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Treating PTSD and Suicide Risk: Separating Myth From Fact

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- Expert consensus and practice guidelines recommend against PTSD treatment for acutely suicidal patients (Cloitre et al., 2011; Foa et al., 2008; Forbes et al., 2007; van Minnen et al., 2012)

- Limited knowledge is due to exclusion of suicidal patients from clinical trials because of concerns about suicide-related iatrogenesis

- Cognitive Processing Therapy (CPT): Acute suicide risk is possible contraindication for trauma-focused therapies even though cognitive restructuring is first-line treatment for depression and suicide risk, and is generally seen as safe

Trauma-focused therapies are unsafe with suicidal patients

Where Did This Come From?

- **Inadequate training in among mental health professionals**
  - Less than half receive training in suicide risk management or treatment during graduate school, internship, or medical school
  - The average clinician attends only a handful of CE hours over the course of their entire career focused on suicide risk management
  - Suicide risk training often emphasizes risk assessment, not treatment
- **Exclusion of individuals reporting suicide ideation from clinical trials**
- **Pervasive myths about PTSD and trauma-focused therapies**
  - PTSD is chronic and "uncurable"
  - Excessive reverence for "triggers"

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Female Sexual Assault Survivors (Non-Military)

Participants

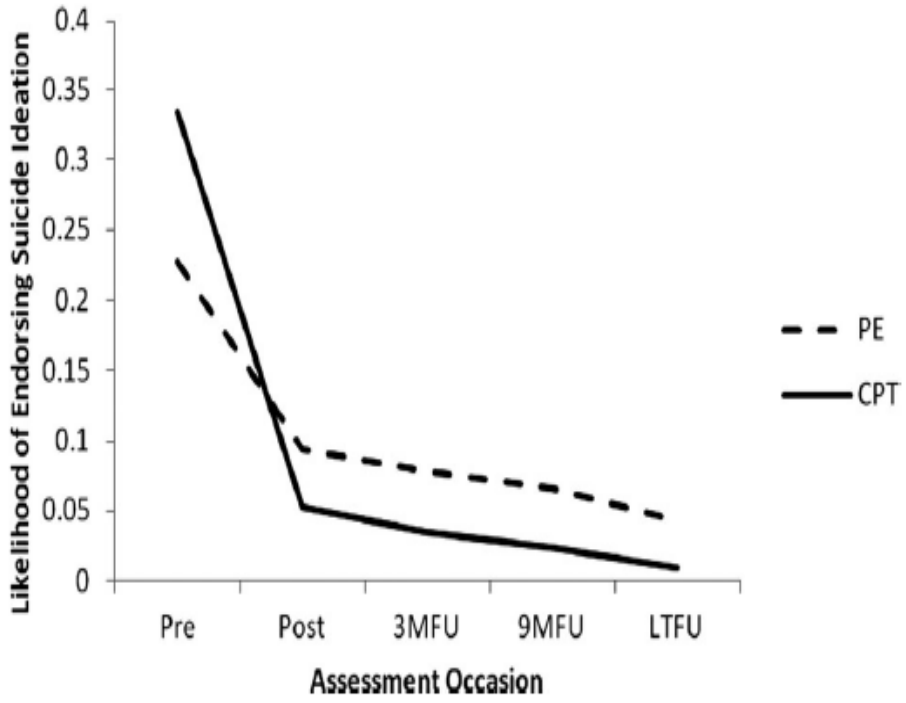
163 women seeking treatment for PTSD subsequent to sexual assault

- Gender: 100% female
- Age: M=32.0 years
- Race: 712% white, 24% black, 4% other

- RCT comparing individual CPT+A to individual PE
- PTSD diagnosis established via clinician-administered CAPS
- Suicide ideation assessed via Beck Depression Inventory item 9

Rates of Suicide Ideation Over Time

- Decline in rate of SI in both CPT and PE
- Significantly larger decline in CPT (OR=1.3 [1.1, 1.6])



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Active Duty Military Personnel: Study 1

Participants

268 active duty Soldiers seeking treatment for PTSD at Fort Hood, Texas, after deploying to Iraq or Afghanistan

- Gender: 91% male
- Age: M=33.2 years
- Race: 40% white, 28% black, 23% Hispanic, 9% other
- Deployed: M=2.3 deployments

- RCT comparing group CPT to individual CPT
- PTSD diagnosis established via clinician-administered PSSI
- Suicide ideation assessed via Beck Scale for Suicide Ideation
- Suicide attempts assessed via Columbia Suicide Severity Rating Scale

Rates of Suicide Ideation Over Time

- Significant decline in SI in both arms from baseline to post-treatment ($\chi^2(2)=13.0$, $p=.002$)
- Significant decline in SI in individual CPT but not group CPT from baseline to 6 months (group: $\chi^2(1)=2.3$, $p=.130$; individual: $\chi^2(1)=4.5$, $p=.034$)
- No differences between groups

	BL	Post	6 mo
Group CPT	17.8%	7.9%	11.7%
Individual CPT	13.4%	5.2%	4.9%

Suicide Attempts During or After Treatment

- There were two suicide attempts in group CPT:
  - One suicide attempt before the start of treatment
  - One suicide attempt during the course of treatment

- There were no suicide attempts in individual CPT

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Active Duty Military Personnel: Study 2

Participants

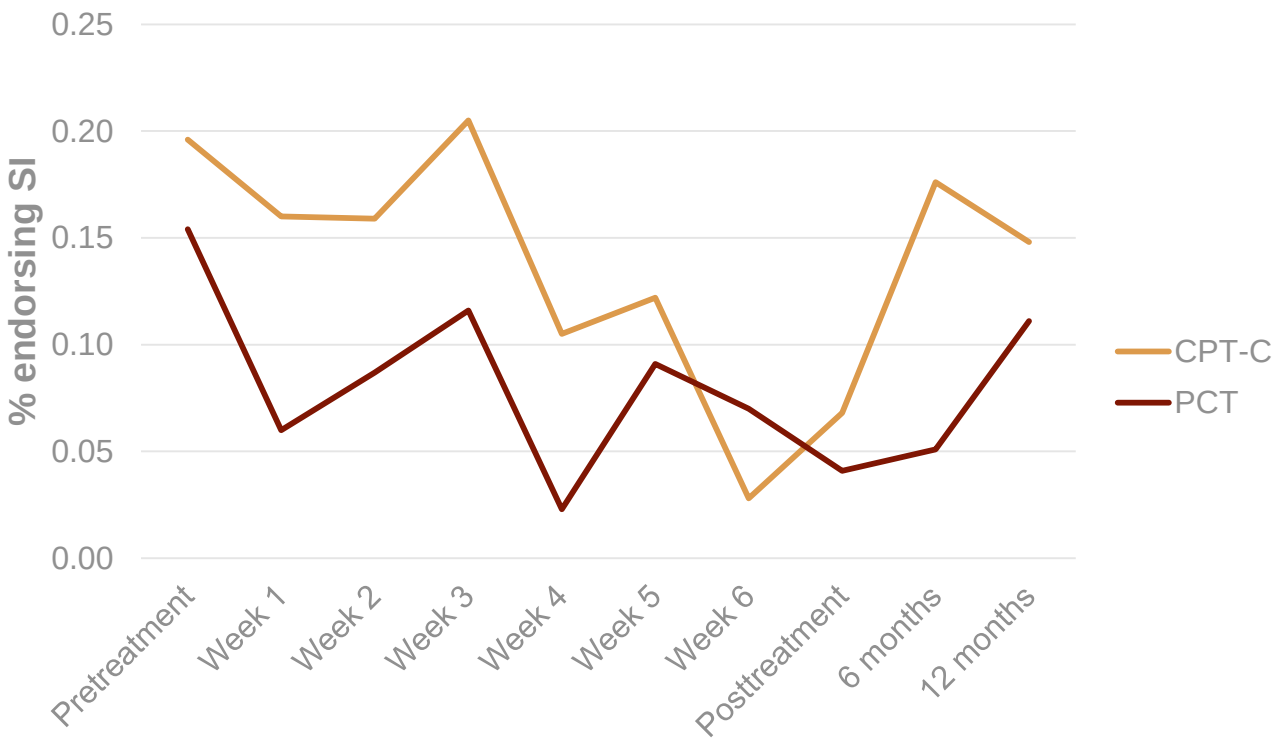
108 active duty Soldiers seeking treatment for PTSD at Fort Hood, Texas, after deploying to Iraq or Afghanistan

- Gender: 93% male
- Age: M=32.7 years
- Race: 57% white, 20% black, 14% Hispanic, 1% Asian, 7% other
- Deployed: M=2.2 deployments

- RCT comparing group CPT to group PCT
- PTSD diagnosis established via clinician-administered PSSI
- Suicide ideation assessed via Beck Scale for Suicide Ideation
- Suicide attempts assessed via Columbia Suicide Severity Rating Scale

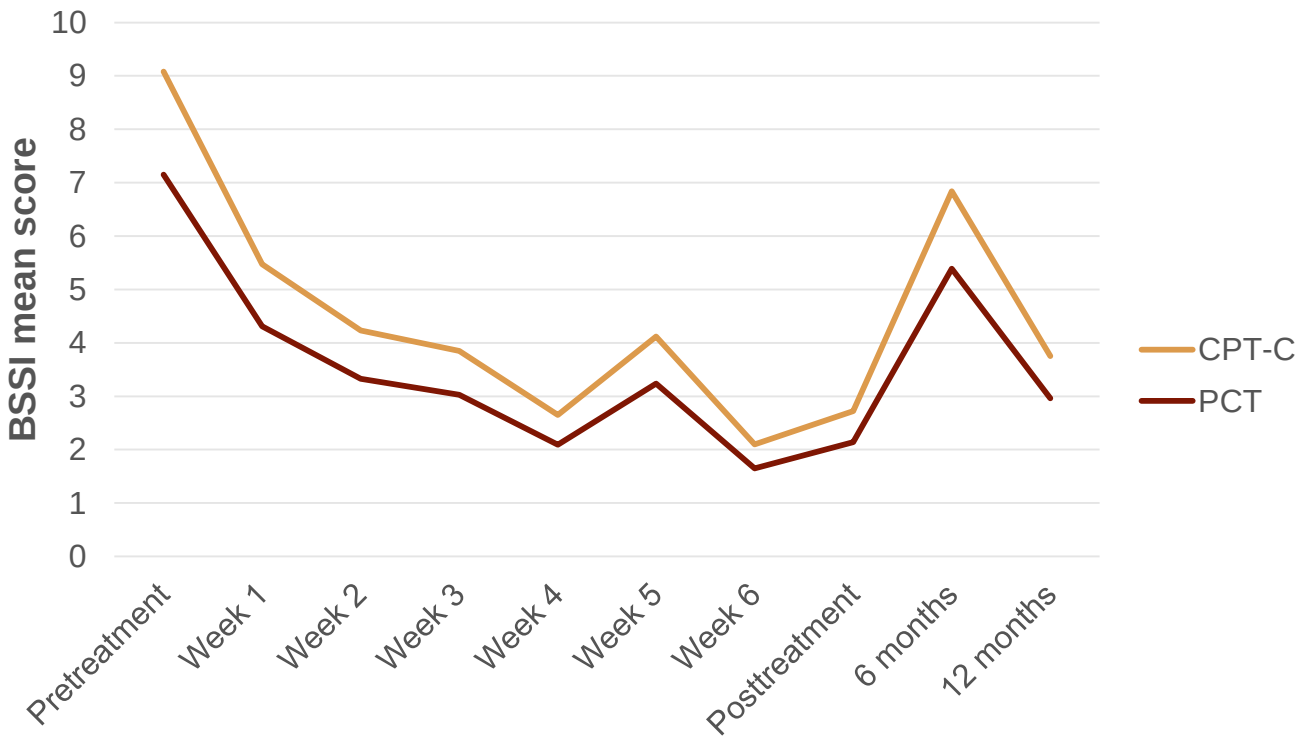
Rates of Suicide Ideation Over Time

- Significant decline in SI in both treatment groups ($F(1,615)=13.81$, $p<.001$)
- No differences between groups ($F(1,613)=0.21$, $p=.647$)



Severity of Suicide Ideation Over Time

- Significant decline in SI severity in both groups ($F(1,107)=30.14$, $p<.001$)
- No differences between groups ($F(1,106)=0.45$, $p=.503$)



Exacerbation of Preexisting Suicide Ideation

- Reliable change index used to examine possible exacerbation of preexisting suicide ideation

- 1 participant in CPT (10%) vs. 3 participants in group PCT (50%) demonstrated exacerbation of preexisting risk, Fisher's exact p=.118, phi=.45

New-Onset Suicide Ideation After Baseline

- New-onset SI defined as endorsement of SI after start of treatment by participant who initially denied SI

- 14.3% in CPT vs. 15.9% in PCE reported new-onset SI, OR=0.25 [0.03, 2.58], p=.245

- Participants with new-onset SI reported more severe PTSD symptoms (F(1,695)=4.88, p=.026) and depression symptoms (F(1,742)=4.97, p=.026) at baseline, and showed significant increase in depression severity over time (B=0.12, SE=0.06, p=.050)

Suicide Attempts During or After Treatment

- There were no suicide attempts during the study period in either treatment group

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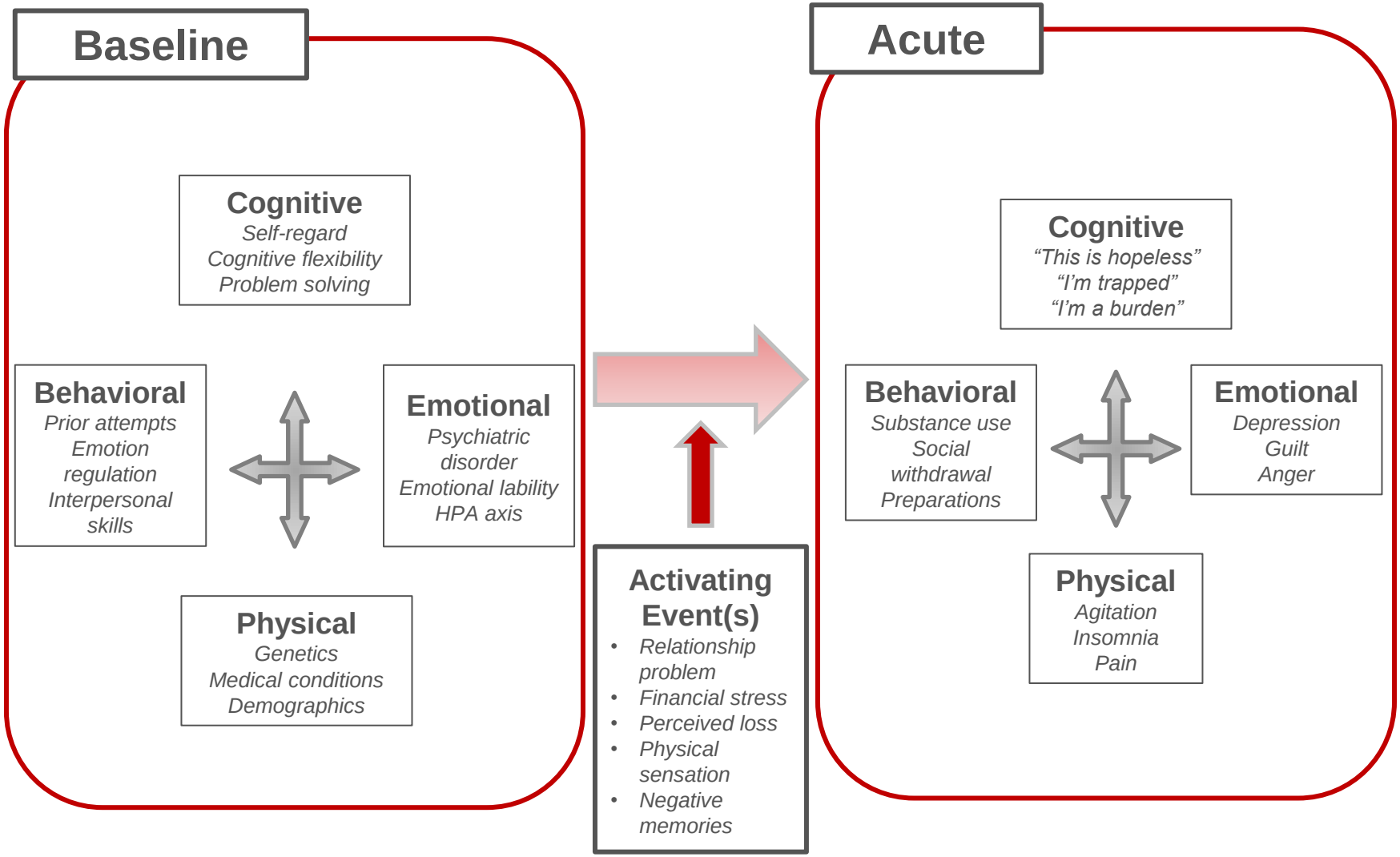
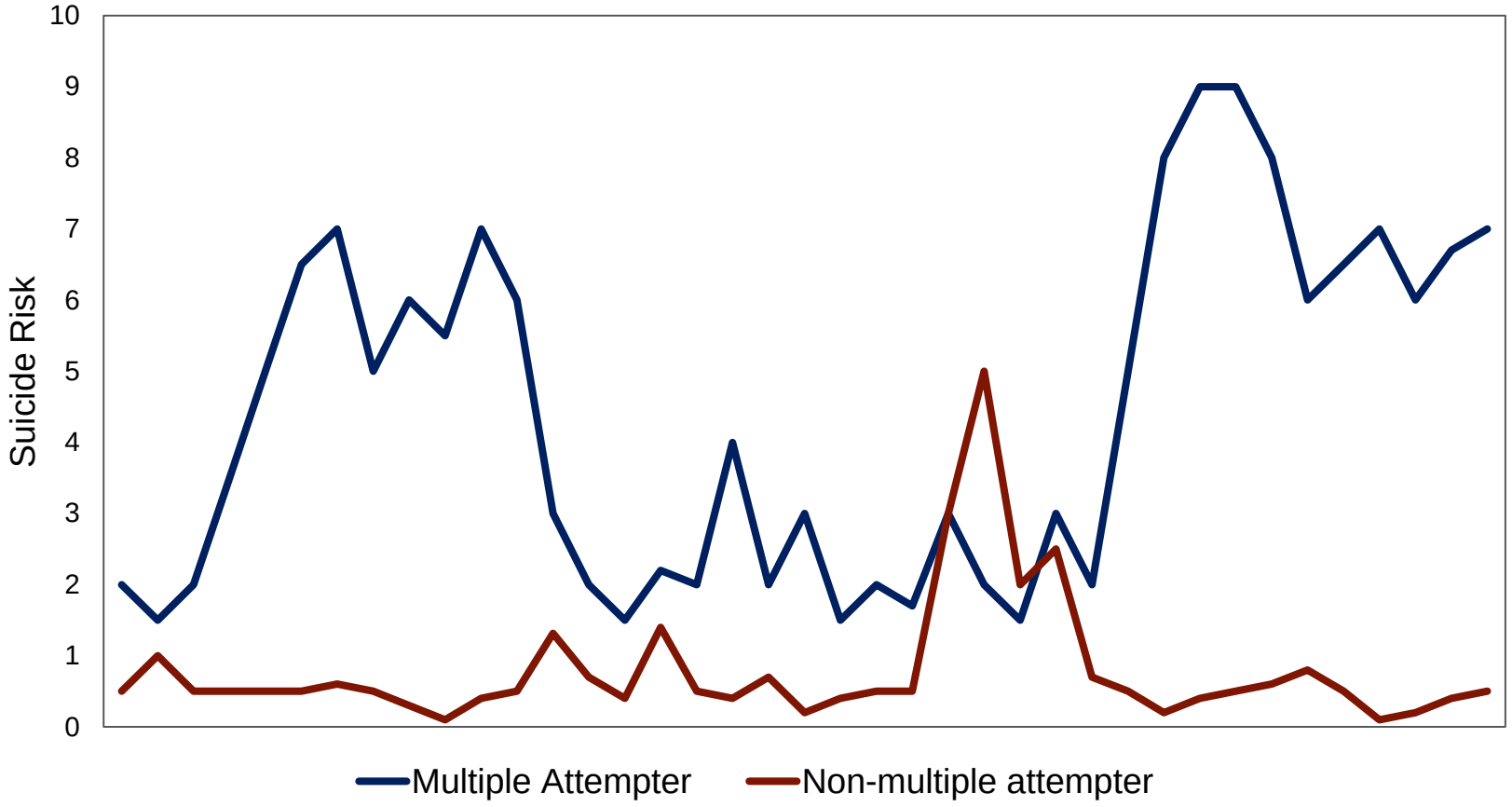
Understanding the Overlap of PTSD and Suicide Risk

The Suicidal Mode



Fluctuations in Suicide Risk Over Time



Treatment Approach

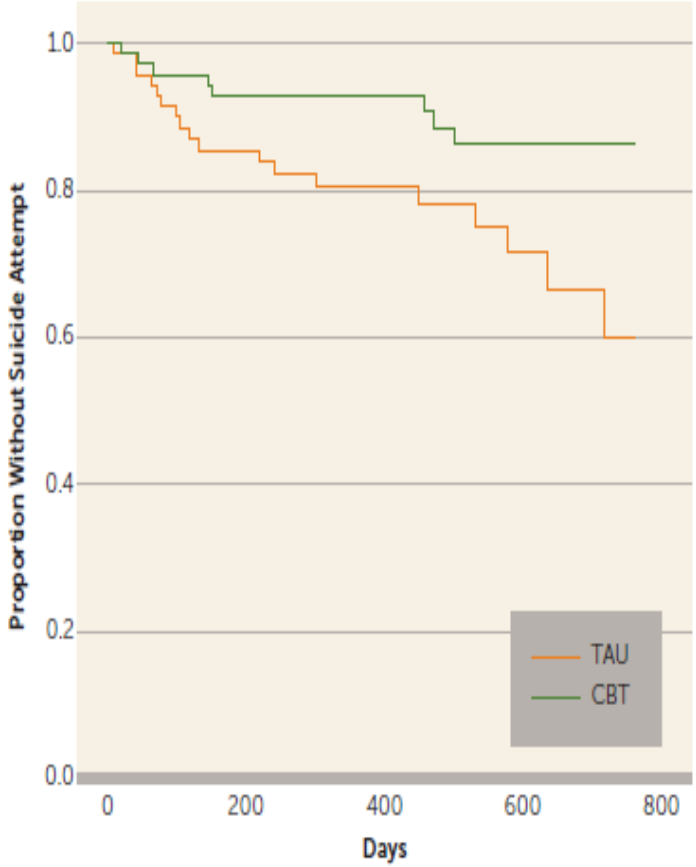
Clinical Presentation	Treatment Approach
• No suicide ideation • Suicide ideation with low intent	Trauma-focused treatment
• Suicide ideation with moderate intent • Suicide planning (nonspecific)	Trauma-focused treatment plus crisis response plan
• Suicide ideation with severe intent • Suicide preparation or rehearsal	Suicide-focused treatment followed by trauma-focused treatment

BCBT Effect on Suicide Attempts

TABLE 2. Estimated Suicide Attempt-Free Probabilities

	Brief Cognitive-Behavioral Therapy		Treatment as Usual	
Assessment Period	Attempt-Free Probability	95% CI	Attempt-Free Probability	95% CI
3 Months	0.96	0.94–0.98	0.91	0.88–0.95
6 Months	0.96	0.94–0.98	0.85	0.81–0.88
12 Months	0.93	0.90–0.96	0.80	0.75–0.85
18 Months	0.86	0.81–0.91	0.75	0.69–0.81
24 Months	0.86	0.81–0.91	0.64	0.55–0.73

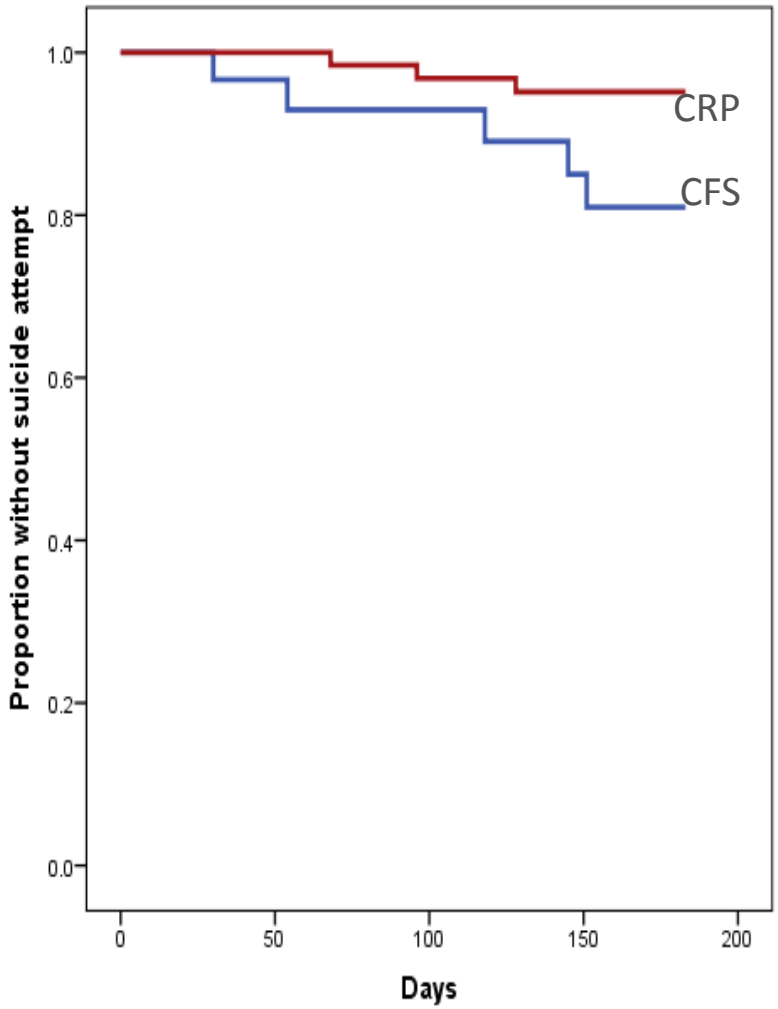
FIGURE 2. Survival Curves for Time to First Suicide Attempt[a]



[a] CBT=cognitive-behavioral therapy; TAU=treatment as usual (log-rank χ^2=5.28, df=1, p=0.02).

BCBT associated with 60% reduction in suicide attempts

CRP Effect on Suicide Attempts



The crisis response plan leads to a 76% reduction in suicide attempts as compared to the contract for safety:

- Crisis Response Plan: n=3/65 (4.9%)
- Contract for Safety: n=5/32 (19.0%)

Log-rank $\chi^2(2)=4.85$, $p=.028$

Cox Wald $\chi^2(2)=4.06$, $p=.044$

HR=0.24 [0.06, 0.96]

Bryan et al. (2017)

Crisis Response Planning

Warning Signs: pacing
feeling irritable
thinking "it'll never get better"

- go for a walk 10 mins
- watch Friends episodes
- play with my dog
- think about my kids
  - vacation to beach in Florida
  - Christmas Day 2012
- call/text my Mom or Jennifer
- call Dr. Brown: 555-555-5555
  - leave msg w/ name, time, phone #
- 1-800-273-TALK
- go to hospital
- call 911

① crying ③ wanting to hit things
② getting angry ④ argument w/ wife

① ~~play videogames~~ ⑤ photography
② woodwork in garage ⑥ writing
③ go for walk ⑦ games on phone
④ breathing 10 mins ⑧ listen to uplifting music
⑤ talk to Bill
⑥ Dr. Smith: 555-555-5555 (voicemail)
⑦ Hotline: 1-800-273-2755
⑧ Hospital or 911

Reasons to live:
Mom
wife
kids (Matt, Katie)
photography
motorcycle rides

Future Directions

Future Directions

- Clinical trials aimed at examining the efficacy of trauma-focused therapies for the prevention of suicidal thoughts and behaviors

- Testing of treatment protocols that combine empirically-supported suicide prevention strategies with empirically-supported trauma-focused therapies

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Please enter your questions in the Q&A box and be sure to include your email address.

The lines are muted to avoid background noise.

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VHA TRAIN

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CEU Process for users of VHA TRAIN (non-VA)

Registration—> Attendance —> Posttest —> Certificate

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Listen to the lecture.

Return to TRAIN for evaluation.

Follow the directions to print certificate.

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NO POSTTEST

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UPCOMING TOPICS

SAVE THE DATE: Third Wednesday of the Month from 2-3PM (ET)

June 21	Measurement-Based Care for PTSD	John Fortney, PhD
July 19	Assessment and Treatment of PTSD in Individuals with Co-occurring Psychotic Disorders	Stephanie Sacks, PhD
August 16	PTSD and Substance Use Disorders	Sonya Norman, PhD *and* Karen Drexler, MD
Later this year	Update on the Revision of the VA/DoD Clinical Practice Guideline (CPG) for PTSD	

National Center for PTSD
POSTTRAUMATIC STRESS DISORDER