Psychiatria Danubina, 2025 Vol. 37, No. 3, pp 374-376 https://doi.org/10.24869/psyd.2025.374 *Case Report*

Another casualty of war: Using the stress-diathesis model to conceptualize a combat veteran suicide death

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INTRODUCTION

Suicide remains a public health issue for United States (U.S.) military veterans (Levine & Sher, 2023). The most recent suicide data revealed there were 6,392 veteran suicide deaths in 2021, an increase of 114 suicides from 2020 (Department of Veterans Affairs, 2023). Combat veterans experience psychological, biological, physical, environmental, and psychosocial stressors, as compared to non-combat veterans and civilians. These unique and unusual experiences may elevate combat veterans' suicide risk.

CASE PRESENTATION

This case report aims to describe a U.S. combat veteran who died by suicide with multiple psychiatric and medical comorbidities, as well as psychosocial stressors. We hope this case report adds educational value to healthcare professionals who work with military veterans or other individuals at risk for suicide.

The veteran described is a 47-year-old, White, male, combat veteran who served in the Army from 2002 to 2006, and he received an honorable discharge. His weapon assignment was machine gunner, where he was responsible for providing heavy gunfire support to other soldiers.

The veteran experienced combat in Iraq from 2003 to 2004. He had psychiatric diagnoses consisting of posttraumatic stress disorder (PTSD), major depressive disorder (MDD) and alcohol use disorder. He had a medical history of type 2 diabetes mellitus and hyperlipidemia. The veteran was diagnosed with diabetes during his military service, and he was insulin dependent. His symptoms of PTSD and MDD included hypervigilance "I feel uncomfortable with people behind me," guilt, difficulty with concentration, sleep disturbances, nightmares, flashbacks, anger outbursts, irritability, hypersensitivity to loud noise and bursts of light, and suicidal ideation.

In Iraq, his missions included protecting his Army battalion, civilian escorts, checkpoint watch, house searches, prisoner escort, marking depleted Uranium sites, and training Iraqi civilians to be soldiers. The veteran reported a significant combat history consisting of multiple firefights, fighting his way out of three ambushes, sniper attacks, and mortars. He also experienced civilians throwing rocks at him, cleaning up the remains of an acquaintance who died by self-inflicted firearm wound "there were bits of hair in the ceiling," and witnessing multiple dead civilian bodies. He also mentioned that he would decline food offered to him by Iraqi locals out of fear of being poisoned.

The veteran had difficulty readjusting to civilian life upon discharge from military service. His neighbor noticed he was struggling and recommended that he present to the Department of Veterans Affairs Hospital (VA). The veteran reported the following readjustment issues: difficulty obtaining employment, financial stressors, relationship issues with family/friends, recent divorce from wife, and homelessness (residing in his van that had no refrigeration for his insulin).

It is important to note that he experienced some childhood adversities. His father was absent for a significant part of his adolescence. The veteran also engaged in non-suicidal self-injurious behavior in the form of cutting during his early teenage years.

The veteran was first brought to the attention of VA mental health staff after he reported purchasing a firearm with suicidal intent during an intake assessment. He reported struggling with symptoms of PTSD and MDD, and having psychosocial stressors consisting of relationship issues and recently losing $3000 due to gambling. The firearm was found in his van by VA police in the VA parking lot, and it was removed from his vehicle. He was subsequently hospitalized on an

inpatient psychiatry unit for a period of 28-days. During his hospitalization, he was treated with Venlafaxine for PTSD and MDD, and Gabapentin for neuropathic pain and anxiety and he showed signs of improvement. The veteran's inpatient psychiatry discharge plan included a referral to an intensive outpatient mental health program, the Psychosocial Rehabilitation and Recovery Center, as well as the outpatient PTSD program. He attended several outpatient mental health appointments following his discharge, and during these appointments he denied active suicidal ideation, plan and intent. Thirteen days after his discharge from inpatient psychiatry, he was found by a bystander hanging outside of his van from an electrical cord in a suicide attempt. The veteran was brought to a local hospital, and died 3-days later due to medical complications.

DISCUSSION

We can discuss this case using the stress-diathesis model of suicidal behavior (Rubinstein, 1986). The stress-diathesis model describes suicidal behavior as a result of an interaction between acute stressors or proximal risk factors and a diathesis or distal factors (Mann & Rizk, 2020). The diathesis refers to suicide-related traits that moderate the likelihood of suicidal behavior in response to stressors. Stressors can be external, such as relationship or financial problems, or internal, such as a major depressive episode.

In this case the diathesis or predisposing factors included:

- Childhood adversities
- Firefights and being ambushed
- Diagnosis of MDD
- Diagnosis of PTSD
- Anger
- Irritability and impulsivity
- An acquaintance suicide
- Type 2 diabetes mellitus, on insulin

The acute stressors or precipitants of suicide included:

- Major depressive episode, probably, the most important precipitating factor
- Divorce from wife and other interpersonal problems
- Unemployment, financial difficulties, money loss as a result of gambling
- Homelessness

In this case, the veteran denied suicidal ideation in each of his post-discharge mental health appointments. Research shows that many individuals who want to kill themselves do not report suicidal ideation (Sher, 2011). Suicidal patients may hide their intentions because they do not want the attempt to be prevented.

Suicide risk is heightened post-discharge from an inpatient psychiatry unit (Chung et al., 2019). This risk can be compounded by having combat veteran status (Kang et al., 2015). In this case, the veteran did appear to have adequate post-discharge follow-up appointments. It is recommended that patients with heightened suicide risk receive increased monitoring following a discharge from an inpatient psychiatric unit (Forte et al., 2019).

Non-psychiatric factors could have contributed to this veteran's suicide death. It has been shown that diabetes, including a need to manage diabetes with insulin, is associated with increased suicidality (Levine & Sher, 2023; Sher, 2022). Some observations indicated that the use of gabapentin may increase suicide risk, although several studies did not support a relation between gabapentin and suicidality (Ghaly et al., 2018).

CONCLUSION

Suicide prevention is a challenging task that requires a comprehensive approach. Effective psychosocial assistance combined with good psychiatric and medical treatment may decrease suicidality in combat veterans. The stress-diathesis model can be used when evaluating complex patient cases with suicide risk.

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