PTSD/Suicide: Conceptualization and Assessment

Beeta Y. Homaifar, Ph.D.
Hal S. Wortzel, M.D.

VISN 19 Mental Illness, Research, Education and Clinical Center (MIRECC); University of Colorado, School of Medicine, Department of Psychiatry
Disclosure Statement

This presentation is based on work supported by the Department of Veterans Affairs, but does not necessarily represent the views of the Department of Veterans Affairs or the United States Government.
Disclaimer

Information during this presentation is for educational purposes only – it is not a substitute for informed medical advice or training. You should not use this information to diagnose or treat a mental health problem without consulting a qualified professional/provider.
Synopsis of Presentation

• The scope of Veteran suicide
• PTSD/Suicide
• Conceptual model of suicide
• Suicide risk assessment
• Questions and Comments
The Scope of Veteran Suicide
Suicide in the Veteran Population

• Approximately 20% of all suicides are identified as current or former military (National Violent Death Reporting System)

• About 5 deaths from suicide per day among Veterans receiving care in VHA (VA Serious Mental Illness Treatment, Research and Evaluation Center)

• About 33% of Veterans who die by suicide have a history of previous attempts (VA National Suicide Prevention Coordinator reports)
Sources of Increased Suicide Risk

• Increased risk for suicide has been noted in the following
  – Those receiving outpatient mental health services
    (Desai et al 2008)
  – Those who have received psychiatric discharge
    (Desai et al 2005)
  – Patients receiving depression treatment
    (Ziven et al 2007)
  – Men with bipolar disorder and women with substance use disorders
    (Ilgen et al 2010)
Risk of Suicide Attempt

- Increased risk for suicide attempts has been noted in the following
  - Those with psychiatric conditions (e.g., PTSD, Depression), prior suicide attempt, alcohol misuse, and history of sexual abuse
Suicidal Ideation

• 21.6% of OEF/OIF Veterans with psychiatric disorders reported having had suicidal ideation in the past two weeks

Pietrzak et al, 2010
PTSD/Suicide
What do we know about PTSD/Suicide?

• Explosion of research in this area in the last ~5-10 years
• The relationship is complicated
A meta-analysis of the association between posttraumatic stress disorder and suicidality: the role of comorbid depression

Maria Panagioti, Patricia A. Gooding, Nicholas Tarrier

School of Psychological Sciences, University of Manchester, United Kingdom
Department of Psychology, Institute of Psychiatry, Kings College London, United Kingdom

Abstract

Objective: A considerable number of studies have reported an increased frequency of suicidal behaviors among individuals diagnosed with posttraumatic stress disorder (PTSD). This study aims, first, to provide a comprehensive systematic review and meta-analysis of the association between a PTSD diagnosis and frequency of suicidality and, second, to examine the role of comorbid depression in the association between suicidality and PTSD.

Methods: Searches of Medline (June 2010), EMBASE (June 2010), PsycINFO (June 2010), PILOTS (June 2010), and Web of Science (June 2010) were conducted to identify studies that examined the association between PTSD and suicidality. The studies had to include an effect size of the association between PTSD and suicidality to be included in the meta-analysis. Sixty-three studies were eligible for inclusion in the meta-analysis. Overall and subgroup effect sizes were examined.

Results: A highly significant positive association between a PTSD diagnosis and suicidality was found. The PTSD-suicidality association persisted across studies using different measures of suicidality, current and lifetime PTSD, psychiatric and nonpsychiatric samples, and PTSD populations exposed to different types of traumas. Comorbid major depression significantly compounded the risk for suicide in PTSD populations.

Conclusion: The current meta-analysis provides strong evidence that a PTSD diagnosis is associated with increased suicidality. The crucial role of comorbid major depression in the etiology of suicidality in PTSD is also supported.
Post-Traumatic Stress Disorder and Suicide Risk: A Systematic Review

Karolina Krysinska and David Lester

There is a gap in the literature regarding suicide risk among traumatized individuals with post-traumatic stress disorder (PTSD) and this article aims to systematically review literature on the relationship between PTSD and suicidal behavior and ideation. A meta-analysis of 50 articles that examined the association between PTSD and past and current suicidal ideation and behavior was conducted. There was no evidence for an increased risk of completed suicide in individuals with PTSD. PTSD was associated with an increased incidence of prior attempted suicide and prior and current suicidal ideation. Controlling for other psychiatric disorders (including depression) weakened, but did not eliminate, this association. The evidence indicates that there is an association between PTSD and suicidality with several factors, such as concurrent depression and the pre-trauma psychiatric condition, possibly mediating this relationship. There are significant clinical implications of the reported relationship for suicide risk assessment and therapy, and further studies might help to understand the mediating pathways between PTSD and increased suicide risk.

Keywords: post-traumatic stress disorder, psychiatric comorbidity, suicide risk, trauma
Subthreshold PTSD matters, too

- It’s not just PTSD – those with subthreshold PTSD are 3x more likely to report suicidal ideation compared to healthy controls

Jakupcak et al, 2011
Factors contributing to risk in this population

• Comorbid disorders, especially depression
• Impulsive behavior
• Feelings of guilt/shame
• Pre-deployment traumatic experiences
• Re-experiencing symptoms
• Combat exposure

Conceptual Model of Suicide in the Context of PTSD
Interpersonal Theory of Suicide

Those Who Desire Suicide

Perceived Burdensomeness

Thwarted Belongingness

Those Who Are Capable of Suicide

Serious Attempt or Death by Suicide

Joiner, 2005
Perceived Burdensomeness

“My death is worth more than my life to my loved ones/family/society.”
Thwarted Belongingness

“No one cares. I’m all alone.”
Those Capable of Suicide

- Habituation to painful stimuli (e.g., suicide attempts, child abuse, exposure to violence/aggression, combat)
  - Habituation functions to lower the fear of death AND ALSO elevate tolerance for pain
    - (A lethal or near-lethal suicide attempt is fear-inducing and often pain-inducing, therefore, habituation to the fear/pain involved is a prerequisite for serious suicidal behavior)
- Capability develops as a function of repeated exposure to painful stimuli, through which the individual habituates to previously aversive stimuli
Interpersonal Theory of Suicide

Those Who Desire Suicide

- Perceived Burdensomeness

- Thwarted Belongingness

Those Who Are Capable of Suicide

Habituation to painful stimuli (e.g., combat exposure)

Serious Attempt or Death by Suicide

Joiner, 2005
The Role of Combat Exposure

• Exposure to painful and provocative experiences such as combat contribute to fearlessness about death and increased pain tolerance, which serve to enhance the individual’s capability to attempt suicide
  – Violent and aggressive combat experiences, in particular, should demonstrate relatively stronger associations to this capability.

  • In a sample of deployed active duty combatants, combat characterized by violence and high levels of injury were associated with relatively stronger associations of the acquired capability for suicide

Craig et al, 2011
Not all combat experiences are equal

- Level of violence
  - Firefights vs. nonhostile, routine patrols

- Proximity
  - Hand-to-hand combat vs. artillery fire at a distance

- Personal responsibility
  - Killing an enemy combatant vs. witnessing others engaged in combat
Combat experiences are influenced by:

- Occupation
  - Medics vs. infantrymen
- Location of deployment
  - Relatively well-controlled areas vs hostile areas with high combat operations

Craig et al, 2011
Additionally

- Combat experiences marked by initiation of violence toward others (e.g., firing upon the enemy) are more strongly associated with suicide attempts than combat experiences without active initiation of violence.

Fontana et al, 1992
What does all this mean?

- Viewed from the perspective of Joiner’s theory, the findings regarding violent and aggressive combat experiences could be explained by differing levels of acquired ability (i.e., fearlessness about death and pain tolerance) associated with these different types of combat.
Interpersonal Theory of Suicide

Those Who Desire Suicide

Perceived Burdensomeness

Thwarted Belongingness

Acquired Ability (e.g., violent combat exposure)

Serious Attempt or Death by Suicide

Joiner, 2005
Treatment Implications

• Joiner’s model posits that prevention of “acquired ability” OR of “burdensomeness” OR of “thwarted belongingness” will mitigate serious suicidality.

• Belongingness may be the most malleable and most powerful.
Suicide Risk Assessment
We assess risk to...

• Take good care of our patients and to guide our interventions

• The purpose of systematic suicide risk assessment is to identify modifiable and treatable risk factors that inform the patient’s overall treatment and management requirements (Simon 2001)

• Fortunately, the best way to care for our potential suicidal patients and ourselves are one in the same (Simon 2006)
Shock, Disbelief, Denial, Grief, Shame, Anger, and FEAR

Clinically Based Risk Management

• Clinically based risk management is patient centered
• Supports treatment process and therapeutic alliance
• Good clinical care = best risk management

Simon 2006
Suicide Risk Assessment

• Refers to the establishment of a
  – clinical judgment of risk in the near future,
  – based on the weighing of a very large amount of available clinical detail.
Good Clinical Practice is the Best Medicine

• Evaluation
  – Accurate diagnosis
  – Systematic suicide risk assessment
  – Get/review prior treatment records

• Treatment
  – Formulate, document, and implement a cogent treatment plan
  – Continually assess risk

• Management
  – Safety management (hospitalize, safety plans, precautions, etc)
  – Communicate and enlist support of others for patient’s suicide crisis

“Never worry alone.” (Gutheil 2002)
Suicide Risk Assessment

• No standard of care for the prediction of suicide
• Suicide is a rare event
• Efforts at prediction yield lots of false-positives as well as some false-negatives
• Structured scales may augment, but do not replace systematic risk assessment
• Actuarial analysis does not reveal specific treatable risk factors or modifiable protective factors for individual patients
Suicide Risk Assessment

• Standard of care does require suicide risk assessment whenever indicated
• Best assessments will attend to both risk and protective factors
• Risk assessment is not an event, it is a process
• Inductive process to generate specific patient data to guide clinical judgment, treatment, and management
• Research identifying risk and protective factors enables evidence-based treatment and safety management decision making
APA Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors


- Quick Reference Guide
- Indications
- Risk/protective factors
- Helpful questions to uncover suicidality
- And more
Important Domains of a Suicide-Focused Psychiatric Interview

- Psychiatric Illness
- History
- Psychosocial situation
- Individual strengths and vulnerabilities

- Current presentation of suicidality
  - Specifically inquire about suicidal thoughts, plans and behaviors
Thorough Psychiatric Evaluation

• Identify psychiatric signs and symptoms
  – In particular, sx’s that might influence risk: aggression, violence, impulsivity, insomnia, hopelessness, etc.

• Assess past suicidal and self-injurious behavior
  – For each attempt document details: precipitant, timing, intent, consequences, and medical severity
  – Substances involved?
  – Investigate pt’s thoughts about attempt: perception of lethality, ambivalence about living, degree of premeditation, rehearsal

• Review past treatment history and relationships
  – Gauge strength of therapeutic alliance
Thorough Psychiatric Evaluation

• Identify family history of suicide, mental illness, and dysfunction

• Investigate current psychosocial situation and nature of any current crisis
  – Acute crisis or chronic stressors may augment risk: financial, legal, interpersonal conflict or loss, housing, employment, etc.

• Investigate strengths!
  – Coping skills, personality traits, thinking style, supportive relationships, etc.
Specific Inquiry of Thoughts, Plans, and Behaviors

• Elicit any suicidal ideation
  – Focus on nature, frequency, extent, timing
  – Assess feelings about living

• Presence or Absence of Plan
  – What are plans, what steps have been taken
  – Investigate patient’s belief regarding lethality
  – Ask what circumstances might lead them to enact plan
  – Ask about GUNS and address the issue
Specific Inquiry of Thoughts, Plans, and Behaviors

• Assess patient’s degree of suicidality, including **intent and lethality of the plan**
  – Consider motivations, seriousness and extent of desire to die, associated behaviors and plans, lethality of method, feasibility
  – Realize that suicide assessment scales have low predictive values

• *Strive to know your patient and their specific or idiosyncratic warning signs*
Identify Suicide Risk Factors

• Specific factors that may generally increase risk for suicide or other self-directed violent behaviors
• A major focus of research for past 30 years
• Categories of risk factors
  – Demographic
  – Psychiatric
  – Psychosocial stressors
  – Past history
Warning Signs

• Warning signs – person-specific emotions, thoughts, or behaviors precipitating suicidal behavior

• Proximal to the suicidal behavior and imply imminent risk

• The presence of suicide warning signs, especially when combined with suicide risk factors generates the need to conduct further suicide risk assessment
## Risk Factors vs. Warning Signs

<table>
<thead>
<tr>
<th>Characteristic Feature</th>
<th>Risk Factor</th>
<th>Warning Sign</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship to Suicide</td>
<td>Distal</td>
<td>Proximal</td>
</tr>
<tr>
<td>Empirical Support</td>
<td>Evidence-base</td>
<td>Clinically derived</td>
</tr>
<tr>
<td>Timeframe</td>
<td>Enduring</td>
<td>Imminent</td>
</tr>
<tr>
<td>Nature of Occurrence</td>
<td>Relatively stable</td>
<td>Transient</td>
</tr>
<tr>
<td>Implications for Clinical Practice</td>
<td>At times limited</td>
<td>Demands intervention</td>
</tr>
<tr>
<td>Risk Factors</td>
<td>Warning Signs</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------</td>
<td>-------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>• Suicidal ideas/behaviors</td>
<td>• Threatening to hurt or kill self or talking of wanting to hurt or kill him/herself</td>
<td></td>
</tr>
<tr>
<td>• Psychiatric diagnoses</td>
<td>• Seeking access to lethal means</td>
<td></td>
</tr>
<tr>
<td>• Physical illness</td>
<td>• Talking or writing about death, dying or suicide</td>
<td></td>
</tr>
<tr>
<td>• Childhood trauma</td>
<td>• Increased substance (alcohol or drug) use</td>
<td></td>
</tr>
<tr>
<td>• Genetic/family effects</td>
<td>• No reason for living; no sense of purpose in life</td>
<td></td>
</tr>
<tr>
<td>• Psychological features (i.e. hopelessness)</td>
<td>• Feeling trapped - like there’s no way out</td>
<td></td>
</tr>
<tr>
<td>• Cognitive features</td>
<td>• Anxiety, agitation, unable to sleep</td>
<td></td>
</tr>
<tr>
<td>• Demographic features</td>
<td>• Hopelessness</td>
<td></td>
</tr>
<tr>
<td>• Access to means</td>
<td>• Withdrawal, isolation</td>
<td></td>
</tr>
<tr>
<td>• Substance intoxication</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Poor therapeutic relationship</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Determine if factors are modifiable

<table>
<thead>
<tr>
<th>Non-modifiable Risk Factors</th>
<th>Modifiable Risk Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Family History</td>
<td>• Treat psychiatric symptoms</td>
</tr>
<tr>
<td>• Past history</td>
<td>• Increase social support</td>
</tr>
<tr>
<td>• Demographics</td>
<td>• Remove access to lethal means</td>
</tr>
</tbody>
</table>
Don’t Neglect Modifiable Protective Factors

- These are often key to addressing long-term or chronic risk
- Sense of responsibility to family
- Reality testing ability
- Positive coping skills
- Positive problem-solving skills
- Enhanced social support
- Positive therapeutic relationships
Establish Diagnosis and Risk

- Axis I, II, III, and IV all extremely pertinent to informed determination of risk
- In estimating risk, combine all elements:
  - Psychiatric illness
  - Medical illness
  - Acute stressors
  - Risk factors and patient-specific warning signs
  - Protective factors
  - Nature, intensity, frequency of suicidal thoughts, plans, and behaviors
  - Veteran specific considerations (i.e., combat exposure, agent of killing)
Acute v. Chronic Risk

• These are very different, and each carry their own specific treatment/safety

A 29 y/o female with hx of 18 suicide attempts and chronic suicidal ideation, numerous psychiatric admissions, family hx of suicide, gun ownership, TBI, intermittent homelessness, alcohol dependence, and BPD presents to ER with c/o SOB; asked to conduct psychiatric evaluation given her well-known history. What is her risk?

• Formulation and plan for such individuals necessitates separate consideration of chronic and acute risk
Acute v. Chronic Risk

• Acute and chronic risk are dissociable
• Document estimation for each

“Although patient carries many static risk factors placing her at high chronic risk for engaging in suicidal behaviors, her present mood, stable housing, sustained sobriety, and SI below baseline suggest little acute/imminent risk for suicidal behavior.”
Psychiatric Management

• Establish/Maintain therapeutic alliance
  – Taking responsibility for patient’s care is not the same as taking responsibility for the patient’s life

• Attend to safety and determine treatment setting
  – Level of observation, frequency of sessions
  – Restricting access to means
  – Consider safety needs, optimal treatment setting, and patient's ability to benefit from such
Develop a Treatment Plan

• For the suicidal patient, particular attention should be paid to modifiable risk and protective factors
• Static risk factors help stratify level of risk, but are typically of little use in treatment; can’t change age, gender, or history
• Modifiable risk factors are typically many: medical illness (pain), psychiatric symptoms (psychosis), active substance abuse, cognitive styles, access to means, etc
• Augment protective factors (i.e. enhance sense of belonging)
References

- CRAIG J. BRYAN, PSYD, ABPP, AND KELLY C. CUKROWICZ, PHD. Associations Between Types of Combat Violence and the Acquired Capability for Suicide. Suicide and Life-Threatening Behavior 41(2) April 2011
VA National Initiatives that Address the Risk of Suicide

• Annual depression and PTSD screens
• Suicide Prevention Coordinators and teams
• Veterans Crisis Line
  – VA Crisis Line (1-800-273-TALK)
  – Online chat (www.veteranscrisisline.net/chat)
  – Text option (838255)
• VA ACE Cards
• Resources for family members
• VA Safety Planning Manual
• Hubs of expertise in suicide prevention (VISNs 2 and 19)
STAND BY THEM

Act Now
Dial 1-800-273-8255 PRESS 1
to talk to someone NOW

Confidential Veterans Chat
Text to 838255 to Get Help NOW
Take a Self-Check Quiz
Confidential Homeless Veterans Chat
Support for Deaf and Hard of Hearing
VA ACE Cards

- These are wallet-sized, easily-accessible, and portable tools on which the steps for being an active and valuable participant in suicide prevention are summarized.

- The accompanying brochure discusses warning signs of suicide, and provides safety guidelines for each step.
Resources for Family Members

“Information and Support After a Suicide Attempt: A Department of Veterans Affairs Resource Guide for Family Members of Veterans Who are Coping with Suicidality”

- This is an online resource that provides sources of information and support to Veterans, their family members, and their care providers.
Resources for Family Members

Guidelines for talking to children (4-8 years, 9-13 years, 14-18 years) about a family member's suicide attempt

- These guides provide an outline of how and what to say to children about the topic of suicide.
New Service for VA Providers

Suicide Risk Management Consultation Program
for VA Providers

1-866-948-7880
Call to Schedule a Consult
Thank you!

beeta.homaifar@va.gov
hal.wortzel@va.gov