontaneously emerged in the content of responses.

We then convened to compare observations and to reach a majority consensus on emerging themes. Each transcript was reviewed separately, and previously reviewed interviews were frequently referenced during discussion, thereby confirming themes and language used. In the process of reviewing all 16 interviews, members of the research team determined that the point of

saturation had been reached (Rubin & Rubin, 1995): No new themes or information were being observed (Guest, Bunce, & Johnson, 2006).

To further examine what types of experiences and events contributed to changes in veterans' ability to tolerate physical or emotional pain, the construct of habituation to painful stimuli was then analyzed. The main goal of the analysis was to understand the psychological mechanisms involved in the development of habituation to painful stimuli. Responses to questions related to habituation to painful stimuli among individuals who reported an increase in pain tolerance were analyzed and coded and themes identified as described above. The data were reviewed several times to verify saturation. Finally, in the course of organizing the structure of the manuscript, we met for further discussion and confirmation of all themes identified.

FINDINGS

Suicide Risk Factors

Habituation to pain. Habituation is defined as a process of learning whereby repeated presentations of a stimulus result in decreased response to that stimulus (Overmier, 2002). Based on this principle, Joiner (2005) proposes that repeated exposure to painful stimuli can result in habituation to pain and fear, both of which contribute to an acquired ability to engage in suicidal behavior when coupled with the desire for death. Individuals who have become habituated to pain are therefore expected to have a higher pain tolerance than others (Joiner et al., 2002). For this group of combat veterans it was believed that the construct of habituation to pain would be particularly relevant. To identify themes related to habituation to pain, participants were asked to describe perceptions of and experiences with emotional and physical pain. Themes emerged regarding combat as a context for pain, pain tolerance, and means of coping.

Many participants discussed combat in Iraq and Afghanistan as a context for exposure to pain (e.g., "mortar attacks," "getting shot at," "being attacked," "explosions," and "pass[ing] through fire fights"). They mentioned that their experiences were or at least seemed to be constant and unrelenting. One veteran stated that in Iraq exposure to danger was something "you live[d] with 24 hours," and noted "that's an everyday, all the time feeling."

In response to how to deal with such painful experiences, many alluded to the notion that individuals vary in their ability to tolerate pain. One veteran expressed what others mentioned: "Some people I think might just have a natural tolerance for pain more than others." However, others viewed pain tolerance as something that was learned through life experiences: "I think it has a lot to do with experience, maybe they've had a lot of pain so they know how to deal with it." Veterans also mentioned general life experiences, such as how one was raised or military training, as factors contributing to pain tolerance:

I have a high tolerance for pain, even when I was a little boy, and in the military I was always told to “man up”—stuff like that—so I really try to shut it out or try not to let them see me sweat, you know.

Others were able to discuss how more specific life experiences, especially repeated exposure to pain and danger in combat, facilitated tolerance. One explained,

I just think sometimes I’m impervious to stuff because there are so many times that I should have been dead. And I mean, when you hear bullets by your ears, there’s like a certain crack it makes and it’s close enough and you think to yourself, “Jeez, I should be dead.”

Similarly, when discussing why it takes more to hurt him now than it did in the past, another veteran said:

I think ‘cause I have been kind of just desensitized to stuff. It is pretty hard, like everything here is so easy compared to being in a combat zone. Just everything...just all the experiences I had just make you a stronger person.

Among the veterans who reported increased pain tolerance, it was often attributed to decreased response to fear. For example, one said, “I think I was afraid” when asked to explain what he believed was contributing to his ability to handle more pain now than in the past. Other veterans discussed using dissociation, namely emotional numbing and detachment, to inhibit fear, particularly when combat-related pain could not be avoided or escaped. One said:

I think that during the time that I was overseas I, ah, kind of lost connection with reality and lost connection with my feelings.... If you don’t have any emotions, then you are not scared or afraid either, which really helps you to get through the days in such a dangerous environment.

Decreased emotional responsiveness persisted post-deployment. One veteran said, “I don’t feel fear very much as far as things going on in my life. I am just kind of numb to everything.” Another mentioned, “I really don’t show emotion any more, love or hate or any of that stuff, you know, I’m just kinda there.” Others described using alcohol and drugs to escape or avoid pain. For example, if his typical strategy of coping with pain by “forgetting about it” was no longer proving effective, one veteran said, “I would drink more and probably turn to drugs, just whatever you can to just forget about it. Bury your thoughts.”

Some veterans seemed to understand the costs of isolating and avoiding painful affect and in turn were able to employ more healthy or adaptive ways of coping with their distress. In their descriptions of how they used social support, a number of veterans emphasized the importance of seeking help: “All the support I’ve been getting—I’ve gotten help for myself, as far as talking about my experiences, actually coming in and talking about my most painful experiences and being able to learn from that.”

Perceived burdensomeness. The second construct is the sense that one is a burden to social supports. To better understand OEF/OIF veterans' beliefs, we posed questions about effectiveness, competence, and the ability to cope with feelings of burdensomeness. Themes identified included burdensomeness to family; loss of self, status, and purpose; and difficulties reintegrating into civilian society.

Many individuals spoke about valuing family and friends as sources of support and some identified them as reasons for living. At the same time veterans were distressed about not being able to provide for partners, spouses, and children, especially financially: "The last X years I haven't had full time employment.... My [child] is ready to go to college and I can't pay for that, so I feel like I have let him down."

In response to questions about burdensomeness, the veterans interviewed consistently spoke about a loss of sense of self post-discharge. The loss seemed to be exacerbated when separation from the military was not their choice: "They made me retire when I got back from this one, and it wasn't a choice.... I still haven't redefined who I am." Often the loss of self was related to a decrease in status or purpose upon return to civilian life. Despite ambivalence about some of the activities in which they had engaged, veterans reported feeling a sense of importance about their mission overseas relative to their civilian avocational and occupational activities:

It was really hard because after leaving the service, I had gained rank and respect.... I had people that relied on me to help them out and as soon as I left, I was a nobody. I was at the bottom of the ladder again. All the time that I spent in the military gaining expertise in my field and gaining the respect of my peers and everything is gone instantly.

Similarly, one participant stated, "I was a good soldier. That's what I was good at."

Several interviewees talked about maintaining independence by creating a new sense of self. Often this new sense of self was related to engaging in a new activity. One veteran recalled a health care provider asking him about retirement post-military and future life goals:

I said I'm going to try and find something where I don't have to worry about hurting people. That would be nice for once in my life, but I don't know what that is. So I'm trying to redefine myself.

Articulated proactive responses about reestablishing a sense of self included returning to school, getting help, reconnecting with family members, and taking on new hobbies (e.g., playing a musical instrument).

Related to the loss of self was confusion about how to integrate back into civilian society—a link between burdensomeness and belongingness. Disconnection from civilians and nonmilitary life and rules was apparent: "I

feel like I am a burden, 100%, I don't feel like I belong anywhere ... like if I'm out with some friends, I don't feel like I belong.... I'm the outsider." Frustration was also expressed about not being able to apply military rules and values to current life. "I actually want to supervise on my job right now, and it's real hard not being able to treat someone I guess in a military manner. You have to be more civil about it."

Failed belongingness. Emphasizing the fundamental human need to belong, Joiner (2005) proposed that a thwarted sense of belongingness can escalate the risk of suicide. In response to questions to elicit veterans' experiences with social connections in military and civilian settings and coping with loss of relationships, the major theme that emerged was a sense of shared experience with comrades in the military coupled with a sense of disconnection from civilian life.

Overwhelmingly, veteran responses emphasized a sense of connection with other military personnel (e.g., "shared experiences," "common values, miseries, and joys"). This sense of connection was clearly solidified through their experiences during deployment. One veteran said, "All you have is each other, and it's such a tight bond, it's awesome." Many stated that these common experiences facilitated a strong bond with other veterans after discharge:

That connection [to other veterans] never weakens. That's the strange thing about it ... I may not communicate as much with active duty soldiers, soldiers from my unit ... but everywhere I go, I run into vets. It's just the way of life, and we talk and we talk about things we've done....

The veterans also discussed a sense of disconnection with people not in the military. One participant reported his sense of connection was with "my Army buddies, the Army, but everyone else, nothing." A veteran of multiple combat theaters said, "I separate myself from society, that part of society. I don't know how to deal with those people ... I just keep myself away." While many veterans could not identify with society in general—as one succinctly stated, "Out in society, there is a disconnection"—others did acknowledge feeling connected to friends and close family who were nonmilitary. Veterans felt "comfortable" and most "at home" at their homes with family and friends. In response to a question about social connections and coping with problems, one said, "Family and friends make it easier."

Suicide

According to the model, those who are at greatest risk of dying by suicide have acquired the ability for suicide in conjunction with burdensomeness and failed belongingness. To explore this relationship, we were interested in whether those interviewed would spontaneously mention suicide in response to questions about the three constructs. Some questions dealt with "the most

extreme” way one might cope with pain, burdensomeness, and failed belongingness. Even though no specific questions about suicide were asked and the word suicide was intentionally never brought up, themes about suicide emerged in response to all three areas. Several veterans explicitly described past suicidal behavior.

Violence toward self or others was a potential response to extreme pain. For instance: “I’d probably say, go back to violence. That’d probably be the most extreme way. You know, violence toward yourself or toward others.” Another veteran said:

They could kill themselves. That’s the easy way out and there’s all kinds of ways they can try to hurt themselves, attempt suicide, slit their wrists, overdose, you know, same things that any other person would, but the only thing is you have military training so you know all kinds of cool ways to, you know, take a life, even if it’s your own.

One interviewee discussed his suicidal ideation when asked about the most extreme way to cope with being a burden on others:

Suicide ... that period in my life that was just a big black hole ... and if it wasn’t for my wife, who challenged me on that, I probably would have followed through And of course, I had a plan, and I stewed over it for some time, but when I did start getting help, I came up with a plan B. Just in case it didn’t work out I had to have an alternate way to deal with this.

Another veteran said, “Probably kill themselves, because they would feel like they are just kind of worthless, like they need too much and stuff.” Others spoke about isolating by running away or abusing drugs or alcohol, and engaging in violence toward self or others.

In relation to extreme ways of coping with losing all or most of their important relationships, suicide emerged as a major theme. One response was:

What’s the most extreme way ... like losing everything? ... Extreme would be like killing themselves. Or they just go down a downward spiral. Alcoholism, drug abuse, we call it self-medication (laughs)....”

Another veteran said, “Most extreme way? Again? Suicide. That’s the most extreme way I can think of.”

DISCUSSION

Central to Joiner’s (2005) theory is the notion that capability for engaging in suicidal behavior is facilitated when individuals habituate to the negative aspects of self-injury (e.g., fear, pain). As expected, veterans spoke about combat being a context for exposure to pain. Moreover, as a result of such com-

bat exposure, veterans indicated increased pain tolerance. Although efforts to manage responses to this pain included employment of pre-existing coping strategies, persistent exposure to combat seemed to require modification of these strategies. The most articulated means of managing pain while in combat was dissociation. The addition of avoidance via alcohol consumption was also noted post-deployment. At one point these dissociative strategies may have been adaptive, but continued reliance on particularly dissociative processes to protect against, escape from, or minimize painful emotions became problematic when veterans returned to civilian life. In the process of transitioning home, some veterans seemed to recognize the ill effects of combat-related coping strategies and had worked on acquiring more adaptive mechanisms. However, others did not perceive a need to learn new strategies.

The findings of this qualitative study also highlight the importance of thwarted belongingness, perceived burden, and suicidal ideation among returning military veterans. We suggest the following strategies for addressing each of these risk areas.

Treatment Recommendations

Habituation to pain. Despite the difficulty inherent in decreasing the negative impact of habituation to pain, Joiner (2005) suggested that working on increasing emotional regulation might decrease self-harm behavior and discourage involvement in provocative experiences. One possible intervention in this regard is mindfulness training. The goal of mindfulness-based therapies is teaching people how to attend to their thoughts and feelings in a nonjudgmental way, which facilitates both awareness of one's internal state and the ability to address potential responses (Hayes, Strosahl & Wilson, 1999; Linehan, 1993; Segal, Williams, & Teasdale, 2002).

Veterans in this study also reported dissociative states or avoidant behavior as strategies for coping with pain. Mindfulness training has been used effectively to reduce self-harm behavior in clinical populations where dissociative and avoidant behavior patterns are common (Linehan, 1993). Mindfulness could also help veterans manage affect triggered by being around other people by increasing their willingness to spend time with others (belongingness).

Perceived burdensomeness. Challenges related to the transition home were exacerbated by veterans' loss of both self and purpose. Outside the military structure, veterans spoke about no longer knowing who they were. Despite expressed ambivalence regarding some of their duties, in general civilian daily activities were seen as having less value than their combat duties, which they viewed as more important and as having more significant consequences.

Veterans reported perceiving themselves as a burden to family and friends particularly due to their inability to provide financial support. For this reason, vocational rehabilitation may be important in helping veterans transition back

into civilian life. Similarly, they reported difficulty in making a post-military vocational choice (e.g., “I still haven’t redefined who I am”). Thus, educational programs directed toward enhancing the ability of traditional vocational rehabilitation services to meet the needs of returning military personnel may also be necessary (United States Department of Veterans Affairs, 2008).

Failed belongingness. Like Joiner (2005), the military recognizes the significance of relationships to success. The “warrior ethos” establishes the mindset of war fighters, supplying the structure for unit cohesion, morale, and professional and personal trust that is essential for success in combat (Headquarters, 2006). The warrior ethos—“I will always place the mission first, I will never accept defeat, I will never quit” and “I will never leave a fallen comrade” (pp. 4–10)—lays a foundation for belongingness and solidarity that, if accomplished, will last a lifetime. However, the sense of loss of that camaraderie and/or the inability to translate warrior ethos principles to a new group of relationships seems to be a challenge for OEF/OIF veterans.

OEF/OIF veterans may benefit from treatment (e.g., couples therapy, family therapy) designed to facilitate socially appropriate interactions with nonmilitary members of their community (Sherman, Zanotti, & Jones, 2005). The finding that veterans experienced difficulty interacting with nonmilitary individuals suggests that clinicians might also consider referring patients for social skills training (Lewinsohn, 1974; Turner, Beidel, & Frueh, 2005). Groups whose members are a mix of veterans and nonveterans or veterans of different conflicts may provide newly returned veterans with a broader experience base from which to learn. Besides working on basic social skills, a group could provide support and ideas about effective coping mechanisms, increase veterans’ socialization, and provide a springboard for socializing with nonveterans (i.e., increase their sense of belongingness with civilian society).

As noted, veterans frequently reported a lack of connection to nonmilitary individuals. Thus, interventions which facilitate smooth transitions from military to civilian life may be helpful. Consistent with this philosophy, current military practices support guided community reintegration. Battlemind training (Walter Reed Army Institute of Research [WRAIR], 2007) is aimed at helping military personnel transition combat skills to daily civilian life. For example, Battlemind training reminds them that “Inflexible interactions (ordering and demanding behaviors) with your spouse, children, and friends lead to conflict (p. 1).” Clinicians are encouraged to review information about Battlemind and incorporate presented language (e.g., mission) when working with OEF/OIF veterans.

Other interventions could target belongingness and burdensomeness together. For example, individual therapy where progress is tracked in concrete ways and the focus is on helping veterans make plans and goals for work and

family could lessen their sense of being a burden. An additional focus of treatment could be building and maintaining healthy interpersonal relationships and effectively managing interpersonal problems. These skills most readily address belongingness issues but could also decrease burdensomeness. While there may be some truth to veterans' perceptions that they are a burden, for many this may be an irrational belief and could be treated as such (Beck, 1995). Cognitive-behavioral family therapy (Piacentini, Rotheram-Borus, & Cantwell, 1995; Schwebel & Fine, 1992) could provide a venue for sharing concerns, reframing beliefs, and finding ways to ease the sense of burden and/or guilt.

A secondary approach to suicide prevention (Maris, Berman, & Silverman, 2000) is to target populations identified to be at greater risk for suicide. Joiner (2005) suggests that the presence of thwarted belongingness, perceived burden, and habituation to pain heighten suicide risk. Thus, targeting these areas when working with OEF/OIF veterans may help to prevent suicide. Utilization of more traditional approaches to reduce depressive and/or other psychological symptoms (e.g. psychopharmacological, psychotherapeutic) is also indicated. Particular attention to interpersonal or cognitive symptoms (Butler & Beck, 1995; Klerman, Weissman, Rounsaville, & Chevron, 1996) may be useful.

The interviews for this study were conducted with mostly male veterans who had a history of seeking mental health services. It would be useful to explore these constructs with women and those who have not identified a need for treatment or have been hesitant to seek it. Moreover, what is clear from the findings is the need for further study of interventions aimed at meeting the needs of returning OEF/OIF veterans.

CONCLUSIONS

For the group of veterans interviewed, exposure to combat seemed to increase pain tolerance and shape coping strategies. Although some of these strategies seem to have facilitated necessary habituation to combat stimuli, they appear to have a negative effect on veterans' ability to reintegrate upon return home. In addition to discussing increased tolerance for painful stimuli, veterans spoke about being burdensome and suffering failed relationships, particularly with civilians. Working with veterans to decrease their suicide risk is likely to require multiple interventions and creative adaptations of existing approaches. It may be that the earlier the interventions, the higher the probability of averting serious long-term problems, including suicide. Finally, these findings suggest that Joiner's theory (2005) may help us understand suicide risk among OEF/OIF veterans. This study is a preliminary step toward a full test of this theory in a veteran population.

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