A Qualitative Study of Potential Suicide Risk Factors Among Operation Iraqi Freedom/Operation Enduring Freedom Soldiers Returning to the Continental United States (CONUS)

Jaimie Lusk,[1,2,3] Lisa A. Brenner,[2,4] Lisa M. Betthauser,[2,5] Heidi Terrio,[6,7] Ann I. Scher,[8] Karen Schwab,[7,8] and Artur Poczwardowski[3]

[1] *The Henry M. Jackson Foundation for the Advancement of Military Medicine, Inc.*
[2] *Veterans Integrated Service Network (VISN) 19 Mental Illness Research, Education, and Clinical Center (MIRECC)*
[3] *University of Denver, Graduate School of Professional Psychology*
[4] *University of Colorado Denver, Anschutz Medical Campus, Departments of Psychiatry, Neurology, and Physical Medicine and Rehabilitation*
[5] *University of Colorado Denver, Department of Psychology*
[6] *Evans Army Community Hospital, University of Colorado Denver, Department of Psychology*
[7] *Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury*
[8] *Uniformed Services University of the Health Sciences*

Objective: A qualitative study among Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) Soldiers was conducted to explore potential constructs underlying suicide according to the interpersonal–psychological theory of suicide (IPTS); these include burdensomeness, failed belonging, and acquired capability. **Methods:** Qualitative semistructured interviews were conducted with 68 Soldiers at 3 months post-OEF/OIF deployment. Soldiers were asked about changes in their experiences of pain, burdensomeness, and lack of belonging. The methodology employed was descriptive phenomenological. **Results:** Transcripts were reviewed and themes related to the IPTS constructs emerged. Soldiers' postdeployment transition experiences included higher pain tolerance, chronic pain, emotional reactivity, emotional numbing and distancing, changes in physical functioning, combat guilt, discomfort with care seeking, and difficulties reintegrating into family and society. **Conclusions:** Findings highlight the utility of the IPTS in understanding precursors to suicide associated with transition from deployment, as well as treatment strategies that may reduce risk in Soldiers during reintegration. J. Clin. Psychol. 00:1–13, 2015.

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When the United States (U.S.) military began tracking suicide in the mid-1980s, suicide in the Army was well below that of a civilian demographically adjusted population (Bush et al., 2013). Despite extensive Army suicide prevention efforts, in 2008 the Army suicide rate surpassed that

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Please address correspondence to: Lisa Brenner, VISN 19 Mental Illness Research Education and Clinical Center, Department of Veterans Affairs, 1055 Clermont St., Denver, CO 80220. E-mail: lisa.brenner@va.gov.

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of a comparable civilian population and has continued to remain elevated, with the 2012 Army suicide rate triple that of 2004 (Kuehn, 2009; Castro & Kintzle, 2014). In examining correlates of suicides among active duty Regular Army Soldiers from 2004–2009, researchers have highlighted Army-specific predictors for suicide, including recent demotion, as well as deployment (Schoenbaum et al., 2014). Among enlisted Soldiers in the first four years of service, the suicide rate was 70% higher among currently and previously deployed than never deployed Soldiers (Gilman et al. 2014). As self-directed violent behaviors are most often preceded by stressful events (Nock et al., 2013), Soldiers may be at elevated risk during transitions associated with deployment.

Transitions

Soldiers may experience significantly more transitions than their civilian counterparts. The average 24-year-old Soldier

> has moved from home, family and friends and has resided in two other states; has traveled the world (deployed); been promoted four times; bought a car and wrecked it; married and had children; has had relationship and financial problems; seen death; is responsible for dozens of Soldiers; maintains millions of dollars worth of equipment; and gets paid less than $40,000 a year. (U.S. Department of the Army, 2010, pp. 1–2).

Ever-shifting work responsibilities (deployments, permanent change of station [PCS] moves and promotions), changing family roles, and military-related stressors (combat exposure, losses, injury, disciplinary problems) may lead to cumulative deterioration in mental health. From 2005–2007, 44.6% of Army suicide deaths were found to be associated with relationship problems, and 41.1% were associated with work stress (Logan, Skopp, Karch, Reger, & Gahm, 2012). In response, the U.S. Army has recommended that research should focus on the Soldier's experience in transitions (U.S. Department of the Army, 2010).

The Interpersonal–Psychological Theory of Suicide (IPTS). The IPTS proposes three constructs that underlie suicidal behavior. Two interpersonal constructs, perceived burdensomeness and thwarted belongingness, are suggested to contribute to the desire to commit suicide; an additional construct, acquired ability, is theorized to be related to one's ability to engage in self-directed violent behavior (Joiner, 2005; Van Orden et al., 2010). Whereas perceived burdensomeness is an individual's belief that they are a liability to their friends, family, work, or society, failed belonging is one's sense that they have failed to establish and maintain relationships. Moreover, the capability to enact lethal self-harm is hypothesized to be acquired through repeated exposure and increased tolerance to physically painful and fearful experiences (Van Orden et al., 2010).

IPTS is considered a valuable theory in understanding suicidality among military personnel and Veterans, as military training and combat experience include painful and provocative experiences, which may increase acquired capability. Moreover, as noted above, transitions related to postdeployment reintegration, discharge from service, physical or psychological injuries, or following significant losses may contribute to experiences of perceived burdensomeness and thwarted belonging (Selby et al., 2010). In one study involving 88 Active Duty Air Force personnel who recently graduated from combat training but had not yet deployed, service members reported higher acquired capability when compared to civilians (Bryan, Morrow, Anestis, & Joiner, 2010). Combat exposure also appears to increase acquired capability. Bryan, Cukrowicz, West, and Morrow (2010) analyzed surveys addressing perceived habituation to pain from 522 service members deployed in service of Operation Iraqi Freedom (OIF). These researchers found that combat experience predicted acquired capability above and beyond other common risk factors for suicide such as depression, posttraumatic stress disorder (PTSD), or previous self-directed violent behavior. According to Joiner (2005), acquired capability for suicide is cumulative and irreversible. Therefore, capability acquired during military service may increase risk over a lifetime.

Central to the IPTS, the interpersonal constructs of perceived burdensomeness and failed belongingness increase desire to commit suicide. In a study examining military personnel deployed to Iraq, researchers found that perceived burdensomeness was significantly associated with suicidality (i.e., suicide attempts, suicidal ideation, suicidal communication, and subjective likelihood of future suicide attempt), above and beyond the effects of other risk factors for suicide (Bryan, Clemans, & Hernandez, 2012). Moreover, in a study involving 72 Soldiers who attempted suicide, Bryan and Rudd (2012), reported that interpersonal and relationship stressors (specifically an argument, criticism, and isolation) were the most common external events occurring within 24 hours of the attempt. Field combat stress clinics have identified that the leading cause of suicidal or homicidal thoughts for Soldiers in Iraq and Afghanistan are distressing state-side romantic relationships (Gottman, Gottman, & Atkins, 2011).

As described above, the IPTS is considered a valuable theory in understanding suicidality among military personnel. The theory may be especially relevant for understanding suicide risk among military personnel during periods of transition. In a qualitative study which explored suicide risk in 16 Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) combat Veterans seeking care at a Veterans Affairs Medical Center (VAMC), interviews highlighted perceived burdensomeness and failed belonging related to transitioning from the military to civilian life (Brenner et al., 2008). Although several studies have explored the relevance of Joiner's (2005) theory for specific populations including Veterans and Active Duty military, to our knowledge, no studies have focused on acquired capability, perceived burdensomeness, and failed belonging in a population of Active Duty Army personnel transitioning from deployment to garrison life.

Qualitative studies have been recommended in the field of suicidology to better understand suicide risk (Hjelmeland & Knizek, 2010). A qualitative study can bring greater understanding to quantitative findings and current theories, subsequently improving interventions and guiding future research (Chwalisz, Shah, & Hand, 2008). Qualitative research has been used to explore Joiner's theory in the military population (Anestis et al., 2009; Brenner et al., 2008). The purpose of this descriptive phenomenological study is to extend understanding of the constructs that contribute to suicide from the perspective of the IPTS to the population of Active Duty Army Soldiers transitioning from deployment to garrison life.

Methods

Participants

After obtaining approval from Departments of Defense (DoD) and the Veterans Affairs (VA) Institutional Review Boards, participants were recruited from the population of OEF/OIF Soldiers from a mountain state Army Base, between 5 and 7 days after returning to the U.S. during the Post-Deployment Health Assessment (PDHA). Participants were from three different brigades whose return spanned a 2-year period. Data reported are from a qualitative project that was part of a larger quantitative effort to study the epidemiology, natural history, and prognostic predictors of mild traumatic brain injury (mTBI). For the qualitative study, a stratified random sample of OEF/OIF Soldiers were identified, recruited, asked to sign informed consent documents, prior to being assessed for eligibility (see Brenner et al., 2014, for detailed selection criteria). Those who completed initial qualitative interviews were contacted by phone at approximately 3-, 6-, and 12-months postdeployment to complete similar follow-up assessments.

Participants in this qualitative study included 68 Soldiers from the original 103 interviewed during the PDHA, with 34 of those originally interviewed unavailable for interview (10 Soldiers changed contact information; 3 were deployed; 2 were unavailable due to participation in training exercises; 19 Soldiers did not answer the phone after five attempts). Three-month interviews were selected because research conducted by Bliese and colleagues (2007) suggests that Soldiers report significant increases in mental health symptomology some time after the first month period of immediate reintegration. See Table 1 for demographic information.

Table 1
Soldier Demographics

Characteristic Subtotal *(n = 68)*	%	
Age at Postdeployment Health Assessment		
18–24	29	42.6
25–29	20	29.4
30–39	17	25.0
40–47	2	2.9
Gender		
Male	66	97.1
Female	2	2.9
Ethnicity		
White	47	69.1
Black	3	4.4
Hispanic	14	20.6
Native American	2	2.9
Pacific Islander	1	1.5
Rank		
E1-E4	36	52.9
E5-E6	25	36.8
E7-E9	2	2.9
O1-O10	5	7.4
Marital status		
Single	19	27.9
Separated	8	11.8
Divorced	3	4.4
Married	38	55.9
Military occupational specialty category		
Combat	38	55.9
Combat support	15	22.1
Combat service support	15	22.1
Theater (OIF or OEF)		
Iraq	46	67.6
Afghanistan	22	32.4
TBI history in lifetime per OSU TBI-ID		
No TBI	11	16.2
1 TBI	17	25.0
2 TBIs	16	23.5
3 TBIs	14	20.6
4 TBIs	5	7.4
5 TBIs	1	1.5
6 TBIs	4	5.9
PTSD history per the PCL-C		
Negative	33	48.5
Positive	35	51.5

Note. OIF = Operation Iraqi Freedom; OEF = Operation Enduring Freedom; OSU TBI-ID = Ohio State University Traumatic Brain Injury Identification Method; PTSD = posttraumatic stress disorder; PCL-C = Posttraumatic Stress Disorder Checklist-Civilian.

Materials

Interview questions pertaining to this study focused on Soldiers' lived experiences related to habituation to pain, perceived burdensomeness, and lack of belonging during the postdeployment transition. Specifically, Soldiers were asked the following interview questions:

- How has the way that you experience physical and/or emotional pain changed as a result of your deployment-related experiences?

- Does it seem like it takes more to hurt you (physically and/or emotionally) now than it did in the past? If so, why?
- Have you had periods of time during which you felt like a burden to your unit, job, family, friends, or society? Please describe your thoughts, feelings, and actions during this period of time. How have you or would you handle it if you felt like this?
- Have you had periods of time in which you felt like an outsider within your unit, at your job, or in social/family situations? Please describe your thoughts, feelings, and actions during this period of time. How have you or would you handle it if you felt like this?

The qualitative study included additional questions related to combat injuries and experiences, which were not the focus of this analysis, but were reviewed. During the interviews, participants were encouraged to elaborate and were asked follow-up questions to expand and clarify the participant's descriptions (Chwalisz et al., 2008).

Procedures

Research team members conducted qualitative interviews by telephone during a window of 2 1/2 months to 5 months after the initial interview. All research team members conducting phone interviews had clinical experience, received qualitative training, completed readings on qualitative methods, and practiced administering the semistructured interview until achieving proficiency. Interviews lasted from 2 to 65 minutes, with a mean of approximately 18 minutes. All interviews were audiotaped. One team member transcribed the audiotapes, another team member reviewed the transcriptions, and the original transcriber approved all corrections.

Data analysis involved a four-stage stepwise replication, including individual and collective attending to the unique experiences of the participants (Giorgi & Giorgi, 2003; Chwalisz et al., 2008). First, three researchers (JL, LAB, LMB) read through transcripts several times, highlighting significant quotations and paying special attention to participant's stories. Second, researchers met to discuss most frequent and salient themes that emerged from the interviews. At this meeting, a preliminary coding sheet was created. The researchers (JL, LAB, LMB) independently coded the first three interviews. These three researchers then met again, and finalized a coding sheet that included the effects of physical and emotional injuries, changes in the Soldier's experience of pain, experiences of burdensomeness, experiences of belonging, and reactions to these experiences. Third, the researchers independently coded transcripts, with at least two researchers coding each interview. Finally, the three researchers reconvened to share relevant quotes and reorganize the quote groupings into themes. Themes were examined for convergence and connection and discussed until researcher consensus was reached.

The rigor of this study was ensured through (a) researcher triangulation, involving use of multiple researchers to collect and analyze the data, and (b) theoretical triangulation, meaning all three researchers coding the data have different personal, clinical, and research expertise specific to this study population (Chwalisz et al., 2008). Data analysis continued until all interviews ($n = 68$) were coded. The interview protocol could not be adjusted; therefore, true saturation could not be ensured because more themes may have emerged with different questions. However, all three researchers achieved consensus on essential themes, concepts and ideas reflected in the data, and no new categories emerged (Creswell, 2006). This informational redundancy indicates sample size was sufficient (Onwuegbuzie and Leech, 2007).

Results

In response to the interview questions, Soldiers described experiences related to habituation to pain, perceived burdensomeness, and lack of belonging. Additionally, Soldiers reported ways that they coped with these experiences.

Habituation to Physical and Emotional Pain

Positive perception of changes in physical and emotional pain. Some Soldiers who reported that their combat experience resulted in higher pain tolerance contended that developing a higher threshold of pain was a necessary adaptation in the combat environment. One Soldier

said, "You learn to push through it just because you have to, and so your threshold of pain becomes greater." Reflecting the resilience gained from combat, a Solder said, "If it's not going to kill you, it's just going to make you stronger." Another participant stated, "I have a little more grit."

Soldiers for whom increased pain tolerance was experienced as positive also spoke of greater self-confidence, resilience and gratefulness for their current well-being. One participant said, "I am not King Kong, but I sure as shit could probably go toe-to-toe with him because of what I've been through." Reflecting on resilience, another said, "Somebody calling me a name now is . . . nothing . . . (I'm) used to getting shot at and blown up." One Soldier stated, "Knowing that I am still here, you know, when I shouldn't be . . . it takes a lot more to get me down."

Negative experiences and consequences of changes in physical and emotional pain. Some Soldiers experienced increased tolerance of emotional pain as problematic. Soldiers described emotional numbing and avoidance. One individual described emotional numbing as protective armor: "In Iraq, you just put layers and layers of kind of like protection, like numbness so . . . whatever you see you just bag it." One Soldier stated, "I don't get very emotional no more. That's just because . . . you can't have real emotions over there." Another Soldier recalled, "I have had a recent death in the family . . . I know it's wrong, I just didn't feel anything." Soldiers described emotional numbing as a way to avoid hurt and loss. One Soldier said: "I'll never let my emotions get in the way of work or the Army again. Just because I went through that once, I won't do it again . . . . My emotions won't ruin my life again."

On the other hand, some Soldiers described increased reactivity to emotional pain as problematic in their daily lives. A Soldier said, "Anything can remind me about the fact that I lost. And that causes emotional pain." Soldiers for whom increased reactivity was more salient described themselves as "fragile." One Soldier expressed embarrassment as he tried to hide "break downs" from his wife. For these Soldiers, painful and provocative events seemed to decrease emotional distress tolerance.

Soldiers for whom chronic pain was a salient aspect of their experience emphasized distress related to constant physical pain. These Soldiers described "the grind of war" and the toll it takes on the body. One Soldier compared his body to a car: "People aren't built to carry that much weight and go that far that fast in that heat, you know. . . . You drive in your car without a good oil change, it takes its toll." Soldiers also described how aging compounds this process. Participants who reported the experience of constant pain emphasized sensitivity to additional pain.

Perceived Burdensomeness

Injuries or loss of functioning. Participants for whom injury and subsequent physical limitations were an essential element of their experience described feeling like a burden. One Soldier expressed his frustration this way: "The minute you can't do something . . . you are a piece of crap." An individual expressed distress related to asking for help: "I don't like the feeling of, you know, feeling like somebody else has to take care of me when I should be taking care of myself."

Difficulty participating in family life. Soldiers described feeling like a burden when they failed to participate in family life as expected. One Soldier said he had trouble responding to his family "in an appropriate noncombat way." Another Soldier explained, "I just have trouble getting myself out of the . . . the couch . . . to do things now." Participants expressed guilt for being "lazy" and not resuming household duties after returning from war.

Guilt following combat. When asked about experiences of burdensomeness, some Soldiers described "survivor guilt," questioning the value of their life compared to Soldiers who died. Participants also described burdensomeness related to combat decisions they regretted. One Soldier said he was "seen as a failure" for his combat actions. Another participant said during

war he was "causing more bad than good." Another stated he "didn't do enough to protect Soldiers." One Soldier said, "I shouldn't be allowed to be with my family for stuff I've done."

Failed Belonging

In unit. The unit was a primary source of support for participants. However, experiences of failed belonging were salient for those who recently changed units, or who experienced themselves as different from others in their unit (in aspects of identity such as gender, age, ethnicity, culture, religion, and values). Also, Soldiers mentioned the loneliness of leadership positions. One Soldier explained of his subordinates, "They have a lot of respect for me . . . but at the same time I don't feel like I can talk to any of them."

Friends. Soldiers described difficulty reuniting with civilian friends. A Soldier said, "It makes you feel sad that for whatever reason, that, uh, they don't understand you and you don't understand them and you feel . . . alone." Several Soldiers expressed intolerance for their friends' problems. One participant explained, "Stuff that doesn't bother me bothers them . . . . When I sit there talking to them and they start complaining about stuff at their jobs, I am, like, 'Wow, you are really complaining about something that stupid?'"

Society. Soldiers described feeling like an outsider around civilians. One Soldier said, "Seeing people die and explosions . . . they try to say oh, they know how you feel when they really don't." Another Soldier expressed frustration with civilian misperceptions, "People are going to either pay you either complete hero worship, which obviously you don't want because you know you don't deserve it . . . or you get taken for granted for what you have done. . . . There's never really a happy medium." Another participant contrasted the respect he earned in the military with his experience of civilian life:

> I have never been better at something than being a Soldier in my life. It came naturally to me, and, you know, my seniors, my peers, and my subordinates all recognized that and respected that right off the bat wherever I went. But now that I am out of the Army . . . especially with my peers, I feel like an outsider.

Perceived Burdensomeness and Failed Belonging

While Soldiers were questioned separately about experiences of burdensomeness and experiences of failed belonging, many Soldiers spontaneously linked concepts of burdensomeness and failed belonging in contexts related to emotional distancing, transitioning into garrison life, and care seeking.

Emotional numbing after a combat tour. Some Soldiers connected emotional numbing with burdensomeness. Regarding his recent divorce, one participant stated: "I'm not as loving and caring as I used to be. Maybe that's why the wife decided to go her own way . . . . I was a burden on her in that way. I should have been more open." Another Soldier connected burdensomeness with lack of joy: "Everything's perfect in my life. I got the perfect job . . . I am ahead in my career . . . I have a perfect family. I have no financial troubles whatsoever. Everything's perfect. But it isn't." Soldiers also connected emotional avoidance with thwarted belonging. In an effort to avoid loss, Soldiers avoided relationships: "I try not to get too close to people unless I have to, just so that if they do die, randomly, in an explosion or whatever, that it just doesn't bother me as much."

Transition into garrison life following combat. When asked about burdensomeness and lack of belonging, Soldiers discussed transition into garrison life. Related to burdensomeness, Soldiers described difficulties reintegrating into the family routine. For example, one Soldier asked, "What purpose do I have here if I am not allowed to make any decisions with the children?" Soldiers described feeling like a burden while both leaving their unit and transitioning

to a new unit. One participant lamented: "No one really cares about you when you are getting out of the Army . . . I put in 5 years of honorable service and was the best Soldier I could be, you know, then I go to get out and everyone's just like, 'We are not going to help him.'"

Participants also reported feeling like an outsider during transitions to garrison life. One Soldier explained, "You get back home, you got to go back through a withdrawal period where you just . . . want to be left alone, you are quiet, not outgoing. It's just terrible, terrible, the transition stage that you have to go through, just horrible . . . . All you think about is . . . it's hard to come back into society." Another Soldier said, "You just don't really feel comfortable anywhere for a while. And by the time you do feel comfortable, you end up leaving."

Care seeking after combat. Seeking help for medical or mental health concerns was connected to both burdensomeness and lack of belonging. A participant explained that his appointments added to the workload of fellow Soldiers: "I am laden with appointments . . . . It doesn't work well for everybody else and they don't make it so easy for you. 'Oh, you got an appointment? I understand.' No, it's like, 'Well, what are you broke or something?' That bugs me—I don't like that feeling." Participants also related care seeking with feeling like an outsider. A Soldier said, "Everybody is giving me a hard time . . . I might be getting med boarded . . . . I just spent almost a year with those guys over there and I come back and . . . they treat me like crap."

Coping With Feelings of Burdensomeness and Lack of Belonging

Loss of desire for life. When asked how they handled it when they experienced burdensomeness or lack of belonging, some Soldiers expressed that they did not feel like they were able to handle feelings of burdensomeness and belonging. Many of these Soldiers went on to speak of loss of desire for life, though simultaneously denying suicidal ideation or behaviors. Soldiers were not directly asked questions related to suicide, but some Soldiers spontaneously endorsed death as a possible end to their pain. One Soldier stated, "I came to a point to where I didn't care if I lived or died." Another said: "I don't have a high value on my life, because I just don't care. I would do anything to keep (my wife and kids) safe, but as far as myself is concerned, I don't care." And later, "You give yourself up to keep your buddy or somebody else alive in a heartbeat." Still another normalized lack of purpose: "We all have our moments where we are just like, you know, 'Why am I still here? What good am I to these people?'" Notably, some participants endorsing significant distress said that they were not to the point of considering suicide. A participant emphasized, "I am not going like do anything crazy like hurt myself." Another explained, "I feel horrible about myself . . . but I don't stress over it to the point where I'm like, 'Oh, well, you know, maybe they are just better off without me.'"

Adaptive coping strategies. Other Soldiers, when asked how they handled feelings of burdensomeness and lack of belonging, described adaptive coping strategies including the efficacy of behavioral health and meaningful connections with friends and family. Regarding the benefits of behavioral health, one Soldier remarked:

> I tell my friends that I don't really care anymore, because if they saw me that I was weak, so be it. I need to get help because the people that don't get help they usually end up in worse situations . . . . They just bag it all in and they never talk to anybody and the next thing you know they're . . . taking their life or they end up doing something else and then they end up in bigger trouble.

Another participant shared the results of seeking behavioral health: "Now . . . I can actually feel other emotions. I am not just angry when something happens. I can actually be happy about stuff. I can actually feel sad when something happens." One Soldier said, "I see myself also as a stronger person because I was able to ask for the help." Another Soldier attributed his stability to psychiatric intervention. He said, "The meds . . . are what's keeping me under control."

Soldiers also spoke about the support they received from friends and family. When asked how he handled feeling like a burden, a Soldier replied, "I would talk about it, especially with my wife." Another Soldier explained, "Somehow these people still see worth. They still see you're of value somehow . . . . I am still around because my family still needs me and I still have friends that care about me." One Soldier described finding purpose in his relationship with his children, "I try my best to be at home to put my kids to bed at night if I can." Another participant explained, after telling his friends about his combat experiences, "Once they understand and know the story then it's pretty easy . . . . I feel more relaxed and more comfortable."

Discussion

The purpose of this qualitative study was to extend understanding of constructs underlying suicide, from the perspective of the IPTS, to the population of Active Duty Army Soldiers in transition from the combat environment to garrison life.

Acquired Capacity for Lethal Self-Harm

The experience of emotional pain as a result of combat appeared to be quite salient for Soldiers, with a lesser focus of chronic physical pain, though Soldiers with constant pain emphasized the effect of pain on their daily life. Habituation to fear and physical pain is an essential component of the acquired capability construct in the ITPS. Habituation is said to result when, after repeated exposure to painful or provocative stimuli, the opponent processes of fear and pain (exhilaration and relief) become stronger, such that the experience of painful and provocative stimuli becomes less negative, sometimes even positive (Van Orden et al., 2010). In this study, some Soldiers described the process of habituation, while other Soldiers reported increased sensitivity to physical and emotional pain after combat. Future research might further explore the relationship the IPTS postulates between experiences of painful and provocative experiences and desensitization towards pain (Ilgen et al., 2010).

Soldiers also discussed how the combat environment elicited the necessity for different coping mechanisms, including building a higher pain tolerance and/or using emotional numbing or avoidance techniques. Some Soldiers viewed these coping strategies as functional for resilience, instilling greater self-confidence, and serving as a protective armor for avoiding hurt and loss. Others viewed these strategies as problematic and expressed feeling insensitive and callused in their relationships upon transition to garrison life. Soldier's attitude toward habituation to pain may mediate opponent process posited to lead to acquired capability. Future research might explore Soldiers' varied perceptions of changes in experience of physical and emotional pain as they relate to the construct of acquired capability.

Burdensomeness and Lack of Belonging

Some Soldiers spontaneously linked experiences of burdensomeness and lack of belonging in conjunction with emotional distancing, transitioning to garrison life, and experiences of care seeking following combat. Related to this, another study found perceived burdensomeness and lack of belonging to be highly correlated (Anestis & Joiner, 2012). Perhaps the correlation between the two variables is greater in contexts of acute risk, such as transition from war.

In this study, some Soldiers' experiences of burdensomeness were related to the acute transition period, whereas others' experiences were related to long-term changes in functioning, including physical impairments, combat guilt, and PTSD symptoms. These findings are consistent with previous quantitative research. In a recent review of psychosocial risk factors for suicide among Soldiers, Nock and colleagues (2013) highlighted stressful life experiences as a significant precursor for suicide to include acute stressors (i.e., family/romantic conflicts, loss, negative unit environment, feelings that one has let their unit down) as well as more chronic stressors (i.e., chronic pain, mental illness, and loss of functioning). In this qualitative study, Soldiers reintegrating postdeployment spoke of these acute and chronic risk factors in their own words.

Regarding belonging, isolation related to transition into different units, and reconnecting with family may be associated with acute risk, whereas personal characteristics and changes in self-identity following combat may contribute to more chronic risk. In exploring IPTS in a population of combat Veterans, Brenner and colleagues (2008) highlighted chronic physical and mental health problems contributing to burdensomeness and belonging. Soldiers in this study distinctly spoke of the commonly shared acute stressors related to transitioning from combat to garrison. The months after abrupt transition from combat may be a unique period of acute suicide risk. Longitudinal research employing quantitative or mixed-method design may better clarify the relationship between acute and chronic risk for self-directed violence, experiences of burdensomeness and lack of belonging as Soldiers transition from combat to garrison, and later to civilian life.

Possible treatment implications for further exploration. Soldiers in this study spoke of difficulty transitioning from combat, which can leave a void of both belonging and meaning. Soldiers coped with this void through use of behavioral health services and relationships with family and friends. An abundance of literature supports strategies to reduce acute risk of burdensomeness and lack of belonging (Joiner, Van Orden, Witte, & Rudd, 2009). Two elements that may be beneficial in existing treatments during periods of transition from combat are acceptance and forgiveness-based interventions and redefining masculine and warrior narratives.

Soldiers who spoke of emotional numbing and avoidance described isolation from loved ones, reduced capability for joy, and lack of emotional connection. In contrast, some Soldiers, even after painful and provocative experiences, described connection with others, personal strength, and gratefulness. Postdeployment treatment focused on helping Soldiers accept emotional and physical changes associated with combat may help facilitate posttraumatic growth and decrease suicidality (Bush, Skopp, McCann, & Luxton, 2011).

Soldiers in this study also described perceived burdensomeness as it related to combat guilt. Combat guilt has been significantly associated with suicidal ideation in the military, even after accounting for shame, depression, and trauma symptoms (Bryan, Morrow, Etienne, & Ray-Sannerud, 2013). Studies dating back to World War II chronicle U.S. Veterans' almost universal experience of lack of self-forgiveness (Glover, 1984; Henning & Frueh, 1998). Veterans who killed during war were twice as likely to report suicidal ideation as those who did not kill, even after accounting for PTSD, depression, substance use, and adjusted combat exposure (Maguen et al., 2011; Maguen et al., 2012). Findings from this qualitative study support the use of evidence-based forgiveness treatments following combat (Orcutt, Pickett, & Pope, 2005).

Finally, Soldiers who challenged aspects of warrior ethos and masculinity reported improved mental health. These Soldiers described willingness to appear weak, pride in asking for the help they needed, and relief when they experienced a range of emotions, including sadness. Soldiers in this study who avoided seeking help indicated that it violated traditional masculine and warrior values. Narratives within the warrior culture and the culture of masculinity may contribute to the belief that seeking help and expressing emotions is unmasculine and decreases a Soldier's value to the unit (Burns & Mahalik, 2011; Braswell & Kushner, 2012). Postdeployment treatment that focuses on exploring masculine and warrior ethos as well as the shame associated with perceived violations of those ethos may prove helpful in reducing the stigma of help seeking, promoting belonging, reducing the perception of burdensomeness, and subsequently reducing suicidality (Witte, Gordon, Smith, & Van Orden, 2012).

Limitations

First, none of the participants were known to have exhibited suicidal behavior. Therefore, exploration of the context of acquired capability, perceived burdensomeness, and failed belonging exhibited by these Soldiers may not be reflective of the population of Soldiers that enact lethal self-harm. Further, data were collected at one military base, and the population did not include Soldiers who had been medically evacuated, a subpopulation with qualitatively different characteristics. In addition, nearly one third of the population that initially agreed to participate in this study were unavailable 3 months postdeployment, and it is unclear whether this population is

significantly different from the population interviewed. Also, semistructured interview questions were developed a priori based on the IPTS; thus themes outside the scope of this theory that may be significant to understanding suicidality among the population of Soldiers transitioning from combat were not explored. Finally, content from the interviews reflect the experiences of the participants, just as the interpretation of these interviews reflect the experiences of the research team members and the major underpinnings of the IPTS. Despite these limitations, findings highlight salient experiences and issues for returning Soldiers in the sample and can be used to inform research and clinical practices.

Conclusion

This qualitative study has highlighted the postdeployment transition as a critical period in which potential suicide factors as defined by Joiner's IPTS may be particularly salient. Soldiers in this study, when interviewed 3 months after returning from combat, spoke about changes in the experience of pain, burdensomeness, and lack of belonging while transitioning to garrison. Salient themes related to postdeployment transition included higher pain tolerance, chronic pain, emotional reactivity, emotional numbing and distancing, changes in functioning, combat guilt, care seeking, and reintegration into family and society. This study both highlighted postdeployment transition-related constructs underlying suicide as defined by the IPTS and suggested treatment interventions that may support transitions to garrison life.

References

Anestis, M. D., Bryan, C. J., Cornette, M. M., & Joiner, T. E. (2009). Understanding suicidal behavior in the military: An evaluation of joiner's interpersonal-psychological theory of suicidal behavior in two case studies of active duty post-deployers. Journal of Mental Health Counseling, 31(1), 60–75.

Anestis, M. D., & Joiner, T. E. (2012). Behaviorally-indexed distress tolerance and suicidality. Journal of Psychiatric Research, 46(6), 703–707. doi:10.1016/j.jpsychires.2012.02.015 U

Bliese, P. D., Wright, K. M., Adler, A. B., Thomas, J. L., & Hoge, C. W. (2007). Timing of postcombat mental health assessments. Psychological Services, 4(3), 141.

Braswell, H., & Kushner, H. I. (2012). Suicide, social integration, and masculinity in the U.S. military. Social Science & Medicine, 74(4), 530–536. doi:10.1016/j.socscimed.2010.07.031

Brenner, L. A., Betthauser, L. M., Lusk, J. L., Terrio, H., Scher, A., & Schwab, K. (2014). Soldiers returning from deployment: A qualitative Study of injury, emotional distress and reintegration. Manuscript submitted for publication.

Brenner, L. A., Gutierrez, P. M., Cornette, M. M., Betthauser, L. M., Bahraini, N., & Staves, P. J. (2008). A qualitative study of potential suicide risk factors in returning combat Veterans. Journal of Mental Health Counseling, 30(3), 211–225.

Bryan, C. J., Clemans, T. A., & Hernandez, A. M. (2012). Perceived burdensomeness, fearlessness of death, and suicidality among deployed military personnel. Personality and Individual Differences, 52(3), 374–379. doi:10.1016/j.paid.2011.10.045

Bryan, C. J., Cukrowicz, K. C., West, C. L., & Morrow, C. E. (2010). Combat experience and the acquired capability for suicide. Journal of Clinical Psychology, 66(10), 1044–1056. doi:10.1002/jclp.20703

Bryan, C. J., Morrow, C. E., Anestis, M. D., & Joiner, T. E. (2010). A preliminary test of the interpersonal-psychological theory of suicidal behavior in a military sample. Personality and Individual Differences, 48(3), 347–350. doi:10.1016/j.paid.2009.10.023

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

Bryan, C. J., & Rudd, M. D. (2012). Life stressors, emotional distress, and trauma-related thoughts occurring in the 24 h preceding active duty US Soldiers' suicide attempts. Journal of Psychiatric Research, 46(7), 843–848.

Burns, S. M., & Mahalik, J. R. (2011). Suicide and dominant masculinity norms among current and former United States military servicemen. Professional Psychology: Research and Practice, 42(5), 347–353. doi:10.1037/a0025163

Bush, N., Reger, M. A., Luxton, D. D., Skopp, N. A., Kinn, J., Smolenski, D., & Gahm, G. A. (2013). Suicides and suicide attempts in the U.S. Military, 2008-2010. Suicide and Life-Threatening Behavior, 43(3), 262–273. doi:10.1111/sltb.12012

Bush, N. E., Skopp, N. A., McCann, R., & Luxton, D. D. (2011). Posttraumatic growth as protection against suicidal ideation after deployment and combat exposure. Military Medicine, 176(11), 1215–1222.

Castro, C. A., & Kintzle, S. (2014). Suicides in the military: The post-modern combat Veteran and the Hemingway effect. Current Psychiatry Reports, 16(460), 1–9.

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

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

Gilman, S. E., Bromet, E. J., Cox, K. L., Colpe, L. J., Fullerton, C. S., Gruber, M. J. . . . Kessler, R. C. (2014). Sociodemographic and career history predictors of suicide mortality in the United States Army Psychological Medicine. 2004–2009. doi:10.1017/S003329171400018X

Giorgi, A. P., & Giorgi, B. M. (2003). The descriptive phenomenological psychological method. In P. M. Camic, J. E. Rhodes, & L. Yardley (Eds.), Qualitative research in psychology: Expanding perspectives in methodology and design. doi:10.1037/10595-000

Glover, H. (1984). Survival guilt and the Vietnam Veteran. Journal of Nervous and Mental Disease, 172(7), 393–397. doi:10.1097/00005053-198407000-00003

Gottman, J. M., Gottman, J. S., & Atkins, C. L. (2011). The comprehensive Soldier fitness program: Family skills component. American Psychologist, 66(1), 52–57. doi:10.1037/a0021706

Henning, K. R., & Frueh, B. C. (1997). Combat guilt and its relationship to PTSD symptoms. Journal of Clinical Psychology, 53(8), 801–808. doi:10.1002/(SICI)1097-4679(199712)53:8<801::AID-JCLP3>3.0.CO;2-I

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

Ilgen, M. A., Zivin, K., Austin, K. L., Bohnert, A. S. B., Czyz, E. K., Valenstein, M., & Kilbourne, A. M. (2010). Severe pain predicts greater likelihood of subsequent suicide. Suicide and Life-Threatening Behavior, 40(6), 597–608. doi:10.1521/suli.2010.40.6.597

Joiner, T.E., (2005). Why people die by suicide. Cambridge, MA: Harvard University Press.

Joiner, T. E., Van Orden, K. A., Witte, T. K., & Rudd, M. D. (2009). The interpersonal theory of suicide: Guidance for working with suicidal clients. Washington, DC: American Psychological Association. doi:10.1037/11869-000

Kuehn, B.M. (2009). Soldier suicide rates continue to rise: Military, scientists work to stem the tide. Journal of the American Medical Association, 301, 1111–1113.

Logan, J., Skopp, N. A., Karch, D., Reger, M. A., & Gahm, G. A. (2012). Characteristics of suicides among US army active duty personnel in 17 US states from 2005 to 2007. American Journal of Public Health, 102(S1), S40–S44.

Maguen, S., Luxton, D. D., Skopp, N. A., Gahm, G. A., Reger, M. A., Metzler, T. J., & Marmar, C. R. (2011). Killing in combat, mental health symptoms, and suicidal ideation in Iraq war Veterans. Journal of Anxiety Disorders, 25(4), 563–567. doi:10.1016/j.janxdis.2011.01.003

Maguen, S., Metzler, T. J., Bosch, J., Marmar, C. R., Knight, S. J., & Neylan, T. C. (2012). Killing in combat may be independently associated with suicidal ideation. doi:10.1002/da.21954

Nock, M. K., Deming, C. A., Fullerton, C. S., Gilman, S. E., Goldenberg, M., Kessler, R. C. . . . Ursano, R. J. (2013). Suicide among Soldiers: A review of psychosocial risk and protective factors. Psychiatry, 76(2), 97–125. doi:10.1521/psyc.2013.76.2.97

Onwuegbuzie, A. J., Leech, N. L. (2007c). Sampling designs in qualitative research: Making the sampling process more public. The Qualitative Report, 12(2), 238–254 Retrieved August 31, 2007 from http://www.nova.edu/ssss/QR/QR12-2/onwuegbuzie1.pdf

Orcutt, H. K., Pickett, S. M., & Pope, E. B. (2005). Experiential avoidance and forgiveness as mediators in the relation between traumatic interpersonal events and posttraumatic stress disorder symptoms. Journal of Social and Clinical Psychology, 24(7), 1003–1029. doi:10.1521/jscp.2005.24.7.1003

Selby, E. A., Anestis, M. D., Bender, T. W., Ribeiro, J. D., Nock, M. K., Rudd, M. D., . . . Joiner, T. E. (2010). Overcoming the fear of lethal injury: Evaluating suicidal behavior in the military through the lens of the interpersonal–psychological theory of suicide. Clinical Psychology Review, 30(3), 298–307. doi:10.1016/j.cpr.2009.12.004

Schoenbaum, M., Kessler, R. C., Gilman, S. E., Colpe, L. J., Heeringa, S. G., Stein, M. B., Ursano, R. J., & Cox, K. L. (2014). Predictors of suicide and accident death in the Army Study to Assess Risk and Resilience in Servicemembers (Army STARRS): Results from the Army Study to Assess Risk and Resilience in Servicemembers (Army STARRS). JAMA Psychiatry, 71(5), 493–503.

U.S. Department of the Army. (2010). Army health promotion, risk reduction, suicide prevention report. Retrieved from http://www.armyg1.army.mil/hr/suicide/docs/Commanders%20Tool%20Kit/HPRRSP_Report_2010_v00.pdf

Van Orden, K.A., Witte, T.K., Cukrowicz, K.C., Braithwaite, S.R., Selby, E.A., & Joiner, T.E. (2010). The interpersonal theory of suicide. Psychological Review, 117(2), 575–600.

Witte, T. K., Gordon, K. H., Smith, P. N., & Van Orden, K. A. (2012). Stoicism and sensation seeking: Male vulnerabilities for the acquired capability for suicide. Journal of Research in Personality, 46(4), 384–392. doi:10.1016/j.jrp.2012