TRAUMATOLOGY

PTSD And Chronic Suicidal Ideation: The Role Of Counter Suicidal Cognition

Joseph Sivak
Twin Ports VA Outpatient Mental Health
Jody L. Swartz
University of Wisconsin - Superior
David X. Swenson
College of St. Scholastica

ABSTRACT

Post traumatic stress disorder is often associated with an increase in suicidal thoughts and behaviors. However, this link remains poorly understood; particularly unclear are the mechanisms victims use to help them persevere through periods of increased suicidal ideation. This pilot study of veterans examines the frequency and quantity of suicidal ideation as well as preventative cognitions the victim utilizes to prevent suicide. These cognitions are known as counter-suicidal cognitions.

In the age of deinstitutionalization, capitation, and managed care, both public and private sector mental health professionals are faced with an ever increasing burden of assessing, facilitating, and helping maintain safety from self-harm in their clients on a strictly outpatient basis. Because of its ongoing and transient nature, chronic suicidal ideation (CSI) compared to active suicidal thinking is often not an indication for hospitalization. This can be a complicating factor in treatment of veterans with PTSD. For many who have experienced significant trauma in their past and continue to cognitively and emotionally re-experience the trauma (i.e. chronic PTSD), CSI is a persistent concern. CSI is distinguished from acute and active suicidal ideation as being ongoing, transient, intermittent thoughts of ending one's life (Motto, 1992). Acute suicidal ideation describes a patient who is in imminent danger of killing themselves, and is an indication for emergency hospitalization. Conversely, passive suicidal ideation is the wish for oneself to die, without active plans to facilitate the process. Since danger is not objectively imminent, these individuals are left to deal with their suicidal thoughts by drawing on their own intra- and interpersonal resources.

Suicidal ideation, attempts, and completed suicide are significant concerns for clinicians working with clients diagnosed with PTSD. Several studies have confirmed an increased risk of suicidal behavior in veterans with a diagnosis of PTSD (e.g. Davidson, Hughes, Blazer, & George, 1991; Hendin & Haas, 1991; Kramer, Lindy, Green, Grace & Leonard, 1994). Thoughts of ending one's life as well as previous suicide attempts have been significantly correlated with a diagnosis of PTSD in veterans, as well as 82.6% of veterans in outpatient treatment reporting symptoms of suicidal ideation (Kramer et al., 1994). Moreover, a high preponderance of anxiety disorders, particularly PTSD, has been found in veterans with completed suicide, relative to the general population of completed suicides (Lehmann, McCormick, & McCracken, 1995). In one

retrospective study, the incidence of PTSD was higher among Vietnam veterans who killed themselves than among Vietnam veterans killed in motor vehicle accidents (Farberow, Kang, & Bullman, 1990). While exposure to war is related to suicidal behavior, Bullman and Kang's (1996) study of veterans found that combat woundedness and physical injury increased suicidal behavior.

The findings are not limited to veterans. For example, in their study of victims of civil unrest in Northern Ireland, Loughrey, Curran and Bell (1992) found the incidence of suicide to be higher in victims who met diagnostic criteria for PTSD than among victims who did not. In a study of refugees from various countries, suicidal behavior was significantly greater among victims with a diagnosis of PTSD than among non PTSD victims (Ferrada-Noli, Asberg, Ormstad, Lundin, and Sundbom, 1998).

While those who experience PTSD may share similar symptom features, the traumatic experience triggering the traumatic reaction is quite diverse. Like combat, victims of sexual and physical violence (child and adult)(Briere & Runtz, 1987; Brown & Anderson, 1991; Carlin et al., 1994; van der Kolk, Perry & Herman, 1991), victims of tragic accidents, and survivors of natural disasters, to name a few, experience a similar repetitive, intrusive and anxiety based reaction which can exact an inordinate amount of cognitive and emotional energy from the survivor; energy which is required just to get through the day.

It is not uncommon for individuals with chronic PTSD to have coexisting psychiatric difficulties (Green, Lindy, & Grace, 1989). Substance abuse, mood disorders, somatoform disorders, and other anxiety disorders complicate the complex symptom picture of PTSD. For some with PTSD, a comorbid diagnosis of depression heightens the sense of hopelessness that may already be present. For example, in their study of Vietnam veterans with chronic PTSD, Roszell, McFall, and Malas (1991) found that nearly 50% indicated a current sense or belief of foreshortened future, and over 64% had a current coexisting diagnosis of major depression (93% were currently diagnosed with some form of mood disorder). In both disorders, the sense of foreshortened future and the sense of hopelessness, quite similar, are cognitive processes. It is these very cognitive processes, in the case of suicidal ideation they can be thought of as suicidal and counter suicidal cognitions, that need to be explored in order to understand what counter suicidal cognitions prevent the individual from attempting or completing suicide.

While the literature linking chronic suicidal ideation and chronic PTSD is growing, and the link between other suicide-related disorders and PTSD is clear, there have been no explorations of what keeps a person with chronic PTSD from killing themselves. As such, this study evaluates the frequency of suicidal ideation,the frequency a participant may share their suicidal cognitions with someone and the counter- suicidal cognitions the participant uses as prevention from carrying out the act of suicide.

Methodology

Participants

One hundred and two war veterans from various war theaters participated in this study. Of those who completed the survey, two were females and, due to the small number, were dropped from the study; the remaining 100 participants were male. The majority of the participants were involved in the Vietnam War (69.6%), 8.8% WW II (Europe), 5.9% WW II (Pacific), 8.8% Korea, 3.9% Persian Gulf, and 2.9% non- combat PTSD. The participants all had a primary

diagnosis of chronic PTSD. All participants met DSM-IV diagnosis for this disorder by archival and historical review, as well as biopsychosocial interview and mental status exam.

Measures

All participants completed a survey inquiring about past and present suicidality, suicide ideations, and coping resources. Questions included information on counter-suicidal cognitions which characterize their typical coping cognitions, behavioral responses to suicidal cognitions, and help seeking strategies when experiencing suicidal cognitions.

Procedure

The study consisted of a self-rating survey that was administered to the participant at the time following their regular clinic appointment. A cover letter on the survey explained the purpose of the study, the anonymous and confidential nature of the data, and that participation was voluntary. For most respondents, the survey took approximately 10 minutes to complete.

Results

Experience of Suicidal Ideation and Behavior

The total reporting any suicidal ideation (n= 83, 82.4%) was in contrast to those participants reporting never having any suicidal thoughts (n= 17, 17.6%). Participants ranged in experience of suicidal ideation, with the majority experiencing thoughts once or twice a month (n= 30, 29.4%). Twenty participants (19.6%) reported suicidal thoughts occurring once or twice a week, 19.6% (n=20) reported thoughts occurring once or twice a year, and 13.4% (n=14) reported daily suicidal thoughts.

Previous suicide attempts were also surveyed with 54.5% no attempts, 11.8% one attempt, 20.7% two attempts, 3.9% three attempts, 2.9% four attempts, 1% five attempts, 1% six attempts, 1% seven attempts, and 2% eight or more attempts.

Coping Resources

The majority of participants (n= 80, 79.4%) indicated that they never discuss the thoughts of suicide, when they occur, with the remaining 20% (n=20) reporting that they discuss these thoughts with someone at the time they are having them. Nearly one in three (n=33, 32.4%) would, however, at some time discuss these thoughts with their mental health provider.

For those who discuss the thoughts with someone when they are having them, the majority seek out a friend (n=8, 40%), spiritual advisor/clergy (n=7, 35%), or spouse/significant other (n=6, 30%). Only one participant indicated he would discuss his suicidal ideation with children or grandchildren. (Respondents could select more than one person/group with whom they would discuss their suicidal thoughts.)

Counter-Suicidal Cognitions

For the majority of respondents who indicated experience of suicidal ideation, thoughts of family and close friends kept them from carrying out their thoughts of suicide (n=61, 76.25%). Thirty-five percent used thoughts and beliefs in their faith, religion, or spirituality to prevent them from

attempting self-harm. Only 10% (n=8) used thoughts of work and financial responsibilities to assist them in preventing a suicide attempt. Nearly one in three (n=23, 28.8%) reported using no counter- suicidal cognitions and that there was nothing that helped them through that time. (Respondents could select more than one thought which they would use to prevent them from attempting to harm themselves.)

Discussion

The findings further clarify the relationship between suicidal ideation and chronic PTSD. The majority of participants report ongoing continuous suicidal thinking, while not discussing these thoughts with anyone. This suggests that even the clinician who gathers collateral information when assessing chronic suicidal ideation may not be obtaining a candid representation of the suicidal ideation. The largest percentage with whom the thoughts were ultimately discussed with was the mental health professional, which emphasizes the need to continuously assess for safety at all outpatient visits, in this type of traumatized population. Interestingly the majority of participants do report counter suicidal cognitions, the majority being thoughts of family and loved ones. This may once again validate the need for psycho- social supports in a traumatized, suicidal population.

Since most participants do not discuss their thoughts, but do identify counter suicidal cognitions, it may prove to be prudent for the clinician to discuss counter suicidal cognitions rather than questioning about suicide, when evaluating safety. In addition, there may be utility in the fact that counter suicidal cognitions are already interventions that the traumatized individual may already be utilizing, and not something that is necessarily installed by the therapist. The counter suicidal cognitions may be a means for the therapist to build upon rather than initiating. Validation of the counter suicidal cognitions and extrapolation upon it may prove to enhance self-efficacy, and a greater internal locus of control for the traumatized individual. An understanding of counter suicidal cognitions may provide the clinician with a therapeutic starting point, in terms of the cognitive reframing that may be needed to enhance a trauma patient's likelihood of survival as well as recovery from the psychological trauma.

Limitations of this pilot study include the fact that this was a subjective self rating scale. Despite the anonymous and confidential nature of the study, respondents may still have feared exposure of suicidal thoughts and the ramifications of such exposure.

Further research is indicated, after the results of this pilot study, to investigate the utility of counter suicidal cognitions in clinical practice, as well as application of the "no suicide" contract between client and therapist in relation to counter suicidal cognitions. The meaning of counter suicidal cognitions as it relates to trauma and any idiosyncratic counter suicidal cognitions that relate to trauma populations need to be further investigated.

In terms of the population, it should be noted that many comorbid diagnoses are associated with PTSD, including Chemical Dependency, Dysthymia, and Major Depression. Another factor is that many personality disordered patients are also afflicted with chronic suicidal ideation, particularly cluster B.

Major depression is often associated with acute suicidal ideation, and dysthymia is sometimes associated with chronic suicidal ideation. Many cluster B personality disorders are significantly traumatized psychologically. Although many patients in this study had additional diagnoses,

the population was random. All affective disordered patients were under treatment for these additional conditions. Chemical dependency issues were continuously addressed, if relevant.

Further research to differentiate these diagnoses with suicidal ideation should also be undertaken. The differences in the frequency of chronic suicidal ideation and counter suicidal cognitions between depressive disorders, chemical dependency diagnoses, and personality disorders, and PTSD needs to be addressed. These distinctions will be important to ascertain. However, the clinician is more often than not faced with a PTSD patient with multiple diagnoses. Clinicians in the field should not artificially separate these diagnoses, but be aware of and address and treat all of them. It may not be clinically practical, for example, to assume that because a patient's chemical dependency is in remission or their major depression has been treated that their chronic suicidal ideation is cured. Further research may help verify this hypothesis. Additional investigations will need to dissect further the exact content, sequence of the formation, and mechanism of counter suicidal cognitions relative to trauma specific populations.

References

Briere, J. & Runtz, M. (1987). Multivariate correlates of childhood psychological maltreatment and physical maltreatment among university women. Child Abuse & Neglect,12 331-341.

Brown, G.R. & Anderson, B. (1991). Psychiatric morbidity in adult inpatients with childhood histories of sexual and physical abuse. American Journal of Psychiatry, 148, 55-61.

Bullman, T.A. & Kang, H.K. (1996). The risk of suicide among combat wounded veterans. American Journal of Public Health, 86, 662-667.

Carlin, A.S., Kemper, K., Ward, N.G., Sowell, H., Gustafson, B., & Stevens, N. (1994). The effect of difference in objective and subjective definitions of childhood physical abuse on estimates of its incidence and relationship to psychopathology. Child Abuse & Neglect, 18, 393-399.

Davidson, J., Hughes, D., Blazer, D., & George, L. (1991). Post-traumatic stress disorder in the community: An epidemiological study. Psychological Medicine, 21, 713-721.

Farberow, N.L., Kang, H.K., & Bullman, T. (1990). Combat experience and post service psychosocial status as predictors of suicide in Vietnam veterans. Journal of Nervous and Mental Disease, 178, 32-37.

Ferrada-Noli, M., Asberg, M., Ormstad, K., Lundin, T., & Sundbom, E. (1998). Suicidal behavior after severe trauma. part one: PTSD diagnosis, psychiatric comorbidity, and assessments of suicidal behavior. Journal of Traumatic Stress, 11, 103-112.

Green, B.L., Lindy, J.D., & Grace, M.C. (1989). Multiple diagnosis in posttraumatic stress disorder: The role of war survivors. Journal of Nervous and Mental Disease, 177, 329-335.

Hendin, H. & Haas, A. (1991). Suicide and guilt as manifestations of PTSD in Vietnam combat veterans. American Journal of Psychiatry, 148, 586-591.

Kramer, T., Lindy, J., Green, B., Grace, M., & Leonard, A. (1994). The comorbidity of post-traumatic stress disorder and suicidality in Vietnam veterans. Suicide and Life-Threatening Behavior, 24 58-67.

Lehmann, L., McCormick, R., & McCracken, L. (1995). Suicidal behavior among patients in the VA health care system. Psychiatric Services, 46, 1069-1071.

Loughrey, G., Curran, P.S., & Bell, P. (1992). Post traumatic stress disorder and civil violence in Northern Ireland. In J.P. Wilson & B. Raphael (Eds.), International handbook of traumatic stress syndromes (pp. 377-383). NY: Plenum Press.

Motto, J. (1992). An integrated approach to estimating suicide risk. In R. Maris, A. Berman, J. Maltsberger, & R. Yufit (Eds.) Assessment and prediction of suicide (pp. 625-639). NY: Guilford.

Roszell, d.K., McFall, M.E., & Malas, K.L. (1991). frequency of symptoms and concurrent psychiatric disorder in Vietnam veterans with chronic PTSD. Hospital and Community Psychiatry, 42, 293-296.

van der Kolk, B.A., Perry, C. & Herman, J.L. (1991). Childhood origins of self-destructive behavior. American Journal of Psychiatry, 148, 1665-1671.

Joseph J. Sivak MD
Chief-Dept. of Psychiatry
Twin Ports VA
3520 Tower Ave.
Superior, Wisc. 54880

Email: limbicdoc@aol.com

Jody L. Swartz
University of Wisconsin - Superior

David L. Swenson
College of St. Scholastica