Challenges and Considerations for Managing Suicide Risk in Combat Zones

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ABSTRACT As suicide rates in the military rise, increased attention has been placed on the effective management of high-risk service members. Military mental health professionals deployed to combat zones face a number of challenges and barriers for effective risk management that are unique to the deployed setting. To date, there exists no body of literature identifying areas in which suicide risk management differs between garrison and combat settings to guide mental health professionals in improving clinical decision making with respect to managing suicidal service members in combat zones. On the basis of experience gained during deployments to combat zones, the authors outline several key features of the deployed context that can impact suicide risk and its effective management in combat zones and integrate empirical findings relevant to each issue. Considerations for clinical care and risk management are discussed.

INTRODUCTION

The suicide rate of military service members and veterans has been quickly rising in recent years, especially among service members exposed to combat operations. The number of suicides within the deployed setting has certainly contributed to this trend. In 2007, for example, 30% of Army suicides and 17% of Marine suicides occurred within the deployed setting. With increased focus on the issue of suicide in general, attention to issues surrounding suicidality in deployed settings has also risen. A topic of frequent discussion and debate among military mental health professionals and military leadership is how best to approach service members at risk for suicide in combat zones, which can differ substantially from the garrison context. Although the core principles of effective risk management remain constant across all contexts, the specific methods and strategies employed to achieve these principles will necessarily differ. Simply put, clinical decision making must oftentimes be modified to fit the unique circumstances of the combat zone to optimize outcomes. In this article, we will identify factors affecting suicidality that differ between garrison (i.e., nondeployed) and combat settings, how this can impact risk management, and specific considerations for addressing each factor within a combat zone.

DEPLOYMENT-SPECIFIC FACTORS AFFECTING SUICIDALITY AND RISK MANAGEMENT

Trauma, Violence, Combat Exposure, and Habituation to the Fear of Death

Suicide ideation has been shown to be associated with greater exposure to war zone violence and atrocities, suggesting that exposure to a combat environment may increase suicidal ideation. The recent increase in the military suicide rate as compared to the unchanging civilian rate similarly suggests that combat exposure might be contributing to the rising suicide rate of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) veterans. Among Vietnam veterans, suicide victims had been in theater approximately twice as long as victims of other causes of death, suggesting that more exposure to combat might contribute to suicide. One model of suicide that has established a high level of empirical support and directly proposes an explanatory mechanism for the observed association between combat and suicidal behaviors is the interpersonal-psychological theory of suicide (IPTS). According to the IPTS, this observed association between combat exposure and suicide is due to what has been termed an “acquired capability for suicide,” a theoretical construct that develops as a result of increased habituation to pain, fear, and death. The IPTS posits that repeated exposure to provocative experiences such as violence, aggression, and death serve to dampen an individual’s fear of death and heighten their tolerance for pain, both of which are necessary for severe suicidal behaviors. Combat inherently entails exposure to provocative and aversive experiences such as witnessing death and destruction, which can initially be highly distressing, but can be attenuated with repetition. Similarly, killing enemy combatants can initially be a difficult experience, but with repeated exposures the aversive reaction can reduce. Indeed, Bryan found that among deployed service members, a wider
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range of combat exposure was associated with the acquired capability for suicide (i.e., fearlessness about death and pain tolerance) even when controlling for depression, PTSD, and past suicidality. Even among service members with no history of deployments or combat exposure, acquired capability is nearly twice as high as among nonmilitary groups. Acquired capability therefore potentially explains at least in part the documented relationship between combat and suicidal behaviors, but combat itself does not directly contribute to suicidal behaviors. Paradoxically, the very qualities that make for an effective warrior (i.e., fearlessness about death, high pain tolerance) can also increase that warrior's capacity to engage in suicidal behaviors. Critically, although combat exposure can increase a service member's ability to enact lethal self-injury, it does not necessarily contribute to increased desire for suicide. In light of this, mental health clinicians and military leaders can target the “desire” for suicide via strategies designed to enhance quality of life and social connectedness, since a service member who does not desire death or suicide, even if capable of killing him- or herself, is unlikely to attempt suicide.

Given that it is only in the combined presence of capability and desire that severe suicidal behaviors will occur, one possible indicator of increased risk in both areas (i.e., capability and desire) is the concept of “In sha’Allah,” which roughly translates to “if God wills.” This phrase, verbalized within many Arab cultures, serves as a reminder to Muslims of the supremacy of Allah in all aspects of life, above and beyond the desires and intentions of humans. Interestingly, the adoption of this Arab concept by many U.S. deployed service members can oftentimes be distorted to reflect a sense of powerlessness and loss of purpose (fueling suicidal desire), as well as a resignation about death (indicating heightened capability). In our experience as forward-deployed mental health clinicians, when verbalized by distressed U.S. service members, In sha’Allah can indicate a fatalistic perspective about life that can contribute to risky decision making and behaviors that mirror “suicide by cop” (e.g., not wearing body armor, not utilizing adequate cover or concealment, exposing oneself in a firefight). Such behaviors and verbalized beliefs might serve as indirect indicators of a neutral stance toward life at best and a desire for death at worst and should be further assessed to determine whether they indicate underlying suicidal intent. Targeting helpless or fatalistic beliefs with cognitive interventions could therefore improve safety and minimize risk, not only for the index service member but potentially for other unit members whose safety is jeopardized by such behaviors.

Everyone’s Packing Heat

Among deployed soldier suicides and suicide attempts, firearms are used with much greater frequency when compared to nondeployed soldiers (e.g., 93% vs. 52% for suicides). Suicidal crises are inherently time limited, and attempts are usually impulsive reactions to short-term peaks in distress. In one study of survivors of life-threatening suicide attempts, for example, 24% made the decision to attempt within the 5 minutes immediately preceding the act, and 70% reported making the decision within the preceding hour. Similarly, suicide rates by firearms are elevated 57-fold within the week following purchase of a handgun, dropping to a 30-fold and 7-fold elevation within a month and year, respectively, following purchase. Because the desire to attempt suicide fluctuates from moment to moment and therefore cannot be predicted with any reasonable amount of reliability, and because suicidal behaviors can only occur in the presence of the means for suicide, restriction of means can be a powerful strategy for managing suicide risk, especially with individuals exhibiting specific planning and preparatory behaviors and a sense of courage or fearlessness about death in general and suicide in particular. Research has demonstrated that in some cases, but not invariably, restriction of access to a particular method results in declines in suicide rates by that method.

Availability of lethal means for suicide—notably firearms—is perhaps the single most salient factor that distinguishes deployed from nondeployed settings. Simply put, “everyone’s packing heat” in a combat zone. In fact, in many areas, military personnel are required to carry their weapon at all times and will be denied access to basic facilities (e.g., dining halls) if unarmed. The utility of restricting access to means in combat zones is further undermined as a risk-management strategy, because securing a suicidal service member’s weapon or ammunition, or rendering the weapon inoperable (e.g., removing the firing pin), does not reduce access to others’ weapons and ammunition. In the face of this undeniable and unavoidable fact of the deployed setting, clinicians will often focus on suicidal intent when conducting risk assessments. Research has demonstrated, however, that the lethality of a suicide attempt is strongly related to the availability of means, but not necessarily the severity of suicidal intent. This is not to suggest that suicidal intent is an unimportant variable when considering suicide risk; research has provided support for the central role of intent in suicidal behaviors. Rather, these data indicate that the role of accessibility to means should not be underestimated or disregarded. The difficulty in limiting access to firearms and other potentially lethal methods for suicide (e.g., explosives) is arguably one of the most significant barriers to suicide prevention in combat zones. Deployed clinicians should therefore give considerable weight to the widespread availability of highly lethal means in combat zones when assessing suicide risk, which may necessitate recommendations to medically evacuate service members from the combat zone to maximize safety.

Insomnia

Several studies have shown a strong relationship between insomnia and suicidality that remains even when depression and other risk factors are accounted for. Nightmares, in particular, significantly predict suicidal ideation even in the presence of global sleep disruption and depression, although breathing-related sleep symptoms (e.g., snoring, gasping for
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Agitation and Hyperarousal

There is wide clinical consensus that agitation is an important indicator for acute suicide risk regardless of diagnosis and that it may indeed be an important “warning sign” for suicide. Among patients with depressive episodes, for example, research has converged on the central roles of irritability, psychomotor agitation, and racing thoughts as specifically contributing to increased suicide risk compared to depressed patients without these symptoms. Preliminary data from psychiatric emergency rooms has similarly linked agitation with current suicide ideation and lifetime frequency of suicide attempts. Critically, agitation was found not to associate with any particular diagnosis, suggesting that it is independent from anxiety or mania. Service members often report a sense of restlessness or feeling “jumpy” or “amped up” while deployed to a combat zone, which is oftentimes a result of increased autonomic activation—an expected and natural response to a context marked by instability and danger. Furthermore, selective serotonin reuptake inhibitors (SSRIs), which are frequently used to manage symptoms of anxiety, depression, and combat stress reactions in the deployed setting, can acutely (i.e., in the first 1–3 weeks of treatment) cause physical agitation and restlessness, although in the long term they can decrease symptoms and impulsivity. Hyperarousal can contribute to and maintain sleep disruption, which can sustain further agitation and arousal. This heightened state of physiological activation and racing thoughts—especially when perceived as uncontrollable and extreme—is a frequently cited source for emotional distress that can reinforce a sense of helplessness. Behavioral interventions (e.g., relaxation training) or medications (e.g., antidepressants with careful monitoring and patient education) to reduce physiological arousal, and/or cognitive interventions (e.g., mindfulness training, cognitive restructuring) to increase resiliency to distress, could be useful strategies for targeting the physiological and cognitive agitation that can feed suicidality.

Social Support

The sense that one belongs to a group and feels connected with others is an important buffer against suicide. Likewise, decreased belongingness is strongly associated with suicide ideation, suicide attempts, and death by suicide. Combat can be a factor that decreases feelings of belongingness in a variety of ways. For example, while deployed, veterans are separated from families and friends, which are often primary sources of support. Methods for communication can be erratic and unreliable (e.g., poor telephone or Internet connections), and at times completely unavailable. When communication is possible, veterans commonly describe difficulty talking about their experiences to friends and family, a sense of being “out of place,” or feeling “emotionally numb,” the latter of which has been associated with increased interpersonal difficulties with family members. It is important to note, however, that military service can have a considerable positive influence on social cohesiveness as well. Combat, in particular, has traditionally been associated with significantly increased belongingness often described as a “brothers-in-arms” bond, which can provide some protection against suicide. Indeed, most suicide prevention efforts within the military have employed a social responsibility paradigm that capitalizes on taking care of one another (e.g., Wingman or Battle Buddy mentalities). “Unit watch” is a widely utilized example of how military clinicians and commanders use social support networks to manage higher-risk service members, although mental health professionals should be wary that it can be easily misconstrued as punitive action and can foster mental health stigma. For recommendations regarding unit watch strategies and minimizing stigma, we direct the reader to Payne and colleagues, who have discussed this issue thoroughly and proposed simple strategies for maximizing its effectiveness, such as developing detailed written instructions for the escort that are specific for the individual under observation and written communication with commanders explaining the rationale for unit watch. As noted above, however, the availability of lethal
means for suicide could be a potentially limiting factor for the long-term utility of unit watch strategies in combat zones, since escorts are typically armed and generally do not receive extensive training in escort duties, which can place the suicidal individual into close proximity of a weapon.

**Limited Access to Mental Health Services**

In a combat zone, the full spectrum of mental health care is unavailable. Specialized services such as substance abuse treatment, inpatient psychiatric units, and family therapy simply do not exist. The distribution of mental health resources is likewise not uniform, with some posts receiving visits from mental health professionals as infrequently as once per month, if at all. This substantially constrains the nature and types of services that can be reasonably offered to deployed service members. Similarly, although many psychotropic medications are generally available in theater, formularies are much more restricted than in the U.S., and access to forward-deployed pharmacies can be limited, depending on their location and conditions on the ground. Even in locations with available mental health resources, psychiatrically trained prescribers are scarce, resulting in a preponderance of general medical providers managing psychotropic medications. Furthermore, use of certain types of medications (e.g., sedatives) in combat zones may be contraindicated in some cases due to side effects that can increase risk for adverse events or mishaps. Another major barrier to care in a combat zone is restricted transportability, since the transport of service members to access mental health services poses unique risks (e.g., improvised explosive devices, firefights, ambushes) that must be balanced out by any potential benefits. Inability to conveniently access mental health resources has been reported by approximately one-quarter of deployed personnel. Simply put, a 20-mile drive to the closest mental health facility in a combat zone is very different from a 20-mile drive in the United States; to move a single person that distance requires a high expenditure of human and material resources and can present a considerable risk of injury and death. The unpredictability of combat operations and mission demands can further disrupt traditional approaches to mental health services and interfere with common strategies for treating and managing suicide risk. For example, the very nature of daily operations in a combat zone can make it difficult for service members to achieve stable sleep patterns, which (as noted above) is an important contributor to suicidality. Service members can undergo several days of continual operations that only allow for a few hours of sleep at a time. Similarly, missions frequently arrive and change without much advance notice, which can result in service members missing scheduled appointments. Without easy access to phone lines, voicemail, and e-mail, the ability for service members and clinicians to coordinate care in the midst of last-minute changes to mission requirements becomes increasingly difficult. The traditional model of “once-a-week check-ins” for treatment and ongoing risk monitoring can many times be an unrealistic strategy within a combat zone, especially for those service members with high operational demands that do not allow for days off. Likewise, group therapy or class models of treatment requiring multiple visits can suffer from the same limitations, which can limit treatment effectiveness. Difficulty getting time off of work is the most frequently cited barrier for accessing mental health services reported among deployed service members. Because situational factors can make regular, ongoing monitoring of risk difficult, clinicians should consider the likelihood of erratic therapeutic contact when determining their ability to adequately manage suicidal service members.

For service members assessed to be at high risk for suicide, admission to forward-deployed combat support hospitals (CSH) for monitoring is a common risk management strategy while the service member awaits medical evacuation from the country. It is critical to note that these forward-deployed medical facilities are not inpatient psychiatric units, and they should not be mistaken as such. Although admission to a CSH might be the safest environment in which to monitor a high-risk service member, and is therefore an important risk management strategy for deployed mental health professionals, this strategy must be differentiated from psychiatric inpatient management. Simply put, forward-deployed medical facilities do not have the resources or manning to meet adequate standards for inpatient psychiatric care. For acutely suicidal service members requiring inpatient care, deployed providers should therefore facilitate rapid medical evacuation. Simply evacuating every single service member reporting suicidal ideation is not a feasible solution, however, as this permanently removes a human resource from the military command’s ability to accomplish their mission and temporarily removes a second human resource to escort the evacuated service member out of theater. Clinicians must therefore balance the needs of the command to successfully accomplish their mission with the possible risk posed by retaining the service member in a combat zone, which can be complicated by the motivations of the service member presenting with suicidality.

**Motivational Issues**

Arguably one of the most frustrating issues in suicide risk management is accuracy of self-disclosure by the service member. Most clinicians can immediately think about the individual suspected of over-reporting or “faking bad”—stating that he is suicidal when really he is not—to avoid an undesired task or responsibility (e.g., wanting to go home instead of remaining deployed). Mental health professionals are often called upon by military leaders to “find the truth” in such cases, so that suspected “fakers” can be confirmed and disciplined appropriately. In cases of suspected over-reporting of suicidality, clinicians are confronted with the issue of possible behavioral acting out on the part of the service member—a situation with particularly severe implications in a combat zone. At other times, the mental health professional might determine that the service member is truly at risk for suicide despite suspicions of over-reporting, which can potentially result in the
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Career impact. Similarly, it is also quite possible that a service member could be in the prodromal stages of a developing crisis but has not yet developed explicit forms of suicidality and thus does not report it (i.e., lack of self-disclosure is not due to intentional concealment but to the fact that suicidality has not yet fully emerged). Although several clinical features have been preliminarily identified as acute indicators of suicide risk (e.g., agitation, insomnia, social withdrawal), the scientific foundation in this area is significantly limited.39

The notion that suicide risk can be neatly dichotomized into one of two categories—e.g., a service member either is or is not suicidal, or a service member will or will not kill himself—is a fallacy due to the low base rate of suicide. In other words, because suicide occurs so infrequently, it is not possible to predict with a high degree of reliability whether suicide will occur. Despite this, an expectation nonetheless exists within the military system that a service member’s suicidal behaviors can be predicted by mental health professionals. Clinicians must be cautious not to fall into the suicide prediction mindset; rather, they should maintain a “risk assessment” perspective (see Bryan and Rudd38 for full discussion). Importantly, when talking about risk management with commanders and military leadership, clinicians should reinforce the risk assessment perspective, stressing leaders’ roles in recognizing when a service member has entered into a heightened period of risk and responding appropriately.

Limited Access to Common Risk-Management Strategies

Suicidality is marked by impaired problem solving. A core feature of effective treatments is therefore skills training that adopts a problem-solving orientation focused on the ability to generate cognitive fluency (i.e., the ability to generate alternative solutions) during times of emotional upset or crisis. Common strategies for managing acute crises include engagement in enjoyable activities or hobbies, use of distress management skills such as relaxation or mindfulness, distraction activities such as watching movies or going for a walk, and accessing social support networks such as talking with a friend or spending time with a family member. Although use of crisis management strategies such as these are feasible within combat zones, clinicians and service members are often faced with a restricted menu of options. The range of recreational activities that are available in a combat zone can be considerably constrained and, as mentioned above, primary sources of social support can be geographically separated and/or difficult to access. During times of crisis in a combat zone, for example, service members cannot always pick up the phone and call a loved one back at home. Clinicians must therefore recognize and be able to adapt to these limitations to design effective interventions and management strategies. Likewise, clinicians must be able to recognize when resources are too limited for effective risk management, necessitating medical evacuation.

**SUMMARY AND CONSIDERATIONS FOR SUICIDE RISK MANAGEMENT IN COMBAT ZONES**

Clinical decision making and management of suicide risk in combat zones can be reasonably straightforward when approached with an adaptability and flexibility that reflects realities of the deployed context, and does not assume that risk management strategies and approaches that are useful or effective in garrison will necessarily translate directly to combat zones. Although the principles of effective risk management remain constant across settings, clinical decision making in a combat zone should reflect situational variables that directly affect the methods and strategies that can be used effectively. Several considerations for mental health professionals deployed to combat zones are therefore provided:

1. Combat can increase fearlessness about death and the capability for suicide, and it can potentially contribute to a fatalistic belief system. Clinical interventions (e.g., cognitive restructuring) should target beliefs that maintain the desire for suicide such as helplessness, and a loss of control.

2. In a combat zone, easy access to firearms and other highly lethal means for suicide is widespread and difficult to limit. Means restriction as a risk-management strategy might not be as effective in a combat zone.

3. Insomnia, agitation, and intrusive dreams/nightmares are important contributors to suicidality and are common in combat zones. Early evidence-based interventions targeting these problems (e.g., cognitive-behavioral therapy, pharmacologic treatments) must be adapted to fit within the deployed context for maximal effectiveness.

4. Certain forms of external social support networks (e.g., family) and risk management (e.g., inpatient psychiatric units) are limited as crisis-management techniques. Fully utilize available resources (e.g., “unit watch”) to acutely manage suicide risk.

5. Access to mental health resources and capabilities is restricted and must be balanced with mission demands. Clinical decisions must therefore factor in the feasibility of the most appropriate level of monitoring, motivational issues of service members presenting for evaluation, and situational factors that restrict traditional risk management strategies.
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(6) Suicide cannot be predicted. Adopting a risk assessment approach that factors in contextual and situational factors is central to effective risk management.

REFERENCES


