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”
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])
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

<table>
<thead>
<tr>
<th></th>
<th>BL</th>
<th>Post</th>
<th>6 mo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group CPT</td>
<td>17.8%</td>
<td>7.9%</td>
<td>11.7%</td>
</tr>
<tr>
<td>Individual CPT</td>
<td>13.4%</td>
<td>5.2%</td>
<td>4.9%</td>
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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
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
Understanding the Overlap of PTSD and Suicide Risk
The Suicidal Mode

Baseline

Cognitive
Self-regard
Cognitive flexibility
Problem solving

Behavioral
Prior attempts
Emotion regulation
Interpersonal skills

Emotional
Psychiatric disorder
Emotional lability
HPA axis

Physical
Genetics
Medical conditions
Demographics

Activating Event(s)
• Relationship problem
• Financial stress
• Perceived loss
• Physical sensation
• Negative memories

Acute

Cognitive
“This is hopeless”
“I’m trapped”
“I’m a burden”

Behavioral
Substance use
Social withdrawal
Preparations

Emotional
Depression
Guilt
Anger

Physical
Agitation
Insomnia
Pain
Fluctuations in Suicide Risk Over Time

(Bryan & Rudd, in press)

(Bryan & Rudd, 2016)
# Treatment Approach

<table>
<thead>
<tr>
<th>Clinical Presentation</th>
<th>Treatment Approach</th>
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</thead>
<tbody>
<tr>
<td>• No suicide ideation</td>
<td>Trauma-focused treatment</td>
</tr>
<tr>
<td>• Suicide ideation with low intent</td>
<td></td>
</tr>
<tr>
<td>• Suicide ideation with moderate intent</td>
<td>Trauma-focused treatment plus crisis response plan</td>
</tr>
<tr>
<td>• Suicide planning (nonspecific)</td>
<td></td>
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<tr>
<td>• Suicide ideation with severe intent</td>
<td>Suicide-focused treatment followed by trauma-focused treatment</td>
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<tr>
<td>• Suicide preparation or rehearsal</td>
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BCBT Effect on Suicide Attempts

BCBT associated with 60% reduction in suicide attempts

TABLE 2. Estimated Suicide Attempt-Free Probabilities

<table>
<thead>
<tr>
<th>Assessment Period</th>
<th>Brief Cognitive-Behavioral Therapy</th>
<th>95% CI</th>
<th>Treatment as Usual</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 Months</td>
<td>0.96</td>
<td>0.94–0.98</td>
<td>0.91</td>
<td>0.88–0.95</td>
</tr>
<tr>
<td>6 Months</td>
<td>0.96</td>
<td>0.94–0.98</td>
<td>0.85</td>
<td>0.81–0.88</td>
</tr>
<tr>
<td>12 Months</td>
<td>0.93</td>
<td>0.90–0.96</td>
<td>0.80</td>
<td>0.75–0.85</td>
</tr>
<tr>
<td>18 Months</td>
<td>0.86</td>
<td>0.81–0.91</td>
<td>0.75</td>
<td>0.69–0.81</td>
</tr>
<tr>
<td>24 Months</td>
<td>0.86</td>
<td>0.81–0.91</td>
<td>0.64</td>
<td>0.55–0.73</td>
</tr>
</tbody>
</table>

FIGURE 2. Survival Curves for Time to First Suicide Attempt

\[ CBT = \text{cognitive-behavioral therapy, TAU = treatment as usual (log-rank } \chi^2 = 5.28, \text{ df}=1, p=0.02). \]
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

Reasons to live:
- love
- photography
- motorcycle rides
- kids (Matt, Kathe)

- crying
- wanting to hit things
- getting angry
- argument w/ wife
- play videogames
- photography
- woodwork in garage
- writing
- go for walk
- games on phone
- breathing 10 mins
- listen to music
- talk to Bill
- Dr. Smith: 555-555-5555 (voicemail)
- Hotline: 1-800-273-2755
- Hospital or 911
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
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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Print certificate from the “Completed Work” section of TMS.

CEU Process (for VA employees)
### UPCOMING TOPICS

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

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