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PTSD From a Suicide Attempt: Phenomenological and Diagnostic Considerations

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Abstract

Objective: A suicide attempt is at least somewhat life-threatening by definition and is, for some, traumatic. Thus, it is possible that some individuals may develop posttraumatic stress disorder (PTSD) from a suicide attempt.

Method: In this article, we consider whether one's suicide attempt could fulfill *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (*DSM-5*) criteria for a PTSD Criterion A event and contribute to the development of attendant PTSD symptoms (e.g., flashbacks, avoidance, shame/guilt, nightmares); discuss theoretical models of PTSD as they relate to suicide attempts; reflect on factors that might influence rates of suicide attempt-related PTSD; highlight methodological limitations that have hampered our understanding of suicide attempt-related PTSD; and posit areas for future scientific and clinical inquiry

Results: Strikingly, the degree to which a suicide attempt leads to PTSD is unknown.

Conclusions: We conclude with a call for research to systematically assess for suicide attempts alongside other potentially traumatic experiences (e.g., combat exposure, rape) that are included in standardized PTSD assessments.

Flashbacks of my jump would overwhelm me. Memories of that wind, tearing me apart. That emptiness of four seconds that stretched out for far longer. The height and water closing fast. The impact of the water. Nearly drowning.—Kevin Hines on attempting suicide by jumping from the Golden Gate Bridge (Hines, 2013, p. 72)

In the United States in 2015, an estimated 1.4 million adults made a nonfatal suicide attempt, among whom 840,000 (60.4%) received medical attention (Piscopo, Lipari, Cooney, & Glasheen, 2016). In many instances, a suicide attempt is life-threatening; in some cases, it can be particularly traumatic. Consider, for example, a suicide attempt by poisoning: Multiple organ failure is a possible consequence. Gunshot wounds, though more often than not fatal (Anestis, 2016), may lead to disfigurement and years of medical care. Hanging may result in neurological sequelae induced by hypoxia and related complications. Retrospective fear may also be at play in these scenarios—fear that one almost died, to be sure, but also fear regarding the seconds or minutes of severe physical anguish endured

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during or shortly after the attempt. Beyond the physical effects of a suicide attempt, there are profound psychological effects (e.g., shame; Wiklander, Samuelsson, & Asberg, 2003). We ask, then: Is it possible—and, if so, to what extent—for individuals who have attempted suicide to develop posttraumatic stress disorder (PTSD) from the suicide attempt? To our knowledge, this question has received remarkably little conceptual and empirical scrutiny.

In this article, we evaluate whether a suicide attempt could fulfill, in part, diagnostic criteria for PTSD per the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (*DSM-5*; American Psychiatric Association [APA], 2013). Following from that, we ponder whether something as proximally traumatic and potentially life-threatening as one's own suicide attempt—and at the same time, something that might be perceived as within one's locus of control (Wulsin & Goldman, 1993)—might yield rates of PTSD comparable to or different than PTSD due to other commonly reported index traumas. We conclude with potential clinical implications and future research directions. We emphasize that the purpose of this article is to ask, rather than to answer, the question: Can one's suicide attempt lead to PTSD?

PTSD *DSM-5* DIAGNOSTIC CRITERIA

We begin by briefly reviewing diagnostic criteria for PTSD as outlined in the *DSM-5* (APA, 2013). Criterion A stipulates that an individual must have been exposed to a trauma that resulted in actual or threatened death, serious injury, or sexual violence. Categories of these traumatic exposures include directly experiencing the event (A1), witnessing the event in vivo as it occurred to others (A2), learning about an event that occurred to close family members or friends (A3), or experiencing repeated exposure to an event (e.g., in the case of first responders; A4). Of note, the central element of Criteria A2 through A4 is that the trauma happened to another person; the *DSM-5* specifically recognizes, for instance, that learning about the suicide attempt of another person is potentially traumatic. While research has examined the degree to which witnessing or learning about the suicide attempt of another person might influence the development of PTSD (e.g., Van Hooff, McFarlane, Baur, Abraham, & Barnes, 2009), our focus is explicitly on one's own suicide attempt. Criterion A1 specifies a traumatic exposure that one physically experienced. It is Criterion A1 that we believe has the most relevance to one's own suicide attempt; that is, it is intuitive that one's suicide attempt could be captured by this category (i.e., directly experiencing actual or threatened death). The remaining diagnostic criteria for PTSD outline characteristic symptoms that occur *in response* to the traumatic exposure and must persist for at least one month, such as intrusions (e.g., distressing memories, flashbacks; Criterion B), avoidance (e.g., of external reminders of the event; Criterion C), negative alterations in cognitions and mood (e.g., guilt, anhedonia; Criterion D), and hyperarousal (e.g., hypervigilance, sleep disturbances; Criterion E).

CURRENT ASSESSMENT INSTRUMENTS FOR PTSD CRITERION A

We recognize that there exists some debate about the objectivity and utility of Criterion A (Stein, Wilmot, & Solomon, 2016). Our point here is not to enter that debate. Instead, we ground our discussion in the current reality of the psychiatric nosology: Criterion A captures

an array of traumatic experiences of which at least one is necessary, but not sufficient, for a PTSD diagnosis. Indeed, the types of traumas that may fulfill Criterion A are vast, at least by current assessment standards. For example, the World Health Organization (WHO) Composite International Diagnostic Interview (CIDI; Kessler & Üstün, 2004), Version 3.0, an interview-based measure utilized in large-scale epidemiological investigations of PTSD and other psychiatric disorders (e.g., Koenen et al., 2017), assesses for 29 types of traumatic events that span six categories. Similarly, the self-report Life Events Checklist-5 (LEC-5; Weathers et al., 2013) lists 16 potentially traumatic events. Both the CIDI and the LEC-5 include an open-ended question to capture events not otherwise assessed. Curiously, across these and other assessment modalities, one's suicide attempt is not explicitly listed as an example of a traumatic event. The omission of one's suicide attempt from these lists could be due to research demonstrating a markedly low base rate of suicide attempts leading to PTSD; however, we were unable to identify empirical evidence for this possibility, as outlined in the section that follows.

SUICIDE ATTEMPTS AS A CATALYST FOR PTSD

We suggest that one's own suicide attempt, which is in many instances life-threatening and is generally traumatic, could qualify as a Criterion A traumatic event. First, consider the case studies presented in Table 1, which highlight the life-threatening and traumatic nature of suicide attempts. Our point is not to suggest that any one of the individuals discussed in Table 1 actually had PTSD from a suicide attempt—though they may have—but to highlight how the phenomenology of a suicide attempt *could* reflect an experience that culminates in PTSD. For clinical scientists, anecdotes, though illuminative, are not enough. However, past research examining one's suicide attempt as a catalyst for PTSD is scarce. This topic was, as far as we can gather, initially discussed in a brief report by Wulsin and Goldman (1993). Wulsin and Goldman (1993) suggested that suicide attempts could fulfill the criteria outlined in the *DSM* for an event that may trigger PTSD. As they astutely question, “[I]s PTSD following a suicide attempt actually rare, or just rarely noticed?” (p. 152). In the ensuing 25 years following this report, to our knowledge, this topic has received scant empirical attention.

Theoretical Rationale

Here, we discuss the theoretical rationale for considering one's own suicide attempt as a catalyst for PTSD. Dating to the initial nosological formulation of PTSD as a fear-based anxiety disorder in *DSM-III* (APA, 1987), most models of PTSD have been rooted in fear processes. These models recognize that exposure to aversive stimuli paired with overextension of the hypothalamic-pituitary-adrenal (HPA) axis result in unwanted, uncontrollable, and distressing intrusive reminders (e.g., cognitions, intrusive images, external sounds, physical sensations). Consequently, the degree to which individuals are afraid of these intrusive reminders influences efforts to avoid stimuli, thoughts, and emotions related to the trauma (Ehlers & Clark, 2000; Foa & Kozak, 1986). These avoidance behaviors undermine an individual's ability to apply appropriate cognitive appraisals of the traumatic event and, in turn, contribute to (1) the overgeneralization of threat as ongoing and ever-present and (2) the maladaptive belief that one is incapable of coping with traumatic

sequelae (Foa, Steketee, & Rothbaum, 1989; Hoge, 2010; Litz, Lebowitz, Gray, & Nash, 2016). The perpetual confluence of traumatic reminders, avoidance behaviors, and maladaptive cognitive-emotional appraisals of trauma-relevant stimuli, therefore, operates in a negative feedback cycle that spurs and maintains PTSD symptoms.

Recognizing that not all stressful events beget PTSD, some research has shifted the conceptual emphasis of trauma from fear to that of moral injury (i.e., engaging in acts of commission or omission that transgress moral beliefs; Litz et al., 2009). Whereas physiological overextension of the HPA axis during a traumatic event could lead to fear and avoidance (cf. PTSD; Litz et al., 2016; Norrholm et al., 2011), social cognitive theories suggest that the same traumatic event might instead damage an individual's self-efficacy regarding protecting his or her physical or moral integrity. Moral injury may, therefore, emerge from the dissonance between one's choices during trauma and one's deep-seated beliefs or moral code (Jinkerson, 2016; Litz et al., 2009). As a result, the primary features of moral injury are intensely negative cognitions and emotions of guilt, shame, and loss of trust in self or others. Notably, these same negative cognition and mood symptoms are incorporated into cognitive and emotional processing models of PTSD (Ehlers & Clark, 2000; Foa & Kozak, 1986), and *DSM-5* PTSD Criterion D (APA, 2013). Thus, it may not be uncommon for individuals who experience a traumatic event to experience moral injury within and outside the context of a PTSD diagnosis (Farnsworth, Drescher, Nieuwsma, Walser, & Currier, 2014; Litz et al., 2009). As such, conceptualizations of PTSD and moral injury do not necessarily oppose each other. Instead, each may help to explain how a suicide attempt may result in heterogeneous phenotypes that resemble moral injury, PTSD, or a combination of these two syndromes.

At this point, we consider how, in the context of fear-based and moral injury models of PTSD, a suicide attempt might produce traumatic sequelae. Consider, for example, a father of two children who attempts suicide by jumping from a high bridge following a lengthy negotiation with emergency service workers. Fear-based models of PTSD would predict that paired experiences of physiological arousal upon jumping, thoughts of near-certain death, and intense physical pain upon impact would result in associative fear learning. In the following weeks and months, he may be reminded of his attempt while driving near bridges or when he hears sirens; when his heart rate increases, he may also be reminded of the similar physiological sensations he experienced during the fall. In turn, he may avoid familiar places because of their proximity to the bridge, any media (e.g., television shows, movies) that involve first responders or sirens, or physical activity that would elevate his heart rate. As this cycle escalates, he may be overwhelmed by thoughts that he is completely ruined and will never be capable of living a normal life—thoughts which contribute to a persistent state of hypervigilance for any triggers of traumatic reminders as well as social withdrawal. Over time, these symptoms might become distressing and introduce a level of impairment consistent with a PTSD diagnosis.

Alternatively, a model of moral injury would emphasize that this same individual, who considers that the most important role in his life is being a father, could have viewed his suicide attempt as a violation of his belief that, as a father, he should put the best interests of his children ahead of his own struggles.¹ Following his suicide attempt, he may experience

marked guilt for violating this belief and shame when facing his children or other parents. Attempts to suppress these emotions may result in intrusive cognitions that he is a failure and that his children will never forgive him, leading him to avoid returning to work or caring for his children, which may ultimately result in social isolation and dysphoria. This confluence of factors may further contribute to additional symptoms of PTSD, such as sleep and concentration difficulties, irritability and aggression, or reckless behavior. Recognizing that psychological responses to trauma and, indeed, attempted suicide are heterogeneous, the presented hypotheticals illustrate how the same suicide attempt may result in PTSD through varying pathways.

These models of PTSD may also illuminate how different suicide attempt methods, which vary in their level of violence and medical seriousness (cf. traumatic nature), may differentially predict the emergence of PTSD. For instance, more severe forms of physical trauma via gunshot wounds, puncture wounds, or physical impact (e.g., heights, trains) may be most likely to evoke fear-based neurocircuitry and physiological responses. Insofar as one views PTSD as a physiological disorder of fear and avoidance (Litz et al., 2016), it may be that these more violent forms of attempts are more likely to result in PTSD. While we maintain that most methods of suicide attempts are both objectively threatening/stressful and painful, we recognize there are suicide attempt methods that might alter perceptual experiences (e.g., by inducing unconsciousness) that mitigate the in vivo traumatic experience of the attempt; these methods include, for instance, ingesting a lethal amount of sleep aids or carbon monoxide poisoning. Though these methods may not activate the HPA axis or introduce physical injury in the same manner as a firearm or physical heights, PTSD could emerge nonetheless.

Preliminary Empirical Data

Despite the theoretical rationale that, for some people, a suicide attempt might lead to PTSD, to our knowledge, only one study has explicitly examined this empirically. Bill and colleagues (2012) recruited a sample of 30 individuals with a history of suicide attempts who were recently discharged from inpatient psychiatry for major depression. Participants were assessed for PTSD independent from the suicide attempt, as well as PTSD related to a suicide attempt. Overall, 14 (46.7%) developed suicide attempt–related PTSD, with an additional 3 (10%) classified as experiencing subthreshold suicide attempt–related PTSD due to reporting an insufficient number of *DSM-IV* avoidance and hyperarousal symptoms. There were no significant differences in sex, number of lifetime traumatic events, or previous PTSD diagnoses between those with and without suicide attempt–related PTSD. Moreover, compared to individuals without suicide attempt–related PTSD, those with suicide attempt–related PTSD—both syndromal and subsyndromal—reported greater precautions against discovery and a higher lethality risk of their index suicide attempt. It is unsurprising that PTSD risk is higher among attempters who engaged in more covert and medically lethal suicide attempts; such attempts are scarier and create more threat to life.

¹Incidentally, theoretical models of suicide suggest that, in the weeks and days leading up to this attempt, this individual might miscalculate his impending attempt as actually in his children's best interest (see Joiner, 2005). However, these perceptions are often recalibrated following a nonfatal attempt; in this regard, the attempt might be subsequently perceived as morally injurious.

The generalizability of Bill and colleagues' (2012) study is hampered by its small sample size and limited focus on patients with a history of major depression. Further, participants' suicide attempts occurred, on average, 11 years prior to the interview; this may have introduced retrospective reporting biases. Nevertheless, this investigation represents, to our knowledge, the first (and only) study endeavoring to empirically document the extent to which PTSD may arise from a suicide attempt.

Unique Features of a Suicide Attempt–Related Trauma

Suicide attempts leading to PTSD may represent a unique trauma scenario because the individual is both “perpetrator” and victim (Joiner & Stanley, 2016). As Joiner and Stanley (2016) note, there is an “unsettling reality that suicide is killing as well as dying” (p. 107). It may be, then, that surviving a suicide attempt (cf. attempted killing, albeit self-inflicted) and trying to make meaning out of this reality increases the probability for PTSD to develop. Relatedly, consider the phenomenon of “suicide by cop,” in which a suicidal individual behaves in a threatening manner and therefore provokes a lethal response from a police officer. A nontrivial proportion of police officers, including those involved in situations such as this, develop PTSD as a result of killing another person (Gersons, 1989). Associations between killing and PTSD are also found among combat soldiers (Maguen et al., 2010), and this association appears to be mediated by manifestations of guilt (Marx et al., 2010), consistent with the aforementioned moral injury model of PTSD. Insofar as a suicide attempt has elements of attempted killing (of the self), risk for PTSD may be elevated. Finally, it is also important to emphasize that the fear and pain of a suicide attempt may be significantly underestimated by some individuals, who, when confronted with this discrepancy, may experience it as a trauma that has many or all of the elements of one that is inflicted by others or outside forces.

On Temporality and Shared Vulnerability Factors

Importantly, a corpus of data has suggested PTSD is a risk factor for suicide ideation, attempts, and fatalities (i.e., PTSD temporally precedes suicidality; see Gradus et al., 2010; Panagioti, Gooding, & Tarrier, 2009, 2012). Yet most of the research examining PTSD and suicide attempts has been cross-sectional (Panagioti et al., 2009)—that is, examining the retrospective reporting of suicide attempts among individuals with a PTSD diagnosis or elevated PTSD symptoms. While we do not disagree that in many, perhaps most, cases it is likely that PTSD served as a risk factor for the suicide attempt, the cross-sectional data do not rule out the possibility that, for some individuals, the PTSD may have flowed from a suicide attempt. Thus, it is important to consider shared vulnerability factors.

Bryan (2016) has highlighted how deficits in problem solving, emotion regulation, and cognitive reappraisal are features of both suicidality and PTSD. Indeed, research has found that deficits in social problem-solving abilities are associated with suicidal ideation (Chu, Walker et al., 2017) and PTSD (Nezu & Carnevale, 1987). Deficits in emotion regulation, moreover, are also present in suicide attempters (Law, Khazem, & Anestis, 2015); and, for individuals with PTSD, emotion-regulation deficits may explain behaviors that are enacted to cope with trauma-related symptoms (e.g., substance use; Bryan, 2016; Steil, Dyer, Priebe, Kleindienst, & Bohus, 2011). Finally, cognitive reappraisal deficits are marked, in part, by

the inability to reframe an event's meaning for oneself, the world, and others (Troy, Wilhelm, Shallcross, & Mauss, 2010). In this regard, emerging research has documented that suicide-specific rumination (i.e., a seemingly intractable mental fixation on suicide-related thoughts; cf. lower levels of cognitive reappraisal) is associated with a suicide attempt history (Rogers & Joiner, 2018). Lower levels of cognitive reappraisal are also associated with more severe PTSD symptoms (Eftekhari, Zoellner, & Vigil, 2009). Another potential shared vulnerability factor is social disconnectedness, which is related to PTSD (Brewin, Andrews, & Valentine, 2000) and suicidality (Chu, Buchman-Schmitt et al., 2017). Finally, given advancements in the understanding of biological vulnerabilities for suicide attempts (Sudol & Mann, 2017) and PTSD (Yang, Wynn, & Ursano, 2018), it is important to consider shared biological processes.

HOW COMMON IS PTSD FROM A SUICIDE ATTEMPT?

Encouragingly, most people who experience a trauma do not develop PTSD (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; Yehuda et al., 2015). Approximately 8.1% of men and 20.4% of women develop PTSD following exposure to a trauma (Kessler et al., 1995). If we accept the premise that one's suicide attempt could fulfill *DSM-5* PTSD Criterion A, then to what extent might one's suicide attempt lead to PTSD? As noted, Bill and colleagues (2012) found that 46.7% of individuals in their sample reported symptoms consistent with PTSD as a result of their suicide attempt; however, this sample included only 30 individuals with a history of major depression. To contextualize these findings, it is worth noting several facts. First, most individuals diagnosed with PTSD have had a previous psychiatric disorder (i.e., 93.5% in Koenen et al., 2008), the most common of which is major depressive disorder (MDD; Kessler et al., 1995). Second, the probability of a trauma exposure leading to a PTSD diagnosis is increased among those with a pretrauma history of MDD (Breslau, Davis, Peterson, & Schultz, 1997; DiGangi et al., 2013). Individuals with preexisting MDD are approximately 2.5 times more likely to develop PTSD following a traumatic exposure (Breslau et al., 1997). Considering this, and considering that Bill and colleagues' (2012) sample was limited to individuals with major depression and demonstrated a 46.7% [$n = 14/30$] conversion rate from trauma exposure to PTSD, it may be that exposure to a suicide attempt trauma yields comparable rates of PTSD to other trauma exposures among samples not selected for MDD (Kessler et al., 1995); this is merely speculative, and research in this area is needed.

Wulsin and Goldman (1993) suggest that it is possible that rates of PTSD resulting from a suicide attempt may be lower than rates of PTSD from other traumas, because "[s]uicide attempts may be appraised by the attempter as relatively within his or her locus of control, helpless as he or she may feel about life in general. This fleeting sense of control may protect many attempters from PTSD symptoms" (p. 155).

This may not always be the case, however. Some individuals who attempt suicide may initially think that their attempt will be under their control. But, especially in particularly dangerous scenarios (e.g., jumping from a high place), the event may quickly feel out of their control. Kevin Hines, for example, wrote about the wave of helplessness he felt not just before his jump from the Golden Gate Bridge but also during it: "What have I done? I don't

want to die. God, please save me!” (Hines, 2013, p. 60). Indeed, it is not uncommon for someone to initiate a suicide attempt and survive—and then to retrospectively report some variant of that plea for survival. As illustrated here, fearless resolve is powerful and operative in the decision to make a suicide attempt (see Joiner, 2005), but the instinct to survive is often even more powerful and may quickly cast doubt on that decision, leading perhaps to an exacerbation of anguish.

Moreover, consider the experience of combat that is associated with notably elevated rates of PTSD, affecting as many as 17.2% of recent service members (Hermann, Shiner, & Friedman, 2012). These individuals signed up for the military, ostensibly with the knowledge that combat was a possibility; one’s decision to enter into a combat role could be conceptualized as within one’s locus of control, at least to an extent, and, therefore, locus of control may not be a protectant against PTSD. On the contrary, some elements that might not be in these service members’ locus of control are unexpected consequences of war associated with PTSD, such as moral injuries; thus, the absence of locus of control in these instances may exacerbate PTSD symptoms. These competing explanations underscore the necessity for future research to disentangle how, why, and for whom suicide attempts may lead to PTSD.

While the aforementioned anecdotal, theoretical, and empirical accounts offer compelling conceptual support for the notion that a suicide attempt could serve as a catalyst for PTSD, we are mindful that there are also factors that might be in opposition to our contention (see Table 2). It is our hope that future research will help clarify this nascent body of literature.

FUTURE RESEARCH DIRECTIONS

Advancements in the assessment of Criterion A traumas are needed to derive a valid estimate of the scope of PTSD following a suicide attempt. An initial study that seeks to expand the CIDI, LEC-5, or a similar assessment instrument to include an item such as “My suicide attempt” might be one feasible step. This has the potential to enhance (a) research efforts, by allowing for the systematic study of the phenomenon in large-scale epidemiological studies; and (b) clinical efforts, by signaling to a clinician of a recent suicide attempter that PTSD symptoms should be monitored and/or targeted in treatment.

An additional next step would be to examine this research question among a sample of individuals selected for a suicide attempt history.² As part of this study, it would be important to assess shared vulnerability factors, such as (deficits in) problem solving, emotion regulation, and cognitive reappraisal, as well as related constructs such as moral injury. Moreover, it would additionally be informative to collect self-report or medical record data on previous PTSD diagnoses due to traumas unrelated to a suicide attempt.

Another consideration is that assessing for a suicide attempt presents the potential for misclassification (Hom, Joiner, & Bernert, 2016). That is, an individual may report having made a suicide attempt when, upon inquiry by a clinician, it is revealed that the action

²-It would be prudent to follow up with and assess these individuals for at least one month following their suicide attempt, in line with *DSM-5* diagnostic criteria for PTSD (APA, 2013).

actually constituted, for example, an aborted or interrupted suicide attempt (i.e., engaging in preparatory behaviors for a suicide attempt but not actually engaging in the behaviors due to interruption by oneself [aborted] or others [interrupted]; Barber, Marzuk, Leon, & Portera, 1998; Crosby, Ortega, & Melanson, 2011). It may be that these suicide-related behaviors, though certainly potentially traumatizing and clinically relevant, may not reach the threshold for a Criterion A traumatic event like an actual suicide attempt may, in which there is a more salient threat of bodily injury or death. However, it may be that an aborted or interrupted suicide attempt could fulfill Criterion A if, as Friedman (2013) notes, “this event is a watershed in their lives ... [and] [t]he memory of the trauma is at the heart of the diagnosis and the organizing core around which all of the other symptoms can be understood” (p. 550). Relatedly, the accurate recall of the traumatic event might also influence assessment findings. For instance, Borges et al. (2017) found that the acute intoxication of alcohol is a robust antecedent to suicide attempts. Insofar as acute alcohol use may impair recall, suicide attempts that are preceded by acute alcohol ingestion might present additional challenges for the assessment and treatment of related PTSD symptoms (Tipps, Raybuck, & Lattal, 2014).

Although the current article is focused specifically on PTSD symptoms that may follow one's suicide attempt, there are other psychological and related consequences of a suicide attempt that deserve concurrent empirical attention, such as stigma (Hom, Davis, & Joiner, 2018; Sheehan, Dubke, & Corrigan, 2017). Stigma, in turn, might contribute to the maintenance of suicide risk, increased shame, and decreased utilization of mental health care services. Another possible consequence is high financial costs: medical costs related to the attempt, lost worktime, and ongoing physical and/or psychological therapies (Shepard, Gurewich, Lwin, Reed, & Silverman, 2016). While stigma and financial ramifications, to take two examples, are potentially catastrophic, they are not symptoms of PTSD and must be considered separately.

TREATMENT IMPLICATIONS

The accurate assessment of PTSD, including triggering events such as a suicide attempt, will allow for the linkage of individuals to appropriate treatment. The treatment implications of PTSD related to a suicide attempt remain to be seen and hinge, in part, on bedrock empirical investigations regarding its epidemiology. Nevertheless, there is reason to believe that treating PTSD from a suicide attempt would follow standard empirically supported treatment approaches, such as cognitive processing therapy (CPT) or prolonged exposure (PE; see Cusack et al., 2016). Regarding PE, for which a core component is systematically reexperiencing the trauma, it would be important for research to systematically assess for potential iatrogenic effects of reexperiencing a suicide attempt trauma, because mental rehearsal of a suicide attempt is theorized to contribute to the capability to engage in suicidal behavior (Joiner, 2005). From a practical standpoint, this issue may tilt the choice toward CPT over PE specifically in these kinds of scenarios, at least until more research on the topic is available. It is worth noting that the treatment of PTSD symptoms with CPT and PE has demonstrable effects on suicidal ideation as well (Cox et al., 2016; Gradus, Suvak, Wisco, Marx, & Resick, 2013).

Other psychotherapies might be efficacious for the treatment of PTSD symptoms, such as nightmares, among suicide attempters. Imagery rehearsal therapy (IRT) has garnered compelling empirical support for the treatment of nightmares (Ellis, Rufino, & Nadorff, 2017; Krakow et al., 2001). IRT helps facilitate cognitive reappraisal through the recall of the nightmare, modification of its ending to yield a more positive outcome, and rehearsal of the revised narrative (Krakow & Zadra, 2006). As noted, deficits in cognitive reappraisal is a risk marker for both suicidality and PTSD; thus, IRT may be particularly relevant for individuals who may develop PTSD from a suicide attempt. More broadly, given that a substantial proportion of individuals who attempt suicide present to the emergency department (ED) following an attempt, brief treatment protocols embedded within ED settings might enhance treatment utilization and prevent the development of PTSD (Rothbaum et al., 2012).

Regardless of the degree to which PTSD may arise from a suicide attempt, and regardless of the treatment provisioned for PTSD-specific symptoms, a central focus of clinical efforts in the period following a suicide attempt should be stabilizing suicide risk through efforts such as safety planning (Stanley & Brown, 2012). Safety planning is a relatively brief intervention that can occur alongside other clinical endeavors, such as the assessment and mitigation of factors that may be consequential to the suicide attempt (e.g., PTSD). We underscore three additional points: (a) a nontrivial proportion of individuals who have made a suicide attempt are admitted to inpatient psychiatry following their attempt; (b) preliminary data suggest inpatient hospitalization might itself be traumatic and iatrogenic (Coyle, Shaver, & Linehan, 2018); and (c) the period following discharge from inpatient psychiatry represents a high-risk period (Chung et al., 2017). Thus, when indicated, clinical efforts should also involve the close monitoring of individuals who have made a suicide attempt in the immediate period postdischarge from inpatient psychiatry.

CONCLUDING REMARKS

In this article, we have asked whether one's suicide attempt could fulfill *DSM-5* diagnostic criteria for a PTSD Criterion A event as well as contribute to the development of other core PTSD symptoms. We emphasize that the purpose of this article was not to be sufficiently probative on this question; indeed, as previously detailed, there are insufficient data available to answer this clinically relevant question. However, compelling preliminary data as well as anecdotal and theoretical evidence suggest that a suicide attempt, which is by definition at least somewhat life-threatening, could reasonably be considered a Criterion A traumatic event, and that the sequelae of a suicide attempt do appear to be associated with other PTSD symptoms, such as flashbacks, shame/guilt, and nightmares. The anecdotal is insufficient evidence, however, and in that spirit, we welcome future research that systematically assesses one's own suicide attempt as a potential Criterion A event alongside other potentially life-threatening and traumatic experiences.

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TABLE 1.
Case Examples Highlighting the Life-Threatening and Traumatic Nature of Suicide Attempts

Cases	Description
1. Brent Runyon	In 1991, 14-year-old Brent Runyon doused himself with gasoline and lit himself on fire with the intention of dying. A suicide attempt by fire is a relatively rare method of suicide; data from the Centers for Disease Control and Prevention (CDC) indicate that in 1991, 182 people died by suicide via this method (versus 30,810 people by all methods combined that same year; CDC, 2018). Runyon survived—with nearly all of his body covered in third-degree burns. He wrote a memoir about his struggles prior to, during, and after his suicide attempt. The purpose of his memoir, he said, was “to set my trauma down on paper” (Runyon, 2004, p. 321). The memoir is replete with details of the incident’s physical anguish, as well as of agonizing medical procedures suggestive of the life-threatening nature of the attempt (e.g., “they took part of my scalp and moved it to my left leg,” p. 41). Procedures such as these were endured for a full year of hospital and rehabilitation stays.
2. Kevin Hines	In 2000, 19-year-old Kevin Hines attempted suicide by jumping from the Golden Gate Bridge. Jumps from the Golden Gate Bridge—220 feet (roughly 22 stories) from the roadway to the waters of the San Francisco Bay—are almost always fatal—if not from the fall itself, then via drowning in the frigid bay waters. Multiple suicide fatalities at this location led public health officials and other stakeholders in recent years to begin construction on a barrier in an effort to prevent people from jumping (Whitmer & Woods, 2013). In his memoir, Hines recounts the physical and emotional trauma he experienced as a result of his suicide attempt, including receiving “twenty-three staples across the side of [his] torso” (Hines, 2013, p. 69) and experiencing unremitting flashbacks to the moment that he jumped.
3. Kay Redfield Jamison	Kay Redfield Jamison, a clinical psychologist and renowned researcher on bipolar disorder and related illnesses, attempted suicide at age 28 by overdosing on lithium. Prescription drug overdoses are, relative to some other suicide methods, less lethal. Yet lithium presents risk for toxicity even when taken as prescribed (when not appropriately monitored, for instance); moreover, Jamison coupled the lithium with an antiemetic medication, increasing the medical seriousness of the attempt. She spent several days in a coma following the attempt. She wrote: “[T]he aftermath of a suicide attempt ... is deeply bruising to all concerned ... living with the knowledge that one has been violent forces a difficult reconciliation of totally divergent notions of oneself” (Jamison, 1995, p. 120).

TABLE 2.
Supporting and Opposing Factors Regarding Suicide Attempts as a PTSD Criterion A Event

Supporting Factors	Opposing Factors
<ul style="list-style-type: none">• Suicide attempts are, by definition, at least somewhat life-threatening and thus reflect a core feature of PTSD.• Clinical experience is in accord with empirical data that suicide attempters experience: (1) flashbacks; (2) avoidance of reminders of the attempt; (3) shame, guilt, and dysphoria related to the attempt; and (4) nightmares. These map onto core PTSD symptoms.• The recognition of a suicide attempt as a PTSD Criterion A stressor might signal appropriate psychiatric treatments (e.g., PTSD specific).• The <i>DSM-5</i> recognizes the suicide of another person as a potential Criterion A stressor (APA, 2013, p. 275); thus, it follows that a more proximally traumatic event—one's own suicide attempt—could serve as a Criterion A stressor as well.• Preliminary data from Bill and colleagues (2012) support the notion that PTSD may arise from a suicide attempt.	<ul style="list-style-type: none">• Suicide attempts, it could be argued, are within one's locus of control and thus might not reflect the underlying features of common PTSD traumas (e.g., unexpected, victimization).• Some individuals may be so intent on dying by suicide, even after a nonfatal suicide attempt, that attendant PTSD symptoms (e.g., shame, guilt, nightmares) are absent.• The recognition of a suicide attempt as a PTSD Criterion A stressor might detract from the detection and mitigation of other catastrophic consequences of a suicide attempt (e.g., financial).• Some suicide attempt methods (e.g., ingesting sleep aids) might alter perceptual experiences (e.g., by inducing unconsciousness) that mitigate the in vivo traumatic experience of the attempt, potentially precluding PTSD symptom development.

Note. Arguments in support of and in opposition to suicide attempts serving as a catalyst for PTSD are presented in Table 2 to provide a balanced view; the arguments presented do not necessarily reflect the views of the authors. PTSD = posttraumatic stress disorder; *DSM-5* = *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition.