The Phenomenology of Suicide

From Science to Practice

Using Research to Promote Safety and Prevent Suicide

Overview

Suicide is multifactorial, complex, and often impulsive. Just over 12 million people will think of killing themselves, just over 3 million will plan for suicide, and just under 2 million will attempt suicide in the last year. Yet, there are between 40,000 and 50,000 suicide deaths in a year.[1] While screening for risk factors can improve early identification for suicide risk, multiple pathways can lead to suicide as factors combine to influence one's risk for suicide.[2] Understanding the relationship between suicide risk factors and suicidal thoughts and behavior can be difficult. Theoretical models can be useful for explaining or describing suicide and improving understanding of suicidal states. However, theories are not necessarily useful for predicting suicide, and none of the existing theories or models necessarily apply to all suicides as suicide is complex. Each theory is useful for understanding some, though not all, suicides.

Key Findings

Understanding Context and Subjectivity in Suicide Risk

- Conceptualizing suicide as a phenomenon requires understanding the subjective suicidal experience.[3] Much research has been conducted to understand the context of risk and protective factors for suicidal thoughts and suicide attempts or behaviors (STB). These factors include psychological states, behaviors, motivators, events, and other associations predating, or associated with, STB. Common risk factors include mental and physical illness, biological or genetic factors, personality traits, and a prior history of, or exposure to, STB.[2] Additionally, even after controlling for mental health diagnoses, social determinants of health (e.g., unemployment, homelessness, justice involvement) have a strong, dose-like-relationship with suicidal ideation and suicide attempt.[4,5] And in these dose-like-relationships, each additional social determinant of health increases the odds of suicidality.[4]

Ideation-to-Action Theories of Suicide

- While traditional approaches have considered risk factors for STB (e.g., depression, hopelessness), they do not account for differences between suicide ideators and attempters.[6] To address this gap, multiple theories for explaining suicidal behavior (called ideation-to-action theories of suicide) have been proposed and tested.[6] Ideation-to-action theories can help explain the interactions between situations, physical states, and risk and protective factors associated with suicidal behavior.[6] Four prominent ideation-to-action theories are detailed below.

Interpersonal Theory of Suicide

- The **interpersonal theory of suicide** posits that three necessary components interact for a person to engage in STB: thwarted belongingness, perceived burdensomeness, and capability to harm oneself.[7] Individuals' perceptions of how easy or difficult it is to change these psychological states impacts suicide risk. For example, hopelessness about the changability of one's perceived burdensomeness and capability is implicated in more severe presentations of risk. **Perceived burdensomeness** is conceptualized as the perception of being a burden to others; **thwarted belongingness** is feeling a lack of belonging and acceptance by others; and the **capability for suicide** occurs when individuals experience a lowered fear of death and an increase in pain tolerance. This theory suggests that experiencing both thwarted belongingness and perceived burdensomeness may result in suicidal ideation.[7,8] When individuals experience all three, they may be more likely to experience

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suicidal intent or to attempt suicide than individuals who only experience thwarted belongingness and perceived burdensomeness.[7,8] There is substantial literature demonstrating that Veterans have a predisposition for prior trauma exposure, substance use issues, and self-directed violence and work that directly tests interpersonal theory of suicide hypotheses about Veterans.[9,10] Moverover, Veterans have greater access to firearms than the general population and are usually more comfortable with, and proficient at, using firearms. These factors may increase Veterans' capability for suicide.[10]

Fluid Vulnerability Theory

- The **Fluid Vulnerability Theory (FVT)** accounts for temporal shifts in suicide risk by conceptualizing suicide risk as dynamic and changing through time. FVT describes suicide risk as fluctuating between baseline (i.e., chronic or stable risk and protective factors that persist through time) and acute dimensions or properties (i.e., fluctuating suicide risk reactive to external forces).[11,12]
- This theory helps explain how interactions between various factors may lead to an increase in suicide risk.[12] The **suicidal mode** is a major concept within FVT that describes the interactions between chronic and acute factors that when activated, may facilitate a suicidal act.[11,12] **Chronic risk factors** for STB include sex, trauma history, psychiatric history, and past suicide attempts, while **acute risk factors** include emotional distress, relationship problems, and negative life events.[11,12] These predispositions, triggers, and other risk factors are related to one's cognition, behavior, physiology, and emotion.[11,12] Triggers, such as environmental stressors and context, can contribute to the severity of a suicidal episode.[12] FVT hypothesizes that reducing triggering risk factors may help individuals in an activated suicidal mode to deescalate their risk transitioning from an acute to a baseline risk state.[11] Research has provided evidence in support of some aspects of this theory, including findings that suicidal ideation can change considerably over just a few hours, as can feelings of hopelessness, loneliness, and burdensomeness.[13]

Three-Step Theory of Suicide

- The **Three-Step Theory of Suicide** (3ST) suggests that experiencing both pain (usually psychological pain) and hopelessness can lead to suicidal ideation, which escalates to stronger suicidal ideation when pain exceeds one's sense of connectedness.[14] Suicidal ideation may progress to a suicidal attempt if the individual experiences factors that increase their **acquired** (i.e., overcoming biological impulses to harm oneself), **dispositional** (e.g., low pain sensitivity, lowered harm avoidance, genetic factors), and **practical** (e.g., ability to access and use lethal means, knowledge and proficiency regarding lethal means) **capability for suicide**.[14,15] 3ST helps explain how pain, hopelessness, and connectedness interact and can lead to escalating suicidal ideation and suicide attempt.[16,17]

Integrated Motivational-Volitional Model

- The **Integrated Motivational-Volitional** (IMV) model posits that defeat and entrapment drive the emergence of suicidal ideation, and volitional moderators guide the transition from suicidal ideation to suicidal behavior. The IMV model proposes three distinct phases: the pre-motivational, motivational, and volitional phases.[18]
- The **pre-motivational phase** describes the context or situations in which an individual may have increased risk for suicidal behavior, such as triggering events, personality characteristics, and biological, genetic, cognitive, and socioeconomic factors. These chronic or acute vulnerabilities confer an elevated risk for suicide.[18] The **motivational phase** describes the interactions and processes of suicidal ideation formation. Here, **entrapment, defeat**, and/or **humiliation** are the key predictors for the emergence of suicidal ideation. The presence or absence of **threat to self-moderators** (TSMs) including social problem-solving, coping, memory biases, and ruminative processes, may increase or decrease the likelihood

that defeat leads to entrapment.[18] The presence of **motivational moderators** (MMs) including thwarted belongingness, burdensomeness, future thoughts, goals, norms, resilience, social support, and attitudes, may increase or decrease the likelihood that entrapment leads to suicidal ideation. Positive MMs (e.g., reasons for living, belongingness, connectedness) may promote a more positive outlook and be protective against suicidal ideation, whereas negative MMs (e.g., burdensomeness, lack of social support) may increase the likelihood of developing suicidal ideation. The **Volitional Phase** occurs when **volitional moderators** (VMs) including access to lethal means, exposure to suicidal behavior, capability for suicide, planning, impulsivity, mental imagery, and past suicidal behavior, drive the transition from suicidal ideation to suicidal behavior.[18]

Ways You Can Help

- The risk stratification table in the VA/DoD Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide is helpful in discerning between chronic and acute risk and identifying corresponding actions.[19] **Find out more at:** ***www.healthquality.va.gov/guidelines/MH/srb***
- The VHA Suicide Risk Identification and Management SharePoint site contains information and resources to support a standardized process for suicide risk screening and evaluation. **Find out more at:** ***https://dvagov.sharepoint.com/sites/ECH/srsa/SitePages/Home.aspx***
- VA's suicide prevention coordinators (SPCs) are specially trained to educate VA staff and connect Veterans with counseling and services. **Find out more at:** ***https://www.veteranscrisisline.net/get-help/local-resources***
- VA's Suicide Risk Management Consultation Program provides free consultation, support, and resources that promote therapeutic best practices for providers who work with at-risk Veterans. **Find out more at:** ***www.mirecc.va.gov/visn19/consult***
- The Office of Mental Health and Suicide Prevention has published a Community Provider Toolkit about suicide prevention for healthcare providers. **Find out more at:** ***https://www.mentalhealth.va.gov/MENTALHEALTH/communityproviders/wellness-suicide-prevention.asp***

There is no single cause of suicide. It is often the result of a complex interaction of risk and protective factors at the individual, interpersonal, community, and societal levels. To prevent Veteran suicide, we must maximize protective factors and minimize risk factors at all of these levels.

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