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Treating Iraq and Afghanistan War Veterans With PTSD Who Are at High Risk for Suicide

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Iraq and Afghanistan War veterans diagnosed with psychiatric disorders commit suicide at a higher rate than the general population (Kang & Bullman, 2008). Posttraumatic stress disorder (PTSD) has been identified as a risk factor for suicide in veterans (Bullman & Kang, 1994) and is the most common mental disorder among Iraq and Afghanistan veterans presenting for treatment at Veterans Affairs (VA) facilities (Kang, 2009). Therefore, it is critical for health providers to identify veterans with PTSD who are at high risk for suicide in order to more effectively intervene to promote safety, stabilization, and reduce psychiatric symptoms. In the following paper, we discuss risk for suicide in veterans with PTSD and application of cognitive behavioral therapies to reduce suicidality in high-risk patients. We also discuss pertinent clinical issues common to treating Iraq and Afghanistan War veterans with PTSD.

Rates of suicide among active-duty service members deployed to Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) have nearly doubled since the beginning of 2001 (Mental Health Advisory Team, 2008). Over 900,000 OEF/OIF military service members have separated from active-duty service since 2002 and 42% of separated veterans have sought care at Veterans Affairs (VA) facilities; of those who sought VA care, approximately 45% were initially diagnosed with a psychiatric disorder, the most common of which was posttraumatic stress disorder (PTSD; Kang, 2009). Veterans diagnosed with PTSD are more likely to die from suicide than those without PTSD, and this risk is substantially greater among veterans with PTSD and comorbid mental disorders such as substance abuse (Bullman & Kang, 1994). Recent findings indicate that OEF/OIF veterans diagnosed with psychiatric disorders commit suicide at a higher rate than the general population (Kang & Bullman, 2008). Thus, it is critical for health-care providers to identify OEF/OIF veterans with PTSD and comorbid disorders who are at high risk for suicide and deliver early interventions to promote safety and stabilization, as well as to provide effective treatments to address underlying symptoms.

Although it is difficult to accurately predict who will commit suicide, warning signs include expressions of hopelessness, threats or plans for self-harm, discussing or writing about death or suicide, and seeking access to lethal means (e.g., obtaining a firearm or hording medications; Rudd, 2008). However, an individual may be at high risk for suicide in the absence of these indicators, and clinicians should identify other factors that are related to an increased risk for suicide (Sullivan & Bongar, 2009). Risk factors for suicide that are common to veteran populations include being of male gender, access to firearms, financial strain, mental and physical disorders, homelessness, and poor social support (Lambert & Fowler, 1997).

Cognitive behavioral therapy (CBT) has been shown to be effective in treating a number of mental disorders (Butler, Chapman, Forman, & Beck, 2006), including PTSD (Harvey, Bryant, & Tarrier, 2003). CBT has also been shown to be effective in reducing suicidality (suicidal ideation, desire, or attempts to commit suicide) in patients at high risk for suicide (Tarrier, Taylor, & Gooding, 2008). However, the complexity of symptoms and common characteristics of OEF/OIF veterans with PSTD can make treatment challenging.

In this paper, we briefly review research findings specific to the risk for suicide in veterans with PTSD and the empirical evidence for CBT to reduce suicidality in high-risk patients. We discuss pertinent clinical issues related to treating OEF/OIF veterans with PTSD, such as perceived stigma, ambivalence toward engaging in mental health treatment, and the challenges and benefits of coordinating the care of PTSD veterans at high risk for suicide. We also describe a composite profile of a veteran with PTSD at high risk for suicide in order to present

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clinically relevant examples of motivational enhancement strategies, suicide risk-reduction planning, and the implementation of CBT.

PTSD and Risk for Suicide in Veterans

Veterans are at greater risk for suicide than non-veterans in the general population (Kaplan, Huguet, McFarland, & Newsom, 2007), and combat veterans with psychiatric symptoms are more likely to make a suicide attempt than combat veterans without psychiatric symptoms (Fontana & Rosenheck, 1995). Psychopathology is typically associated with an increased risk for suicide attempt (Kessler, Borges, & Walters, 1999). However, there is growing evidence of suicidality specific to PTSD symptoms among civilians (Sareen et al., 2007) and combat veterans (Bell & Nye, 2007). Jakupcak and colleagues studied the relationship between suicidal ideation and self-reported psychiatric symptoms among 407 OEF/OIF combat veterans initially evaluated in a specialty VA postdeployment clinic and referred to mental health services. Accounting for symptoms of major depressive disorder, alcohol abuse, and illegal drug abuse, veterans who screened positive for PTSD were found to be more than four times as likely to report suicidal ideation relative to non-PTSD veterans. Furthermore, the likelihood of endorsing suicidal ideation was 5.7 times greater among OEF/OIF veterans who screened positive for PTSD and multiple comorbid mental disorders compared to veterans who screened positive for PTSD alone (Jakupcak, Cook, Imel, Fontana, Rosenheck, & McFall, 2009).

OEF/OIF veterans with PTSD may be at increased risk for suicide because of social alienation and a perceived burden to family members (Brenner et al., 2008). Marital status (Bullman & Kang, 1994; Thoresen, Mehlum, Roysamb, & Tonnessen, 2006) and the presence of a cohesive community (Desai, Dausey, & Rosenheck, 2008) are associated with a decreased risk for suicide among veterans. However, emotional numbing and aggression can cause stress to veterans' family members (Evans, McHugh, Hopwood, & Watt, 2003; Jordan et al., 1992) and undermine the quality of veterans' intimate relationships and social support following deployment (Benotsch et al., 2000). Sayers, Farrow, Ross, and Oslin (2009) found that 75% of married/cohabitating OEF/OIF veterans referred for mental health services reported a significant problem in family functioning within the week prior to seeking VA care.

OEF/OIF veterans with PTSD may also be at increased risk for suicide because of comorbid physical disorders such as poor physical health, pain, and traumatic brain injury (TBI). Pain and physical health impairment are positively associated with PTSD symptoms in active-duty OEF/OIF service members (Hoge, Terhakopian, Castro, Messer, & Engel, 2007) and in OEF/OIF veterans seeking postdeployment VA care (Jakupcak, Luterek, Hunt, Conybeare, & McFall, 2008). Physical pain increases risk for suicidality in the general population (Ilgen, Zivin, McCammon, & Valenstein, 2008), and limitations in physical activity increase risk for suicide in veterans (Kaplan et al., 2007). OEF and OIF veterans with TBI and war-related injuries often have comorbid psychiatric symptoms (Sayer et al., 2008), and the constellation of TBI and psychiatric symptoms increases risk for suicide (Silver, Kramer, Greenwald, & Weissman, 2001). For example, Gutierrez, Brenner, and Huggins (2008) found evidence of recurring suicide attempts in psychiatrically hospitalized veterans with TBI.

CBT to Reduce Suicidality

Several studies have shown CBT to be effective in reducing suicidal behaviors (Tarrier et al., 2008). Effective treatments for suicidality share common features, including theory-driven, structured strategies that are designed to target suicide risk factors, increase motivation and treatment compliance, and introduce skills training to promote self-reliance, responsibility, and the ability to manage distress and crises (Rudd, Joiner, Trotter, Williams, & Cordero, 2009). Brown and colleagues (2005) found that, compared to participants receiving usual care from community providers, participants in CBT therapy for suicidality reported significantly less depression and hopelessness 6 months after initiating therapy and were significantly less likely to reattempt suicide in the 18 months following their initial suicide attempt. Dialectical behavior therapy (DBT) has been shown to be effective in reducing suicidal behaviors in patients with borderline personality disorder. Linehan and colleagues (2006) compared DBT to expert community treatment and found that, over 2 years of treatment and follow-up, patients in the DBT condition were half as likely to make a suicide attempt, had significantly fewer hospitalizations for suicidal ideation, and were significantly less likely to drop out of treatment than patients in the expert community treatment condition. The emphasis in DBT on emotion regulation and distress tolerance are highly relevant to treating persons with PTSD at high risk for suicide, and DBT strategies can be readily incorporated into exposure-based treatments for PTSD (Becker & Zayfert, 2001; Harned & Linehan, 2008).

Common Complicating Factors in Treating OEF/OIF Veterans With PTSD

The factors that typically interfere with mental health treatment may be prevalent in OEF/OIF veterans with PTSD. Unstable housing, financial distress, unemployment or underemployment, divorce or separation may present barriers to initiating mental health treatments.

Even for veterans who have generally stable employment and positive relationship functioning, everyday realities such as work schedules and childcare demands can be obstacles to engaging in regular therapy sessions.

Stigma associated with mental health treatment is a common barrier to seeking care for OEF/OIF service members, especially among those with mental health symptoms (Hoge et al., 2004). Fear of violating traditional male gender norms (e.g., values supporting self-reliance and stoicism) may interfere with male veterans' ability to identify and communicate vulnerable emotional states and may also limit the availability of social support (Jakupcak Osborne, Cook, Michael, & McFall, 2006), which may in turn increase the risk for suicide. Indeed, conformity to traditional male norms has been implicated as a risk factor for suicidal behavior in men (Houle, Mishara, & Chagnon, 2008) and as a potential barrier to identifying veterans at risk for suicide, as they tend to seek help less readily and be more reticent to discuss emotionally painful material (Bahraini, Breshears, & Brenner, 2008). The increasing role of women in combat (Carney et al., 2003) and the military's reinforcement of perseverance in the face of challenge raises the possibility that these phenomena will also be present in female veterans.

The complexity of problems presented by many returning veterans may also present challenges. It may be difficult to sequence and coordinate care for veterans with complex mental, physical, and cognitive disorders. Screening for mental disorders in primary care settings may increase the likelihood that OIF/OEF veterans accept a referral for mental health care, and embedding mental health services within VA primary care settings may help to reduce stigma and improve the continuity and quality of postdeployment care (Seal et al., 2008). However, OEF/OIF veterans with PTSD and significant physical injuries or cognitive impairments may forget appointments or become confused about the respective roles of various providers in multiple clinics. Furthermore, veterans may prioritize medical appointments over mental health appointments, even though PTSD and comorbid psychiatric disorders may interfere with health promotion and physical rehabilitation, increasing physical pain, hopelessness, and suicidal ideation. Likewise, veterans' chronic pain, physical health impairment, and cognitive difficulties may interfere with CBT interventions that are designed to promote active coping, in vivo exposure, and cognitive restructuring.

Three Phases of Treating OEF/OIF Veterans With PTSD at High Risk for Suicide

Our proposed approach to treating OEF/OIF veterans at high risk for suicide is based on our clinical experiences with this population and is consistent with core features of psychosocial interventions designed for the treatment of suicidal behavior (see Rudd et al., 2009) and the treatment guidelines proposed by the International Society for Traumatic Stress (http://www.istss.org/treatmentguidelines/). The approach consists of three phases: (a) comprehensive assessment, treatment engagement, and initial safety planning; (b) suicide risk reduction and CBT skills specific to suicidality; and (c) CBT for PTSD and comorbid mental disorders. In addition to these three goals, maintaining regular supportive contact, fostering motivation for treatment, and continuously assessing changes in risk factors and symptoms should remain priorities throughout treatment. The following are examples of these three phases of treatment applied to an OIF veteran with PTSD at high risk for suicide. The veteran, "Eric," is based on a composite profile of several veterans at high risk for suicide who were treated in a VA specialty clinic for returning OEF/OIF veterans:

Eric is a 26-year-old, single, male Caucasian veteran who served two combat tours in Iraq as part of an Army infantry unit. Eric was brought to the VA by his parents after he complained of severe and recurring headaches. The primary care physician who evaluated Eric referred him to a neuropsychologist for further evaluation of potential traumatic brain injury after Eric reported a loss of consciousness resulting from a roadside bomb that struck his vehicle during a convoy. The primary care physician also referred Eric to a mental health provider for further evaluation after Eric reported that he often felt hopeless and had frequent fleeting thoughts of taking his own life. Eric described a recent episode in which, after learning that a friend and fellow soldier had been killed in combat, he loaded his handgun with the intent to commit suicide. He reports he was interrupted when his parents came home and he put the gun away before they could see what he was doing. On the day he presented for care, Eric denied any imminent plan to harm himself but indicated that he continued to wish for death. He declined a referral for a voluntary inpatient mental health admission, but agreed to a same-day appointment with a psychologist for a full mental health evaluation.

Phase I: Assessment, Treatment Engagement, and Initial Safety Planning

The initial assessment is an opportunity to fully assess for warning signs and risk factors for suicide. Providers should ask directly about past and current suicidality, confident that initiating a discussion of suicidality does not lead to an increased risk for suicidal behavior (Reynolds, Lindenboim, Comtois, Murray, & Linehan, 2006) and facilitates candid discussions specific to promoting safety (Sullivan & Bongar, 2009). The assessment interview can be critical in establishing rapport necessary to engage the veteran in care. Rapport may be facilitated by the mental health provider's knowledge of

typical environmental conditions of Iraq and Afghanistan deployments as well as relevant geographic names and battle time lines. In addition, providers should consider using structured clinical interviews (Wright, Adler, Bliese, & Eckford, 2008) and self-report batteries (see King, King, Vogt, Knight, & Samper, 2006) specifically designed to capture common symptoms and features of combat deployments. Self-report combat exposure instruments can provide useful information about specific types of combat-related events that may inform PTSD symptoms and/or features of suicidality, including witnessing the deaths or injuries of close friends, performing duties that involved caring for the severely wounded or handling human remains, causing the deaths of enemy combatants, and witnessing injury or death of noncombatants. Clinicians are also encouraged to ask about unanticipated duty assignments outside of the veteran's Military Occupational Specialty (MOS) and the possibility that the veteran (or a veteran's friends or family member) will again be deployed to a combat zone. Assessing for other risk factors for suicide behaviors, such as recent aggression, smoking status, family history of suicide (Mann, Waternaux, Hass, & Malone, 1999), childhood or adult sexual and physical victimization (Tiet, Finney, & Moos, 2006), and current access to firearms (Desai et al., 2008) will assist the provider in estimating the level of current risk and will help to guide safety and treatment planning.

Veterans with no prior mental health treatment may experience embarrassment or shame during the initial assessment. The mental health provider can help reduce the veteran's experience of stigma by providing educational information during or immediately following the initial assessment. Emphasizing physiological features of sustained stress and the dose-response nature of posttraumatic responding may help to reduce the veteran's negative self-evaluations or shame. Educational materials (http://www.ncptsd.va.gov/ncmain/veterans/ and http://www.realwarriors.net/) may also be shared by the veteran with his or her family or support to further reduce the experience of stigma. Strategies to promote treatment engagement, such as motivational interviewing (Miller & Rollnick, 2002), employ objective assessment, feedback, and empathetic and reflective statements to address ambivalence toward change and increase motivation for treatment. Motivational enhancement strategies may increase treatment engagement and treatment compliance with exposure therapies for anxiety disorders (Slagle & Gray, 2007), including military-related PTSD (Murphy & Cameron, 2002).

Male veterans may initially be hesitant to engage in therapies that emphasize the expression of emotional sensitivity and vulnerability (Brooks, 2005). During the initial assessment, the mental health provider has an opportunity to introduce broader definitions of "strength" that include seeking support and treatment while reinforcing the veteran's efforts to continue to cope in spite of suicidal thoughts. The CBT provider may also reduce stigma or culturally informed aversions to mental health treatment by emphasizing the active, skills-based components of CBT. Overt parallels made between CBT training and other forms of learning commonly accepted by traditional male culture (e.g., military or athletic training) may increase some veterans' openness to mental health treatment. Although ambivalence regarding therapy may remain present throughout treatment, it is important for the provider to convey confidence in the proposed therapy, acknowledging the need to work together to make appropriate adjustments as therapy proceeds, and encouraging the veteran to make a commitment to the treatment process.

Developing a safety plan with the veteran at risk is an immediate priority in treatment. Safety planning should be a collaborative effort between the mental health provider, the veteran, and, when possible, the veteran's primary social support. It is important to have a candid discussion of the frequency and severity of suicidal thoughts, all past and current plans for suicide, the potential lethality of these plans, and strategies to reduce suicide risk, including attempting to limit immediate access to means. Veterans may be reluctant to give up firearms, either because of hypervigilance and safety concerns, lifestyle activities (e.g., hunting, recreational or competitive shooting), or strong beliefs regarding firearm ownership. Clear communication of risk, collaborative planning with the veteran, and motivational enhancement strategies should be used to help remove or limit access to means of suicide. Many veterans are willing to incorporate friends or family members in this plan (e.g., a veteran may let a friend or family member take his guns for safe holding). In designing a safety plan, it is also important to list factors that might increase suicidality or impulsivity (e.g., abusing alcohol or illegal drugs, changes in medical conditions, physical pain symptoms, poor sleep, and patterns of social isolation).

The provider should listen carefully to assist the veteran in identifying reasons for living (e.g., important relationships with family and friends, religious or philosophical beliefs that are barriers to self-harm, future life goals), supportive others and the degree to which each may be relied upon (e.g., as a "distraction" or as a more involved confidant), and adaptive coping strategies (e.g., exercise or calling a trusted family member or friend). The plan should also include a list of emergency telephone contacts (i.e., 911 and the National Suicide Prevention Lifeline: 1-800-273-TALK). After developing the plan collaboratively, the therapist should print a copy

for the patient to carry with them in case they feel in crisis or impulsive towards suicide.

Eric was notably anxious in his first meeting with the mental health provider. He indicated that his parents had encouraged him to go to the VA because of his recurring headaches and back pain. He also indicated that he was not surprised to learn that his symptoms were consistent with a diagnosis of PTSD, but explained that he had reservations about receiving mental health treatment.

PROVIDER: Eric, You indicated you were part of the initial invasion force. Many of the combat veterans I have met who served at that time describe their deployment as highly stressful. They describe long hours, little sleep, and a lot of exposure to combat or other dangerous situations. This kind of extended stress is hard on the body, and people's nervous systems may adapt to this intense day-to-day stress by staying on "high alert," even if there is no immediate threat.

ERIC: That pretty much sums it up.

PROVIDER: How do you feel about talking to a mental health provider about your experiences?

ERIC: I don't know, it is probably a good idea, but lots of other guys I know had it worse than me. They need the help more than I do. I feel like I should be able to handle this on my own.

PROVIDER: I can understand being concerned about the other guys, and it is normal for veterans who are experiencing symptoms of stress to be concerned about seeking mental health treatment. It's hard for a lot of guys, and maybe especially service members, to talk about things like fears, worries, or problems they're having.

ERIC: I'm not sure how talking about this stuff is going to change anything.

PROVIDER: There are many different approaches to treating stress-related problems. The treatment I propose is focused on adapting the skills you already have and practicing new skills in order to help you better negotiate the symptoms you are experiencing. Many of the things you learned in the military served you well in a combat zone, but some of those same strategies may be causing difficulties in your life now. What worked over there may not work so well back here. You may also have developed some of your own ways to cope with the stress since your deployments. The focus of our work together would be to identify the strategies that are working and the strategies that aren't working. We can also practice some new skills in order to give you a better sense of control over how you respond to your thoughts and feelings.

ERIC: I just don't know if anything can help.

THERAPIST: On a scale of one to ten, how hopeful are you that things can improve, with one being not at all hopeful and ten being extremely hopeful?

ERIC: I don't know, maybe a three. It's been ten months since I came home. I thought it would be better by now.

THERAPIST: You expected that things would be better by now. A moment ago, you said you probably thought treatment was a good idea. Why do you think it would be useful to talk to a mental health provider?

ERIC: I'm not sure. I'm definitely not the same person I was before Iraq. I'm angry all the time. My parents are worried about me. If this is how I will feel for the rest of my life, I'm not sure I want to keep going.

PROVIDER: It sounds to me as though you are really frustrated that things haven't improved after you returned home. You're not sure if meeting with me could be useful to you, but you want things to be different from how they are now. Is that accurate?

ERIC: Yeah, that's right.

PROVIDER: It also sounds as though you have really worked hard on your own to cope with all of these challenges. I believe that we can give you some new skills that will help. But learning new skills is easier if you have someone else to provide feedback and guidance. In some ways, I would be acting like a coach. I would help you adapt the skills you already have and introduce you to new strategies to manage these difficult thoughts and feelings.

ERIC: I don't know.... I guess I'll give it a shot.

PROVIDER: Eric, I appreciate your openness to try a new approach. You said you really want things to be different from how they are now and I'm confident that we can help you feel more in control of how you

respond to your thoughts and feelings. As you and I work together to discover new ways for you to manage these difficult experiences, I'm going to ask you to make a commitment to try out these new approaches in between our sessions so we can see what will work best for you and make adjustments along the way if necessary.

ERIC: OK, I'll try them out if you think they will help.

PROVIDER: I *do* believe many of these strategies will help you find new ways to manage things and I appreciate that you're willing to work hard at this. In the meantime, it will be important that we keep you as safe as possible while we try and make these changes. First, we need to develop a plan to address the things that are interfering with your safety....

Phase II: Suicide Risk Reduction and CBT Strategies Targeting Suicidality

After the initial safety plan is in place, suicide risk reduction and safety plan refinement are ongoing processes. Whenever possible, the mental health provider should recruit a comprehensive treatment team and the active participation of other health care providers and the veteran's key sources of social support. The primary mental health provider is encouraged to take the lead in facilitating a coordinated treatment plan, with each provider identifying their role in reducing suicide risk. We conceptualize the primary mental health provider as the practitioner who has the most knowledge of the veteran and the most regular or meaningful therapeutic contact with the veteran, whether this person is a psychologist, counselor, psychiatrist, psychiatric nurse practitioner, or social worker. There are numerous ways in which other treatment team members may provide critical support to the suicidal patient. For example, assuming the primary mental health provider is a mental health counselor, he or she might enlist the help of a primary care provider who might help stabilize and treat medical disorders or physical complaints such as chronic pain. Psychiatrists or primary care physicians may prescribe medications to improve pain, sleep quality, nightmares, mood symptoms, or agitation. Rehabilitation specialists may identify appropriate goals and specific strategies to promote the veteran's recovery from TBI or other injuries. Social workers may have specific knowledge of resources to help the veteran to address psychosocial needs such as problems with employment, housing, or financial debts. Finally, but importantly, the primary mental health provider should encourage the veteran to identify family members or close friends who are informed of the safety plan and who agree to help provide encouragement, support, and monitoring of safety. Necessary signed releases of information should be obtained early in the process and updated as necessary to facilitate ease of communication between key players in the veteran's safety plan.

The provider and veteran should conduct a behavioral analysis to identify the antecedents of suicidal ideation and the ways in which the veteran's suicidal ideations and behaviors function and are reinforced by internal and contextual factors. The veteran should be encouraged to identify specific emotional states that frequently cue suicidal thoughts. Veterans who either devalue or fear discussing vulnerable emotions may benefit from an examination of personal and cultural schemas regarding traditional gender norms as part of the emotional skills training. Reviewing both general and idiosyncratic functions of specific emotional states (e.g., sadness, love, anger, or fear) can normalize the experience of vulnerable emotions and help to address emotional skills deficits such as alexithymia. Providers should pay particular attention to feelings of guilt or remorse associated with combat service, as these are emotional reactions that may increase the risk for suicide behaviors in veterans (Hendin & Haas, 1991; Hyer, McCraine, Woods, & Boudewyns, 1990).

PROVIDER: Eric, what emotions are you feeling at the moment that you start to think of hurting yourself?

ERIC: I don't know....I just feel like crap.

PROVIDER: So you're feeling negative emotion. Can you put a name to it like anger, fear, guilt, shame, sadness...?

ERIC: I don't know.

PROVIDER: People can have many emotions at once, but it can be useful to use names to describe what we feel. For example, if someone hurts us physically or emotionally we may feel anger and want to defend ourselves or seek revenge. We may feel guilt if we regret something or if something that we do breaks some rule that is important to us. We may feel sadness or grief if we lose something or someone who is important to us.

ERIC: I guess it's guilt. I think of my friend getting hurt and I feel bad for his family. I don't have a wife or kids....maybe if I had gone back for a third tour, I

might have been able to do something to prevent what happened.

PROVIDER: Eric, is this how you were feeling the day you were thinking of suicide, that day when you got your gun out, but were interrupted when your parents came home?

ERIC: I was taking my gun out of my jacket to put it away and I started to feel like crap...I guess I started to feel guilty that I was still alive.

THERAPIST: You mentioned that you carry your handgun with you most places you go. You leave it near your bedside at night. Ready access to a loaded firearm is a significant risk factor for suicide, so I'd like to discuss the benefits and risks of keeping your handgun with you.

ERIC: It makes me feel safer.

THERAPIST: Having the gun with you makes you *feel* safer, but it also sounds as though seeing or handling your gun may make you to think more about hurting yourself.

ERIC: I look over at it and I remember that day when my friend died and I think, if I had the courage to follow through with it, I wouldn't have to keep feeling like this all of the time.... It would be over.

THERAPIST: So let's look at this pattern. It sounds as though seeing the gun will often cue thoughts of suicide. You see the gun then think of your friend who was killed, and then start to experience feelings of guilt because he was killed and you are still alive. The thoughts of suicide allow you to imagine an end to these difficult emotions. Is that accurate?

ERIC: Yeah. It sounds weird, but just thinking about killing myself sometimes makes me feel better.

THERAPIST: When you imagine escaping the feelings of guilt, you feel better, but unfortunately, this pattern actually reinforces your suicidal thoughts and makes them more common over the long term.

ERIC: I'm not sure what you mean.

PROVIDER: You keep the gun with you because of your symptoms of hypervigilance, you feel unsafe a lot of the time. However, the sight of the gun reminds you of your friend and you then feel guilty. Then the thought of suicide causes you to imagine an end to the guilt, and you feel better, which means you are more likely to have those same types of suicidal thoughts next time you feel guilt. The thoughts of suicide work in the short term, but this pattern may be increasing the frequency of suicidal thoughts without helping you negotiate those feelings of guilt. I'd like to suggest that we can find a way to change this pattern, so that if you are cued to remember the death of your friend, you are able to use different coping strategies to manage your feelings. First, let's discuss the pros and cons of keeping your gun with you when you out in public or when you are at home...

Phase III: Treating PTSD and Comorbid Psychiatric Symptoms

Following the introduction of a safety plan and CBT skills to reduce suicidal thoughts, impulses, or self-harm behaviors, it is important to address specific psychiatric disorders (keeping in mind that suicide risk reduction planning is ongoing throughout the treatment). The provider should maintain a flexible approach to treating specific disorders and psychiatric symptoms, carefully monitoring safety, continued ambivalence, and resistance to treatment. In our clinical experience, many OEF/OIF veterans remain ambivalently connected to therapy throughout the treatment process, commonly expressing beliefs that negate the need for treatment (e.g., "I should be able to handle this on my own"). In addition, because the treatment of PTSD generally involves, in some form or another, purposeful engagement with previously avoided thoughts, memories, and emotions, resistance is common to this third phase of treatment. As trauma material is actively engaged and recall is elicited, resistance to the treatment process may be a natural response. This may be seen through active resistance (e.g., canceling or no-showing multiple appointments, using alcohol, or other substances immediately prior to or following a session) or may be expressed less directly through such behaviors as forgetting to do "homework" for sessions, or bringing up topics that distract from trauma-related sessions. It is not assumed that feelings of ambivalence to treatment or resistance within therapy will arise immediately or remain stable throughout this phase of treatment, but practitioners should be sensitive to these issues and the distress that they represent during this often emotionally evocative work. In general, the patient's subjective appraisal of distressing symptoms should be used to guide treatment.

During this third phase of treatment, special attention should be paid to comorbid disorders and psychosocial stressors associated with increased suicide risk and the

provider should help the patient to prioritize targets of treatment that will facilitate and improve safety. For example, marital status and positive social support are protective factors for suicide, and CBT-based couples interventions can both reduce marital distress and improve relationship functioning in veterans with PTSD (Monson, Schnurr, Stevens, & Guthrie, 2004; Rotunda, O'Farrell, Murphy, & Babey, 2008). Veterans and family members may be reluctant to engage in formal couple or family therapy. Brief relationship "check-ups" that utilize motivational interviewing techniques may lead to immediate improvements in intimacy and openness to make changes within relationships, as well as increase the likelihood that families will accept a referral for couple or family therapy (Cordova et al., 2005; Uebelacker, Hecht, & Miller, 2006). Depressive symptoms are strongly associated with suicidality (Kessler et al., 1999) and they are common in combat-related PTSD (Orsillo et al., 1996). Behavioral activation is an effective treatment for depression (e.g., Dimidjian et al., 2006) and includes strategies designed to target avoidance behaviors common in PTSD and promote future-oriented thinking through goal identification (Martell, Addis, & Jacobson, 2001). Substance use can increase impulsivity and suicidality, but OEF/OIF veterans abusing alcohol may not be aware of the problematic nature of their drinking because they reference their behavior to peer-based norms and may even perceive benefits from alcohol consumption in terms of sleep and anxiety reduction. Motivational interviewing and educational tools (www.niaa.nih.gov) can help orient veterans to normal use patterns and promote reduction or abstinence. Integrated therapies such as "Seeking Safety" have empirical support for the simultaneous treatment of PTSD and substance abuse treatment in female trauma survivors (Najavits, Weiss, Shaw, & Muenz, 1998) and have been adapted for the treatment of male combat veterans (Weaver, Trafton, Walser, & Kimerling, 2007).

Prior to initiating a specific approach to treating PTSD, the provider should have an understanding of the nature of the veteran's individual profile of PTSD-related symptoms and the veteran's readiness to address these symptoms. Motivational interviewing strategies may increase the veteran's readiness to address trauma-specific content while improving or maintaining the veteran's engagement in regular treatment sessions. Empirically supported CBT therapies for PTSD include exposure-based therapies such as Prolonged Exposure (PE), systematic desensitization, Cognitive Processing Therapy (CPT), cognitive therapy, Stress Inoculation Training (SIT), Eye Movement Desensitization and Reprocessing (EMDR), and relaxation training (Rothbaum, Meadows, Resick, & Foy, 2000). Exposure-based therapies have been shown to reduce PTSD symptom severity and improve functioning in male and female veterans (e.g., Cooper & Clum, 1989; Keane, Fairbank, Caddell, & Zimering, 1989; Schnurr et al., 2007) and are considered a first-line treatment for PTSD (Rothbaum et al., 2000). Targeting of PTSD reexperiencing symptoms through exposure may be effective in quickly reducing the frequency and intensity of intrusive trauma memories and this is important, especially in light of recent evidence that suggests that reexperiencing symptoms (more so than the avoidance or hyperarousal symptoms) may inform suicidality in veterans with PTSD (Bell & Nye, 2007). However, the therapist should weigh the potential benefits of exposure therapies as an initial strategy with the consideration that these therapies may not be as effective for treating PTSD for individuals who are highly avoidant of trauma cues or who have guilt associated with violence perpetration (see Rothbaum et al., 2000) and findings that suggest that veterans in trauma-focused group therapies may be more likely to drop out of treatment (Schnurr et al., 2003). There is strong support for CPT as a treatment for PTSD in male and female veterans (Monson et al., 2006; Resick et al., 2008), and the results of a dismantling study suggest that cognitive restructuring, even when delivered without the trauma-focused components of CPT, can reduce PTSD, depression, and trauma-related guilt (Resick et al., 2008). As such, veterans who express confidence in the potential benefits and rationale of exposure therapy and whose primary emotional reactions to trauma cues are fear and anxiety are good candidates for exposure therapies such as PE or systematic desensitization, whereas veterans who refuse to discuss traumatic memories or whose feelings of guilt or remorse are primary to their distress may be more receptive to initiating stress inoculation skills training and cognitive processing strategies. Introducing the transition to PTSD-specific treatments is facilitated by reviewing the veteran's previous successes in therapy and reinforcing gains specific to managing suicidal thoughts and impulses.

> PROVIDER: Eric, you've done a great job of putting these new skills in place to improve your safety. I know that it's a struggle for you, and I'm going to keep asking you when we meet whether you've been feeling suicidal and if there are other things we should be doing to make sure you stay safe.

> ERIC: Some days are better than others. It's still hard, but I guess that I can talk about it in here. I'll tell you if it gets bad again.

> PROVIDER: This is hard work and I'm glad we can keep talking about the suicidal thoughts and continue

practicing the skills you have learned. You filled out the symptom measures today; looking over them now, which symptoms are giving you the most trouble in your daily life?

ERIC: I'd say the headaches and my energy. Even if I sleep 'till noon, I just don't feel like I have any energy.

PROVIDER: Before you leave today, we can call your primary care doctor and set up an appointment with her to review the medicines she is prescribing for your headaches. Tell me more about the low energy; looking at your report of symptoms, it seems as though the low energy is connected with some of the other depressive symptoms, such as the feelings of guilt, and feelings of hopelessness. Is that right?

ERIC: Yeah. I don't really have any reason to get up in the morning. I end up sleeping all day and when I do wake up I'm upset that I just wasted another day in the house.

PROVIDER: So, in addition to the headaches, the depression symptoms are really giving you a lot of trouble right now. You are sleeping more than you want, and you are feeling down on yourself for not accomplishing more during the day. I would like to propose that we spend our next several sessions developing a plan to build more activities into your day. These need to be activities that are important to you, that have the potential to improve your mood, and that are in line with the some of your goals in life.

ERIC: I don't really have any goals in life. That's the problem.

PROVIDER: That's a great place for us to start. Let's take a look at life-goals, goals you had before your deployments, and goals that you might want to set for yourself now. However, I also want to keep an eye on some of the PTSD symptoms you are reporting. Looking over your report of PTSD symptoms, it seems like the nightmares have been really disrupting your sleep, which may be part of the energy problem and why you're sleeping more during the day. There may be some other medicines available that may reduce your nightmares. I also notice that you continue to go out of your way to avoid thinking about or talking about Iraq.

ERIC: Yeah. I don't want to talk about that stuff.

PROVIDER: These are difficult memories and it makes sense that you would instinctively avoid thoughts or discussions of those events, but I wonder if there are costs to the avoidance.

ERIC: What's the point? It's not going to change what happened.

Provider: That's true. The events that you experienced won't change, but I wonder if we might change some of the ways in which you react to and experience the memories of those events. You have already learned to identify the emotions that cued the thoughts of suicide and you practiced alternative ways of coping with those feelings.

ERIC: Yeah, that's true... But I'm not sure I'm ready to talk about Iraq.

PROVIDER: When we started working together, the first thing we did was discuss the costs and benefits associated with trying a new approach to coping with the suicidal thoughts. Do you think we could do the same thing now? Could we discuss some of the costs and benefits that might come from talking about and thinking about those events as part of our work together? It might also help if you knew more about the specific approaches we could use to cope with the feelings that might come if you choose to talk about those memories.

ERIC: I guess that would be OK ... just to talk about what it would look like.

Most CBT protocols are specifically structured across sessions in order to provide psychoeducation, skills training, and guided support to the patient as he or she addresses the trauma-related emotional and cognitive reactions that maintain chronic PTSD symptoms. This ordered structure should be considered an important feature of these approaches and the clear expectation of treatment duration and session content can provide a reassuring framework that benefits both the patient and therapist. However, rigidly adhering to structured therapy sessions may dissuade the veteran from disclosing suicidal thoughts or make it more difficult for the clinician to detect increases in a veteran's sucidality and potentially cause the veteran to lose confidence in the therapist's ability to appreciate his or her distress. Although the therapeutic alliance is always a priority

in therapy, it is a critical tool for promoting safety when working with patients at high risk for suicide. Thus, the therapist may consider extending educational and coping skills training stages of treatment, augmenting treatment with DBT distress-tolerance skills training (Linehan, 1993), and/or repeatedly reviewing the rationale for trauma-focused therapies prior to engaging in imaginal exposure or trauma-focused scripting sessions. Once trauma-focused stages of treatment are initiated, the therapist must continue to be open to flexibility in organizing session content, remaining mindful of the possibility that suicidal ideation and impulses to self-harm may increase during these phases of treatment. Should increases in suicidality arise, it can be helpful to explicitly point out the association between PTSD symptoms (e.g., intrusive thoughts or emotional and physical reactivity to trauma cues) and an increase in the frequency or intensity of veteran's suicidal thoughts and impulses to self-harm. Highlighting these associations also affords the veteran an opportunity to practice distress-tolerance skills specific to suicidality in session, potentially increasing the veteran's perceived self-efficacy to manage suicidal thoughts and seemingly overwhelming emotions within the context of discussing traumatic events.

PROVIDER: Eric, you wrote out your description of the day your friend saved your life in Mosul. What was it like for you to put this down on paper?

ERIC: Honestly, I started thinking about hurting myself again. I thought about asking my dad for the keys to the gun safe, but I knew that would make him upset and it probably wasn't a good idea.... I started feeling like I don't deserve to be here. It's been a rough couple of days. I've been trying to go for walks and listen to music, but I still feel pretty bad.... He saved me. I should have been there to save him. I guess I still feel guilty for being alive.

PROVIDER: You used the skills you have learned and you were able to see what was happening in the moment. Thoughts of your friend's death, in this case, thoughts that came up while you were writing down the details of the event in which he saved your life, triggered those old patterns of suicidal thoughts and impulses to use your gun to kill yourself. But you did a great job of sticking to the safety plan that you and I developed together. Your dad had the keys to the gun safe and you chose not to ask him for those keys, so you chose not act on those thoughts. Instead, you were able to use some of your alternative coping strategies, like talking walks and listening to music. Eric, this is really impressive. You took steps to revisit the memory that before had felt too painful to think about. You not only thought about it, you wrote it down. You were able to allow yourself to feel the grief while you put into play all of the skills that you have learned to manage the thoughts of suicide that also came up.

ERIC: Yeah, I guess that's true.

Conclusions

OEF/OIF veterans with PTSD, especially those with complex psychiatric profiles and physical disorders, may be at increased risk for suicide. It is important for providers to ask directly about past and current suicidality. Careful monitoring of warning signs for suicide and thorough assessment of suicide risk factors should be thought of as an ongoing process and continued throughout treatment, as should collaborative suicide risk reduction planning. Therapists should prioritize treatment-engagement and continuity of care, employing motivational enhancement strategies and flexible applications of CBT interventions to reduce or remove suicide risk factors and treat underlying disorders. Providers are encouraged to adopt a multidisciplinary team approach and, when possible, enlist the support of veterans' friends and family.

Effective treatment of patients at high risk for suicide is facilitated by an awareness of national and local resources relevant to suicide, training in therapeutic strategies specific to suicidality, and professional support and consultation. In addition to the veteran-specific resources available through the National Suicide Prevention Lifeline, the VA has implemented screening procedures to detect symptoms of PTSD, depression, and substance abuse for all veterans enrolled in care. Additional standard comprehensive suicide risk screening and evaluation procedures have been developed for veterans who indicate symptoms of PTSD and depression. VA and community health providers treating veterans are encouraged to review online materials produced by the National Institute of Mental Health (http://www.nimh.nih.gov/health/publications/suicide-in-the-us-statistics-and-prevention.shtml) and the Department of Veteran Affairs (http://www.mentalhealth.va.gov/MENTALHEALTH/suicide_prevention/index.asp). Mental health providers are also encouraged to seek out specific texts (e.g., Kleespies, 2009) and specialized training (e.g., DBT training) specific to the treatment of high-risk patients. Finally, it is important to acknowledge that treating patients who are at high risk for suicide is often both challenging and stressful for providers. A

substantial portion of mental health providers report having experiencing a patient suicide (rates that vary from 11% to 50% across types of profession and clinical settings) and providers may experience significant emotional distress in response to a patient's suicide attempt or completed suicide (see Kleespies & Ponce, 2009). Thus, providers who are caring for patients at high risk for suicide should frequently seek out appropriate supervision, consultation, and peer support. Providing care to OEF/OIF veterans with PTSD who are at high risk for suicide is often challenging but also highly rewarding. The mental health provider has the opportunity to provide critical support to men and women who served in OEF/OIF and witness their recovery from the traumatic experiences associated with their military service.

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