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A Novel Adaptation of Distress Tolerance Skills Training Among Military Veterans: Outcomes in Suicide-Related Events

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Although clinical services designed to address suicide-related behaviors are available to veterans, some factors may limit their effectiveness. Relevant factors include the presence of barriers to accessing existing services and a lack of interventions that address the unique needs of veterans. In an effort to address this gap, a modified DBT distress tolerance drop-in group was offered to a population of military veterans in an outpatient setting. This exploratory study reports clinical outcomes on this skills training group intervention informed by Dialectical Behavior Therapy (DBT) principles among a population of self- and clinician-referred veterans. Findings suggest a significant reduction in suicide-related behaviors among veterans who attended 8 or more skills training groups. Clinical implications of study findings warrant further research into novel adaptations of evidence-based treatments for this population with unique needs.

Dialectical Behavior Therapy (DBT; Linehan, 1993a) is an evidence-based psychotherapy that has been shown to be effective in reducing self-harm behavior, suicide attempts, and suicide-related hospitalizations (e.g., Kliem, Kroger, & Kosfelder, 2010; Linehan et al., 2006; Lynch, Trost, Salsman, & Linehan, 2007). The full DBT protocol incorporates weekly individual psychotherapy sessions, group skills training, consultation team meetings for the DBT therapists, and telephone skills coaching. As the evidence base for DBT has accumulated, disseminating this empirically supported treatment among real-world clinical settings can result in the need to balance fidelity to the treatment as developed in research settings with adaption to varying clinical settings and populations (Koerner, Dimeff, & Swenson, 2007; McHugh, Murray, & Barlow, 2009). As DBT is increasingly used in a wide variety of community-based, outpatient, and inpatient settings, it is important that modifications or alterations to the treatment as previously tested be carefully evaluated. To contribute to this effort, the current study reports exploratory findings on a novel modification of DBT skills training offered to military veterans who are at high risk for suicide.

Originally designed as a treatment for seriously suicidal clients, studies suggest that DBT may be particularly useful for treating this target behavior (Linehan, Comtois, & Ward-Ciesielski, 2012). The DBT framework conceptualizes suicide as a maladaptive problem-solving strategy employed in the context of unbearable suffering. Because keeping patients alive is the highest priority if they are to benefit from treatment, reducing suicide crisis behaviors (defined as "any behaviors that place the client at an imminent risk for suicide or threaten to do so, including credible suicide threats, planning, preparations, obtaining lethal means, and high suicide intent"; Linehan & Dexter-Mazza, 2008, p. 379) is the first priority in DBT. Reducing suicidal behaviors in DBT occurs by making this target and its high priority explicit in the first DBT treatment session. When suicidal behavior is present, standard behavioral interventions are employed within the context of the DBT framework, which is a blend of three theoretical positions: behavioral science, dialectical philosophy, and Zen practice (Linehan, 1993a).

Suicidal Behaviors and Unique Needs of Veterans

Previous studies suggest that the high rates of suicide among military personnel are a critical public health concern. While findings regarding the comparative increase in risk for suicide among veterans with respect

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to the civilian population are mixed (Langford, Litts, & Pearson, 2013), the results of some epidemiological studies have pointed to the potential of an increased risk for suicide among Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) veterans with existing psychiatric disorders (Corson et al., 2013). In a related study, Kuehn (2009) found that suicide rates among military personnel had reached a 28-year high in 2008, which represents the continuation of a disturbing trend that has seen a steady rise in the number of completed suicides among service members. Considering these estimates in the context of further studies that suggest a threefold increase in the onset of PTSD among recently deployed military personnel (Riddle et al., 2007; Smith et al., 2009) and research that demonstrates increased risk for suicide among service members with PTSD (Pietrzak, Russo, Ling, & Southwick, 2011), effective interventions to address the mental health needs of veterans who are at increased risk for suicide are urgently needed. Although mental health services designed to address suicide-related behaviors are available to veterans, there are limitations to the effectiveness of these interventions, including barriers to accessing existing services and a lack of interventions that address the unique needs of veterans (Langford et al., 2013).

The U.S. Department of Veterans Affairs (VA) has made significant changes to its mental health delivery system to address the growing need for services among veterans. Specifically, a 2005 VA strategic plan called for the integration of primary care and behavioral health in order to increase access to mental health services (Edwards, 2008). As part of this strategic plan, the VA has also prioritized the dissemination of evidence-based psychotherapies to further integrate research and clinical practice, helping to ensure that veterans receive the most effective treatments available (Karlin & Cross, 2014). Furthermore, recognition of the significance of suicide and self-directed violence as a major veteran mental health issue has led to other system-wide changes in infrastructure. Changes included the addition of personnel, called Suicide Prevention Coordinators to VA Medical Centers, a 24-hour crisis hotline and chatline, and significantly increasing the number of mental health professionals overall (Bruce, 2010).

Despite efforts to expand the availability of mental health services, research indicates that these services are underutilized (Fasoli, Glickman, & Eisen, 2010).Studies of mental health service utilization among veterans recently returned from Iraq or Afghanistan indicate that although approximately 25% to 30% of the veterans in this sample reported some mental health concern after deployment, only 23% to 40% of those who met criteria for a psychiatric disorder sought mental health care (Hoge et al., 2004). This underutilization of available mental health services has been a longstanding issue in the VA. For example, Hankin, Spiro, Miller and Kazis (1999) reported that although 40% of veterans met criteria for at least one psychiatric disorder, almost a third of those diagnosed had never sought treatment. Many barriers have been reported that interfere with veterans' access to care, including (a) stigma associated with mental illness, which may include embarrassment and worries about being perceived as weak, or (b) logistical barriers such as not knowing where to get help and difficulty scheduling appointments (Pietrzak, Johnson, Goldstein, Malley, & Southwick, 2009). It is likely that these barriers have in part contributed to high rates of dropout, low session attendance, and frequent no-shows among those who do seek out treatment (Erbes, Curry, & Leskela, 2009; Lorber & Garcia, 2010) such that often the number of sessions attended is less than that identified in treatment protocols necessary to result in significant reductions in symptoms (Rotem-Harpaz & Rosenheck, 2011). Taken together, results suggest that psychological interventions offered to veterans must account for the unique needs of this population, as well as existing barriers to treatment, within the current system of service delivery.

DBT in the VA Setting

In the sparse literature on DBT in the VA setting, studies suggest a superior reduction in suicide-related behaviors, hopelessness, and depression among female military veterans compared to a treatment-as-usual group (Koons et al., 2001). However, implementing the standard DBT protocol in the VA is fraught with the challenges discussed above. Unfortunately, offering a modified DBT protocol to a veteran population is largely untested and therefore the degree of efficacy noted in controlled clinical trials cannot necessarily be expected in modified deliveries. However, a small body of literature is suggesting that certain modified DBT protocols can be delivered with beneficial clinical outcomes. For example, Spoont, Sayer, Thuras, Erbes, and Winston (2003) noted that in order to deliver DBT to their veteran population successfully, addressing the unique needs of this population with cognitive impairment, literacy issues, diagnostic heterogeneity, and limitations on the availability of clinicians and of training funds was necessary. The authors concluded that adaptations to the standard DBT protocol could be made while still successfully achieving both client satisfaction and client- and clinician-rated benefit.

Studies also suggest that skills training alone can result in beneficial outcomes for clients. For example, Miller, Wyman, Huppert, Glassman, and Rathus (2000) found that adolescents demonstrating suicide-related behaviors reported that distress tolerance and mindfulness skills were the most helpful in reducing self-injurious behaviors. DBT skills group training alone has also been found to be