Understanding, Assessing, and Conceptualizing Suicide Risk Among Veterans With Posttraumatic Stress Disorder

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A thorough clinical interview combined with self-report measures can help gauge suicide risk.

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Increased risk of suicide among veterans with posttraumatic stress disorder (PTSD) is well established. Posttraumatic stress disorder and related consequences are associated with higher rates of suicidal ideation and suicidal self-directed violence (S-SDV).[1] Based on a systematic review, several explanations for this relationship have been hypothesized.[1] Particular emphasis has been placed on trauma type (eg, premilitary childhood abuse, combat exposure), frequency of trauma exposure (ie, a single traumatic episode vs multiple traumatic experiences), specific PTSD symptoms (eg, avoidance, sleep disturbance, alteration in mood and cognitions, risky behaviors), and other psychosocial consequences associated with PTSD (eg, low social support, psychiatric comorbidity, substance use). However, there is limited understanding regarding how to conceptualize and assess risk for suicide when treating veterans who have PTSD.

PTSD AND THE INTERPERSONAL-PSYCHOLOGICAL THEORY OF SUICIDE

Although PTSD is associated with risk for S-SDV among veterans, a diagnosis-specific approach to conceptualizing risk of suicide (ie, an explanation specific to PTSD) might not be enough because most individuals with a psychiatric diagnosis do not engage in S-SDV.[2] Rather, theories that are able to conceptualize suicide risk across many different psychiatric diagnoses are likely to improve mental health providers' ability to understand risk of suicide. Although many theories attempt to understand suicide risk, the Interpersonal-Psychological Theory of Suicide (IPTS) has robust empirical support.[3]

The IPTS proposes that suicidal ideation is driven by perceptions of stable and unchanging thwarted belongingness (TB), defined as an unmet psychological need to socially belong, and perceived burdensomeness (PB), defined as the perception that one is a burden on others.[4] However, PB and TB are not considered sufficient for S-SDV to occur unless an individual also has acquired the capability for suicide. Capability for suicide is thought to happen when an individual loses the fear of dying by suicide and develops tolerance to physical pain, which is proposed to occur through habituation or repeated exposure to painful stimuli.[3]

Several studies have examined the IPTS in a number of clinical populations, including veterans and active-duty service members; yet limited research has applied the IPTS to veterans with PTSD.[3] However, a recent article proposed that a number of PTSD-related factors increase risk of suicide through the lens of the IPTS.[5] In particular, repeated exposure to painful and provocative events—especially those characterized by violence and aggression—might increase acquired capability for suicide by causing habituation to physical pain and discomfort and reducing fear of injury and death. This concept is especially concerning because of the

frequent occurrence of both military- (eg, combat, military sexual trauma) and nonmilitary-related (eg, childhood abuse, intimate partner violence) stressful and traumatic events among veterans, especially individuals with PTSD.

Moreover, the acquired capability for suicide correlates highly with anxious, intrusive, and hyperarousal symptoms of PTSD.[5-7] Over time, these PTSD symptoms are thought to increase habituation to the physically painful and frightening aspects of S-SDV, resulting in increased pain tolerance and fearlessness about death.[3]

In addition, PTSD-related cognitive-affective states (ie, thoughts and emotions), such as guilt, shame, and self-deprecation, might drive beliefs of PB and TB.[5,8] Repeated exposure to such trauma-related thoughts and emotions could further reinforce beliefs of self-hate or inadequacy (PB).[2] Trauma-related beliefs that the world or others are unsafe also might reduce the likelihood of seeking social support, thereby increasing TB.[2] The PTSD symptoms of avoidance and self-blame also are likely to reinforce beliefs of PB and TB.[2]

ASSESSING SUICIDE RISK IN THE CONTEXT OF PTSD

The IPTS framework is one that can be used by mental health providers to conceptualize risk of suicide across populations and psychiatric diagnoses, including veterans with PTSD. However, integrating additional risk assessment and management techniques is essential to guide appropriate risk stratification and treatment.

One such method of suicide risk assessment and management is therapeutic risk management (TRM).[9] Therapeutic risk management involves a stratification process by which temporal aspects (ie, acute and chronic) and severity (ie, low, moderate, and high) of suicide risk are assessed using a combination of clinical interview and psychometrically sound self-report measures, such as the Beck Scale for Suicide Ideation, Beck Hopelessness Scale, and Reasons for Living Inventory. Appropriate clinical interventions that correspond to acute and chronic suicide risk stratification are then implemented (eg, safety planning, lethal means counseling, increasing frequency of care, hospitalization if warranted).

Therapeutic risk management emphasizes the necessity of assessing current and past suicidal ideation, intent, plan, and access to means. Moreover, additional considerations might be indicated when assessing and conceptualizing suicide risk among veterans with PTSD. Assessing lifetime trauma history, including traumas that occurred before, during, and after military service, is important for understanding whether traumatic experiences influence acute and chronic risks of suicide. As previously described, careful attention to stressful and traumatic experiences with violent and aggressive characteristics is recommended because research suggests that these experiences are associated with increased capability for suicide.[5] Awareness of the diversity of traumatic experiences and the importance of contextual factors surrounding such experiences also are essential. For example, the nature of violence and proximity to violence (eg, directly involved in a firefight vs hearing a mortar explosion in the distance) are key components of military-related combat trauma that might differentially influence risk of suicide.[10]

Similarly, although military sexual trauma can include repeated threatening sexual harassment or sexual assault, research suggests that military sexual assault is particularly important for understanding suicidal ideation, and experiences of military sexual harassment are less important.[11] Therefore, a careful and nuanced

understanding of how contextual aspects of a veteran's trauma history might relate to his or her chronic and acute risk of suicide is critical.

Also important is considering the individual and institutional reactions to trauma. For example, veterans whose behaviors during traumatic experiences violated their values and moral code (ie, moral injury) might be at increased risk for S-SDV. Similarly, veterans who believe that the military institution did not adequately protect them from or support them in the aftermath of traumatic experience(s) (ie, institutional betrayal) might be at higher risk of suicide.

During a clinical interview, mental health providers should pay attention to beliefs and behaviors the veteran is reporting. For example, endorsement of perceptions of low social support (eg, "no one likes me") or self-esteem (eg, "I'm just not as good as I used to be") might be indicative of TB or PB, respectively. Additionally, providers should be aware of current or lifetime exposure to painful stimuli (eg, nonsuicidal self-injury, such as cutting or burning, previous suicide attempts) because these exposures might increase the veteran's acquired capability of future S-SDV.

Although unstructured clinical interviews are a common suicide risk assessment approach, TRM proposes that using a thorough clinical interview along with valid self-report measures could further illuminate a patient's risk of suicide.[9] Implementing brief measures allows mental health providers to quickly assess several risk factors and decrease the likelihood of missing important aspects of suicide risk assessment. Providers can use a number of measures to inform their suicide risk assessment, including augmenting a clinical interview of suicide risk with a valid self-report measure of recent suicidal ideation (eg, Beck Scale for Suicide Ideation, which assesses the severity of suicidal ideation in the past week).

Additionally for veterans with PTSD, mental health providers can include measures of PTSD symptoms (eg, PTSD checklist in the *Diagnostic and Statistical Manual of Mental Disorders–5*) and common PTSD comorbidities (eg, Beck Depression Inventory-II for depressive symptoms) that might contribute to current risk of suicide. Based on previous research, providers also might consider adding measures of trauma-related beliefs (eg, Posttraumatic Cognitions Inventory) and emotions, such as guilt (eg, Trauma-Related Guilt Inventory).[5]

These measures could aid in identifying modifiable risk factors of suicide among veterans with PTSD, such as the extent to which certain beliefs or emotions relate to an individual's risk of suicide. In addition to asking about characteristics of traumatic events during the clinical interview, measures of moral injury (eg, Moral Injury Events Scale) and institutional betrayal (eg, Institutional Betrayal Questionnaire) might further inform understanding of contextual aspects of trauma that could help explain an individual's risk of suicide.

Finally, interpersonal measures also could be helpful. For example, because avoidance and social isolation are risk factors for suicidal ideation among veterans with PTSD, measures of perceived interpersonal functioning (eg, Interpersonal Needs Questionnaire) might add further data to assist in suicide risk conceptualization. Although the selection of specific measures likely varies based on the specific needs of an individual patient, these are examples of measures that can be used with veterans with PTSD to inform suicide risk assessment and conceptualization.

By combining data from various measures across multiple domains with a thorough clinical interview, mental health providers can use a TRM approach to understand and conceptualize suicide risk among veterans with PTSD. This approach can facilitate mental health providers' ability to provide optimal care and guide intervention(s) for veterans with PTSD. One brief intervention that has been used with veterans is safety planning. During safety planning, the provider assists the veteran in identifying warning signs, internal and external coping strategies, and individuals the veteran can reach out to for help (eg, friends and family, providers, Veterans Crisis Line), in addition to collaboratively brainstorming ways the veteran can make his or her environment safer (eg, reducing access to lethal means, identifying reminders of their reasons for living).

Specific to veterans with PTSD, symptoms such as avoidance, hyperarousal, social isolation, and beliefs that others and the world are unsafe might affect safety planning. Such symptoms could hinder identification and use of coping strategies while deterring openness to reach out to others for help. A collaborative method can be used to identify alternate means of coping that take into account PTSD-related avoidance and hyperarousal (eg, rather than going to a crowded store or isolating at home, taking a walk in a quiet park with few people). Similarly, because substance use and risky behaviors are common among veterans with PTSD and might further increase risk of suicide, exploring healthy (eg, exercise) vs unhealthy (eg, substance use; unprotected sex) coping strategies could be helpful.

Further, based on their lived experience, veterans with PTSD could experience difficulty identifying a support system or be reluctant to reach out to others during acute crisis. This might be particularly daunting in the presence of PB and TB. In these situations, it is important to validate the veteran's difficulty with reaching out while simultaneously encouraging the veteran to examine the accuracy of such beliefs and/or helping the veteran develop skills to overcome these obstacles.

The mental health provider also can work with the individual to ensure that the veteran understands that if he or she does engage emergency resources (eg, Veterans Crisis Line), information likely will be held confidential. Providers can tell their patients that breaks in confidentiality are rare and occur only in circumstances in which it is necessary to protect the veteran. In doing so, the provider facilitates the veteran's understanding of the role of crisis resources and clarifies any misconceptions the veteran might have (eg, calling the crisis line will always result in hospitalization or police presence).

CONCLUSION

Several PTSD-related factors might increase PB, TB, and the acquired capability for suicide among veterans with PTSD. Because suicide risk assessment and management can be time sensitive and anxiety provoking, mental health providers can use a TRM approach to increase their confidence in instituting optimal care and mitigating risk by having a structured, therapeutic assessment process that gathers appropriate suicide- and PTSD-related data to assist in developing suicide risk-related treatment. However, more research is needed to determine the most useful self-report measures and effective interventions when working with veterans with PTSD at risk of suicide.

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