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Research Paper

Elucidating the chronic, complex nature of suicidal ideation: A national qualitative study of veterans with a recent suicide attempt

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ABSTRACT

Background: Understanding the nature of suicidal ideation, or how suicidal ideation is experienced by the individual in its course and development, is important for informing suicidal ideation assessment and treatment. In this study, we conducted qualitative interviews with a national sample of fifty United States (U.S.) military veterans with recent suicide attempts to elucidate the nature of suicidal ideation from the perspective of those with lived experience.

Methods: We interviewed 25 women and 25 men veterans from Veterans Health Administration healthcare facilities across the U.S. who made a recent (prior 6 months) suicide attempt. Data were analyzed using a thematic analysis approach.

Results: Suicidal ideation was characterized as chronic, varying in severity and duration. Two typologies characterized increases in suicidal ideation severity: those whose ideation increases due to negative self-evaluations and those whose ideation increases without clear warning. Additionally, participants described needing help recovering from severe episodes of suicidal ideation, which often disrupted their lives and everyday functioning.

Limitations: This was a study of U.S. military Veterans with a recent suicide attempt; our findings may differ from studies of nonveterans or those with suicidal ideation but have never attempted suicide.

Conclusions: Our findings align with prior research that suicidal ideation is often experienced as chronic, fluctuating, and nonlinear. Suicide risk assessment may benefit from use of a combination of ideation severity and functional measures. Future work should investigate treatment of suicidal ideation that targets active symptom management and ameliorates the negative impacts that suicidal ideation has on patients' functioning.

1. Introduction

Suicidal ideation, defined as thinking about, considering, or planning suicidal self-directed violence (Crosby et al., 2011), is a distressing and often private battle experienced by many. While over an estimated 800,000 people worldwide die by suicide every year (World Health Organization, 2014), the number of those suffering with suicidal ideation is more widespread. The lifetime prevalence of suicide attempts, estimated across multiple countries, is approximately 2.7% whereas suicidal ideation is estimated at 9.2% (Nock et al., 2008). While not all who experience suicidal ideation go on to attempt suicide, it is a well-known precursor to suicidal behaviors (Beck et al., 1999; Britton et al., 2012; Mann et al., 2008). Suicidal ideation is therefore often used to identify those at risk for suicide in clinical settings (Bongiovi-Garcia et al., 2009; Posner et al., 2011), and it is viewed as a target of therapeutic interventions aiming to reduce suicide deaths (Bruce et al., 2004; Wilkinson et al., 2018).

To better understand how to treat suicidal ideation and how to use it as an indicator of risk level, considerable effort has gone into understanding and characterizing the nature of suicidal ideation – or how suicidal ideation is experienced by the individual in its course and development. In an Australian study investigating patterns of suicidal ideation leading up to suicide attempts in a non-clinical sample, researchers found that just over half (59%) of participants described experiencing suicidal ideation as suicidal thoughts that fluctuate with intensity over time (a non-linear pattern) while the remaining 41% experienced suicidal ideation as increasingly worse over time (a linear pattern) (Wyder and De Leo, 2007). Other work has focused on understanding the patterns of change in suicidal ideation intensity and has found within-person variability in the intensity and duration of suicidal thoughts, with some people experiencing low intensity thoughts that come and go quickly and others experiencing high intensity ideation that fluctuates less rapidly (Bryan and Rudd, 2018; Bryan et al., 2019). Together, this previous work suggests considerable variability in temporal patterning of suicidal ideation severity but lends little insight into the lived experience of suicidal ideation, what precipitates increases and decreases in intensity, or how patients handle suicidal thoughts in their

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day to day lives. Data in these areas may help inform methods for assessment and treatment.

Qualitative inquiry provides a strong basis from which to understand the development of phenomena to generate hypotheses for future quantitative work (Braun and Clarke, 2006; Charmaz, 2006). This bottom-up approach increases the ecological validity of study findings and is especially valuable for understanding complex phenomena such as suicidal ideation (Hjelmeland and Knizek, 2010). Yet, no known qualitative studies have examined the nature of suicidal ideation, meaning that our current understanding of suicidal ideation does not account for the lived experience of those with suicidal ideation or prior suicide attempts. In this study, we conducted qualitative interviews with a national sample of fifty United States (U.S.) military veterans with recent suicide attempts to elucidate the nature of suicidal ideation from the perspective of those with lived experience, towards improving suicidal ideation assessment and treatment.

2. Methods

Data for this study were collected as part of a larger national, mixed-methods project examining suicide risk and resilience among Veteran Health Administration (VHA) healthcare-utilizing U.S. military veterans. Methods are reported in more detail elsewhere (Denneson et al., 2020). The study was approved by the medical center's institutional review board where the study was conducted, and all participants gave their informed consent before engaging in study activities.

2.1. Setting and sample recruitment

The VHA is an integrated healthcare system that serves over 9 million patients across 1255 facilities in the United States. Participants were recruited from the VHA's National Patient Care Database, which contains diagnosis and healthcare utilization data for all VHA patients. VHA uses Suicide Behavior and Overdose Reports to record patient-reported self-harm-related events (including drug overdose) in patients' medical records, including suicidal and non-suicidal self-directed violence. The records contain details of the self-harming behavior, such as the date and time of the reported event, a description of the behavior, the level of suicidal intent and assessment of lethality (Hoffmire et al., 2016). Data from these reports are uploaded to the VHA's National Patient Care Database. International Classification of Disease Clinical Modification – 10th (ICD-10) diagnoses codes for self-directed violence (codes X71-X83, T14.91, T14.91XA, T14.91XD, and T14.91XS) are sometimes, but less frequently, used to document self-harming behavior. We used both the Suicide Behavior and Overdose Reports and the ICD-10 codes to identify patients who had engaged in self-harming behavior within the prior 6 months. Study staff then reviewed the details of the Suicide Behavior and Overdose Reports and clinical progress notes to determine suicide attempt status. Patients with a suicide attempt (self-directed violence with the intent to die) within the prior 6 months were considered eligible. Hearing impaired, non-English speaking, and institutionalized patients were excluded from the study, as were patients with dementia and a designated guardian.

We used purposive sampling to recruit a demographically, geographically, and clinically diverse sample. Study staff reached out to eligible patients' clinicians via e-mail or telephone. Clinicians were given an overview of the study and invited to refer their patient (i.e., clinicians obtained patients' permission for study staff to call). With clinician and patient permission, we telephoned patients interested in the study, confirmed their eligibility and invited them to be interviewed. Patients provided their informed consent and self-reported demographic information over the phone before the interviews were scheduled. As recruitment and enrollment progressed, we monitored the diversity of the sample, adjusting the prioritization of patients with certain demographic and clinical characteristics, as well as geographic locations to ensure diversity.

2.2. Data collection

A master's-level qualitative analyst conducted semi-structured telephone interviews with participants. The interview guide was adjusted as new themes emerged throughout data collection. Interviews began with rapport building and background information about military experiences. In this part of the interview, the questions focused on reasons for joining the military, military experiences, and the experience leaving the military. The second section of the interview contained questions about suicidal ideation and recent suicide attempt(s); what led to thinking about suicide, health and psychosocial concerns contributing to thoughts of suicide, and recovery needs. The interview concluded with questions about healthcare experiences related to suicide attempts and help-seeking. For the purpose of the present analysis, data pertaining to participant experiences with suicidal ideation were used, and other data are presented elsewhere. Interviews lasted approximately one hour. All interviews were audio recorded and transcribed. After the interview, participants were mailed a check for $50 for participation.

2.3. Analysis

We used a basic thematic analysis approach to analysis (Braun and Clarke, 2006), which allows for both inductive and deductive identification of themes across the data. As interviews were completed and transcribed, two analysts (KT and LD) read each transcript and wrote analytic memos to contribute to codebook refinement and initial analysis. Once the codebook was complete and all interviews transcribed, the analysts coded interviews in Atlas.ti® 8; interviews were coded by each analyst, with continued discussion of themes to ensure agreement. Upon completion of coding, the research team examined code reports to refine core concepts. We came to the data with a wide range of experience in suicide prevention research (from months to over a decade) and training (social psychology, sociology, psychology, public health, theology). Though we used practices to support validity such as identifying negative cases (participant experiences that contradicted our emerging findings) and comparing individual cases across the larger dataset, we acknowledge that our prior experiences necessarily influenced our interpretations of the data.

3. Results

3.1. Participants

Fifty veterans completed interviews, half of whom (n=25) self-identified as women and half (n=25) self-identified as men. Participant demographic and clinical characteristics as well as military service history are summarized in Table 1.

3.2. Overview of findings

Overall, suicidal ideation was experienced as chronic, with variations in intensity and duration. Differences within the larger group were observed with regard to how and why suicidal thoughts became more intense. Many participants felt that suicidal thoughts worsened without warning, were unpredictable, and uncontrollable. However, some clearly spoke about a self-evaluation process that led to increases in intensity or frequency of suicidal thoughts. That is, when participants perceived their lives as not going well, or as planned, the frequency or intensity of their suicidal thoughts increased. Finally, participants described needing help recovering from severe bouts of suicidal thoughts, as these episodes could severely disrupt their lives – creating a cyclical pattern of worsening suicidal thoughts.

3.3. Theme 1: the chronic nature of suicidal ideation

Most of the participants reported struggling with suicidal thoughts for a long time prior to attempting suicide. The severity of suicidal

Table 1
Participant demographic, clinical, and military service characteristics, *n*=50.

Characteristics	*n* (%)
Age (mean, SD)	45 (13.8)
Women	25 (50.0)
Race/ethnicity	
White	28 (56.0)
Black/African American	7 (14.0)
Multi-racial	4 (8.0)
American Indian or Alaskan Native	3 (6.0)
Asian	2 (4.0)
Hispanic/Latino	6 (12.0)
Mental health diagnoses	
Anxiety/panic disorder	23 (46.0)
Depression	42 (84.0)
Personality disorder	7 (14.0)
PTSD	27 (54.0)
Schizophrenia/bipolar disorder	11 (22.0)
Substance abuse disorder	20 (40.0)
Medical diagnoses	
Chronic pain	23 (46.0)
Sleep disorder	17 (34.0)
Rural residence	27 (44.0)
Military service era (multiple eras possible)	
Vietnam	5 (10.0)
Post-Vietnam	14 (28.0)
Persian Gulf War	2 (4.0)
Gulf War	12 (24.0)
OEF/OIF/OND	30 (60.0)

Note: OEF = Operation enduring freedom; OIF = Operation Iraqi freedom; OND = Operation New Dawn.

thoughts fluctuated over time, but suicidal thoughts were described as "always there." Their chronic thoughts of suicide were described as somewhat passive, or in other words, their suicidal thoughts could be described as a lack of fear regarding death, a lack of concern about risky behavior, or an overall apathy towards life. Feelings of exhaustion from these thoughts were also apparent. Although for most participants suicidal ideation appeared to behave non-linearly day-to-day, some described a general increase in overall intensity across many years.

> "I thought about [suicide] while I was in Basic, but I didn't act on it, and I thought about it soon after I left Basic, but I never acted on it. It was just a thought, and then that was that. [My suicidal thoughts] didn't begin to be severe until three or four years ago." (Participant 991)

> "But I guess I kind of just take it one day at a time. Because [suicidal ideation is] always there. And I'm not sure if it will ever go away. But the intensity of it can go up and down according to what's going on, but I do think about it… But I am trying not to feel that way and sometimes, some days are harder than others." (Participant 508)

> "Oh, a long time. That's probably one of the reasons I was doing drugs because subconsciously you figure like maybe one of these drugs would do you out, but that never happened." (Participant 501)

> "I've thought about it for forever, as long as I can remember. I told you [my superior officers] didn't care if I lived or died, that was kind of one of the pivotal moments for me. I kind of stopped caring too. Besides the incident [a few months ago] which is why you're wanting to talk to me, I've never been proactive in it, I've never really done anything, but if an opportunity would have presented itself, I wouldn't have run from death. If someone wanted to rob me, and they held me at gunpoint, I would just let them shoot me. It would be on someone else, it wouldn't be on me, but I wouldn't be the person that would fight to live, I would fight to die." (Participant 760)

3.4. Theme 2: the etiology and management of suicidal ideation fluctuations

Many participants talked about the unpredictable or uncontrollable nature of the severity of suicidal thoughts – that increases in suicidal thoughts can come and go without warning and are not necessarily associated with specific experiences. The participants who experienced increases in suicidal ideation this way also talked about not understanding what was happening, lacking the insight to understand their thoughts and feelings around suicidal ideation, though they were aware their ideation was getting worse. Accordingly, these participants talked about working hard to distract themselves from suicidal thoughts when they do arise, perhaps just waiting for them to pass, though some tried to manage their suicidal thoughts by trying to find ways to live or trying to avoid making a suicide attempt.

> "There's not a day goes by that I don't think about it, but I won't do it…I don't know, just something in the mind that clicks, I don't know what it is." (Participant 518)

> "I just didn't think about them. All the things I saw, the traumas and stuff, I just didn't think about them. But when I was alone, quiet, it's like somebody opened up an accordion and it all just poured out. It just ran in my mind like it was a slow leak and then it just turned into a fire hydrant. I started having nightmares, suicidal thoughts, and all of that other stuff, flashbacks. And I was just like, 'where is this coming from?'" (Participant 647)

> "It's been rough. A couple of days ago I was really close to having a breakdown. The thoughts of harming myself were definitely there but I didn't act on it. I tried to watch TV, sleep, just sleep it off. I know how bad I can get when I start thinking like that, so I try to take preemptive steps." (Participant 831)

> "Blocking them out. Not thinking about them. Going off to la la land and thinking about other things— until recently. Now I'm learning new skills that force me to think about them and force me to ask myself why I feel the way I do but when I was in the Marine Corp it was just burying it, that's what helped me get through." (Participant 833)

Although many participants talked about suicidal thoughts as feeling beyond their control, there was some indication that, for other participants, a self-evaluation process was involved in the fluctuation of suicidal thoughts. In these participants' attempts to explain their suicidal thoughts, they relayed comparisons of what they desired to achieve versus what they think they have achieved, or a 'taking stock' of themselves or their lives – suggesting that worsening thoughts of suicide may reflect a self-evaluative process by which they hold themselves accountable to some defined standard (either self- or socially-prescribed). In these descriptions, suicidal thoughts fluctuated in accordance with stress levels or setbacks towards achieving these standards.

> "One day again I fell off the wagon and ended up drinking, drugging, whatever I was doing and ended up taking a bunch of more pills and I said, 'what have you done now?' It was like I just couldn't seem to face stuff that was going on. It was so bad I said, 'you know you just might as well check out of here, you're really in a mess now.'" (Participant 566)

> "After the military is when I started to think about it, the depression, I was having horrible nightmares, I have PTSD… I couldn't relate to anybody. Things just started getting hard, I started abusing alcohol and all this stuff. The depression and everything did not help. Thinking about my friends who committed suicide, stuff like that. All of my battle buddies overseas, my brothers, my best friend who committed suicide in one of the barracks. He was my bunk mate overseas, and my best friend. I guess, yeah, I got super depressed, I got hurt, and I

was miserable, things in life were not going as planned." (Participant 516)

"It just felt like everything was kind of coming down on me and for some reason that day, and after that therapy session, I just felt like I couldn't take it anymore." (Participant 603)

3.5. Theme 3: the vicious cycle of setbacks from experiencing suicidal ideation

For some participants, experiencing bouts of severe suicidal thoughts was sometimes in itself a setback, a disruption in their lives from which the veterans had to then recover – potentially worsening suicidal thoughts in the future. They spoke about how it was a struggle to find time to get help for their suicidal thoughts because that would sometimes mean they had to sacrifice work, school, or other areas of their lives, which compounded their stress.

"I had to quit my job [recently] because that's when it really started going downhill for me, that's when I started feeling all of these feelings again. I was going to work and I would just—I would stand there, and I would sit there, and these thoughts would just be in my mind, and I couldn't focus on my job, so I had to tell them that I couldn't be there anymore. And then it all just came crashing down and I said, 'I'm done with it. I don't want to do this anymore. I don't want this to happen every two years, I don't want to have to pick up the pieces every two years and find a new job.'" (Participant 831)

"But the thing that they don't realize is that people have children. Or that there's people that have work. Or people like me, I have to go to school because I have to make ends meet. You don't – you're not able to just, 'Oh okay, I'm going to go a week to the hospital so I can try to get myself straight again because I'm trying to kill myself.' Because all this other stuff is still happening." (Participant 737)

4. Discussion

This is the first known study seeking to understand the nature of suicidal ideation from the perspective of those with lived experience to inform assessment and treatment approaches. We interviewed a national sample of U.S. military veterans with recent suicide attempts about their experiences with suicidal thoughts. Our findings indicated that suicidal ideation is often experienced as a chronic condition; though it may come and go and change in severity over time, individuals often perceive suicidal ideation as "always there." We also identified two typologies for the etiology of worsening suicidal thoughts. For some people, suicidal ideation severity increases as a result of self-evaluation, while for others it fluctuates organically, without warning or known precipitants. These findings have several implications for assessment and treatment of suicidal ideation.

The chronic, fluctuating nature of suicidal ideation described in this study is consistent with previous quantitative research indicating that the presence and severity of suicidal thoughts fluctuates in a non-linear manner (Bryan and Rudd, 2016; Bryan and Rudd, 2018; Kleiman and Nock, 2018). Our findings suggest that perceptions of linear growth of suicidal ideation severity may be reflected in larger time periods, such as years, or perhaps within a smaller unit of time defined by an acute episode of intensity that builds and then decreases. These findings are also consistent with fluid vulnerability theory, which proposes that suicide risk is both chronic and dynamic, and it emphasizes the importance of understanding individual differences in the course and trajectory of increased risk to reduce the likelihood of suicidal behaviors (Rudd, 2006).

Taking current and previous findings together, quantitative measurement of suicidal ideation severity (which is typically thought of as linear) needs to account for the non-linear chronic fluctuations as well as individual variation in duration and intensity of fluctuations identified in previous research. One potential approach may be to borrow from the chronic pain field, which recognizes that pain intensity is both transient and subject to considerable individual differences. As such, it has long been recommended that pain assessments measure both intensity and pain-related functioning (Dworkin et al., 2005). Likewise, suicidal ideation-related functional measures may be combined with severity measures to produce more clinically relevant assessments of patient risk as well as more useful assessments of treatment effectiveness than suicidal ideation severity measures alone.

Approaches to treating suicidal ideation should also consider the chronic, fluctuating nature of suicidal thoughts. Our findings suggest that an area for future investigation may be the use of suicidal ideation symptom management approaches, especially among patients with chronic suicidal thoughts. A biopsychosocial approach to treatment, which has been adopted in the management of other chronic conditions and recognizes the need to manage the complex relationships among biological, psychological and social factors associated with illness, may benefit patients with chronic suicidal ideation (Gatchel et al., 2014). This is consistent with other work highlighting the complex interplay of factors associated with suicide risk (Franklin et al., 2017). As such, additional research to develop and implement symptom management approaches that are responsive to individual differences in biopsychosocial factors associated with suicidal ideation is warranted.

Our findings suggest important individual differences in suicidal ideation severity fluctuations, which may inform methods for tailoring treatment approaches to two different patient groups. A few studies have examined precipitants of suicidal ideation fluctuations (Handley et al., 2013; Kleiman and Nock, 2018), with one study finding that changes in psychological and social well-being may account for increased severity of suicidal thoughts (Handley et al., 2013). This, along with other related work (e.g., O'Connor and Nock, 2014) reinforce the notion that self-evaluative and other psychological processes are important contributors to worsening suicide risk. However, our findings suggest that while many patients experience worsening suicidal thoughts as a result of a self-evaluative process, at least some patients may experience fluctuations in ideation severity without being able to identify the cause or without any warning. Use of cognitive behavioral therapies, which focus on modifying maladaptive thought processes, may be more effective in the management of suicidal ideation among patients who experience increases in severity as a result of self-evaluation than among patients who perceive increases in severity as resulting from unknown origins (Hofmann et al., 2012). Additional research, however, is needed to better understand the differences between these two typologies and why some patients perceive suicidal ideation as beyond their control, which may further inform treatment approaches as well as effect moderators for treatment effectiveness trials. Finally, symptom management approaches should also be limited in their intrusiveness into patients' lives (i.e., hospitalization may be counter-productive in some cases) and increase patients' ability to recover from severe bouts of ideation.

4.1. Limitations

Our study has multiple limitations that should be considered. This was a study of military Veterans who recently attempted suicide, so our findings may produce different results than studies of nonveterans or those who have suicidal ideation but have not attempted suicide. However, our sample was clinically and demographically diverse, representing all major U.S. regions. We excluded institutionalized patients (e.g., hospitalized, imprisoned) because they represent a patient population with potentially unique needs or experiences, but also due to logistical challenges obtaining permission and conducting interviews in these settings. This exclusion may also have impacted study findings. Participants were recruited through their treating clinicians, which may have resulted in a more clinically stable sample, although we note that some of our participants were diagnosed with serious mental illness.

4.2. Conclusions

Our findings corroborate prior research demonstrating a chronic, fluctuating, nonlinear course of suicidal ideation, reinforcing the need to use assessment measures that do not rely on suicidal ideation severity alone. Combining severity measures with functional measures may produce more clinically useful assessments of patient progress and risk for suicide. Our study further explicates the precipitant experiences of increases in suicidal ideation severity, finding that two typologies may exist: patients whose ideation worsens due to negative self-evaluations and patients who perceive worsening ideation to be random. Future research should investigate the potential modifications to suicidal ideation measurement proposed here as well as the potential benefit of clinical interventions that focus on active, personalized symptom management and reduces negative impacts of worsening ideation on patients' lives.

Authorship statement

Dr. Denneson designed the study, analyzed the data, drafted sections of the manuscript, and edited manuscript versions. Ms. McDonald conducted literature searches, analyzed the data, drafted sections of the manuscript, and edited manuscript versions. Ms. Tompkins analyzed the data, drafted sections of the manuscript, and edited manuscript versions. Ms. Meunier drafted sections of the manuscript and edited manuscript versions. All authors contributed to and approved the manuscript in its final form.

Role of the funding source

The funding source had no role in study design, data collection, analysis or interpretation of data, writing the report, or decision to submit the article for publication.

Declaration of Competing Interest

None.

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