PTSD and Suicidal Ideation: Cognitive Phenomena as experienced by the suicidal patient, Facts vs. Fiction, and Treatment Options

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Objectives

- Describe a cognitive behavioral model of suicide
- Identify common myths about individuals with PTSD and suicide risk
- Describe recommended approaches for treating suicidal patients with PTSD

PTSD Statistics

- Persons with PTSD, including sub-threshold PTSD, are at high risk for suicidal ideation (Marshall et al., 2001)

- The majority of US soldiers in Iraq were exposed to some kind of traumatic, combat-related situations, such as being attacked or ambushed (92 percent), seeing dead bodies (94.5 percent), being shot at (95 percent), and/or knowing someone who was seriously injured or killed (86.5 percent) (Hoge, 2004).

- In a nationally representative sample that compared the relationship between anxiety disorders and suicidal ideation or suicide attempts, PTSD was significantly associated with suicidal ideation and suicide attempts. None of the other anxiety disorders was significantly associated with suicidal ideation or attempts (Sareen, 2005).

https://www.healthquality.va.gov/guidelines/MH/ptsd/cpg_PTSD-FULL-201011612.pdf

PTSD Statistics

- Older and younger veterans are more prone to suicide than are middle-aged veterans (Zivin, 2007). Veterans with PTSD have been reported to have high levels of suicidal ideation and behaviors (Oquendo, 2005).

- Jakupcak (2009) found PTSD to be a risk factor for suicidal ideation in Iraq and Afghanistan War veteran. Veterans from OEF/OIF who screened positive for PTSD were more than 4 times as likely to endorse suicidal ideation relative to non- PTSD veterans.

https://www.healthquality.va.gov/guidelines/MH/ptsd/cpg_PTSD-FULL-201011612.pdf

Cognitive Approach to Suicide

- Cognitive disturbances- abnormalities in thinking and reasoning
- Hopelessness is a robust predictor for eventual suicide
- Per Aaron Beck, psychiatrist "Patients who ultimately committed suicide seemed to be among those who were the most hopeless."

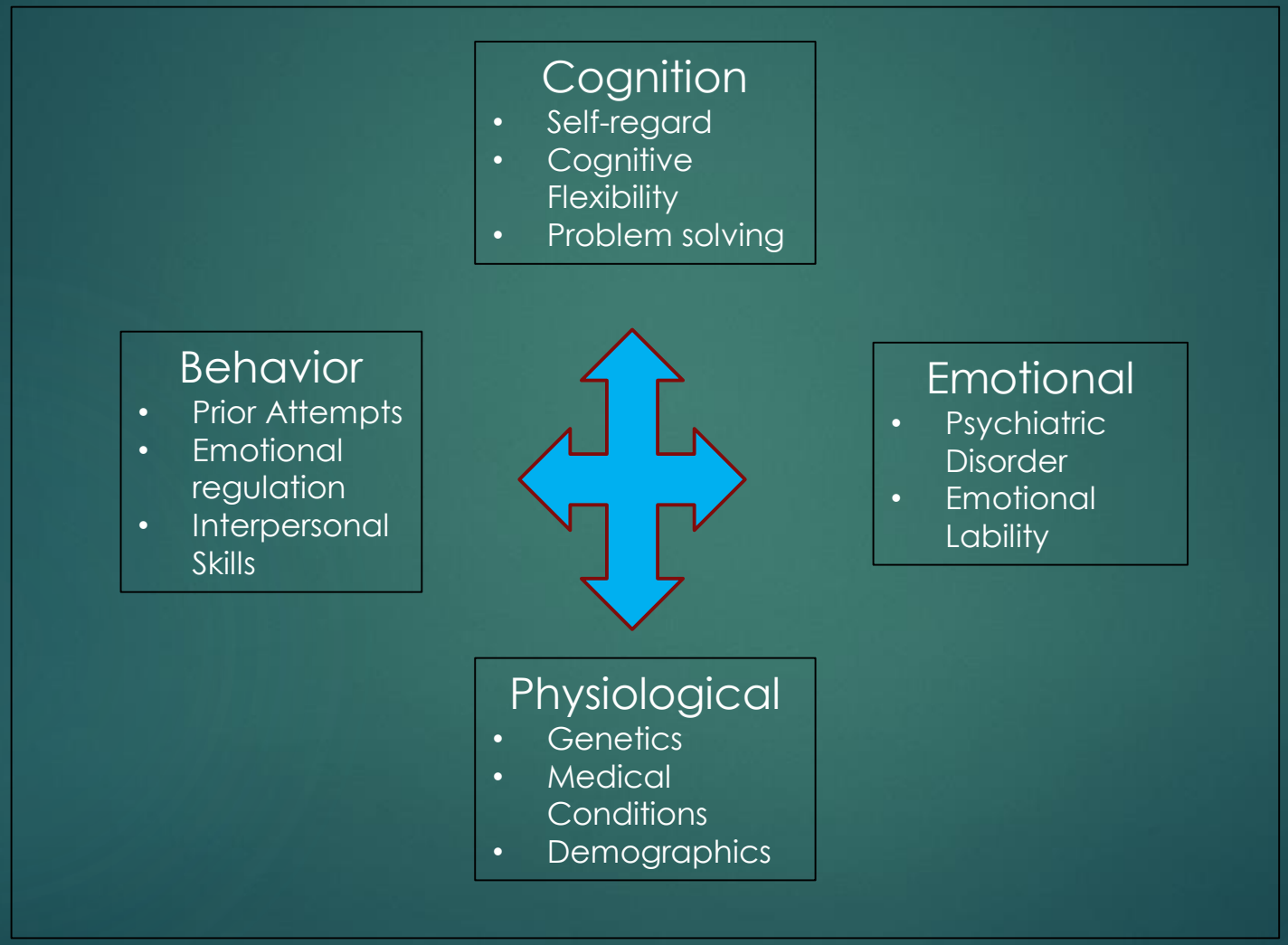
https://www.ncbi.nlm.nih.gov/books/NBK223847//

Cognitive Approaches to Suicide

- Cognitive vulnerabilities, including deficits and distortions may underlie suicidal ideation
  - Deficits: lack of certain forms of thinking (problem-solving deficits or passivity in problem-solving, avoidance, low cognitive flexibility)
  - Distortions: active but dysfunctional thinking processes

https://pubmed.ncbi.nlm.nih.gov/28580021/

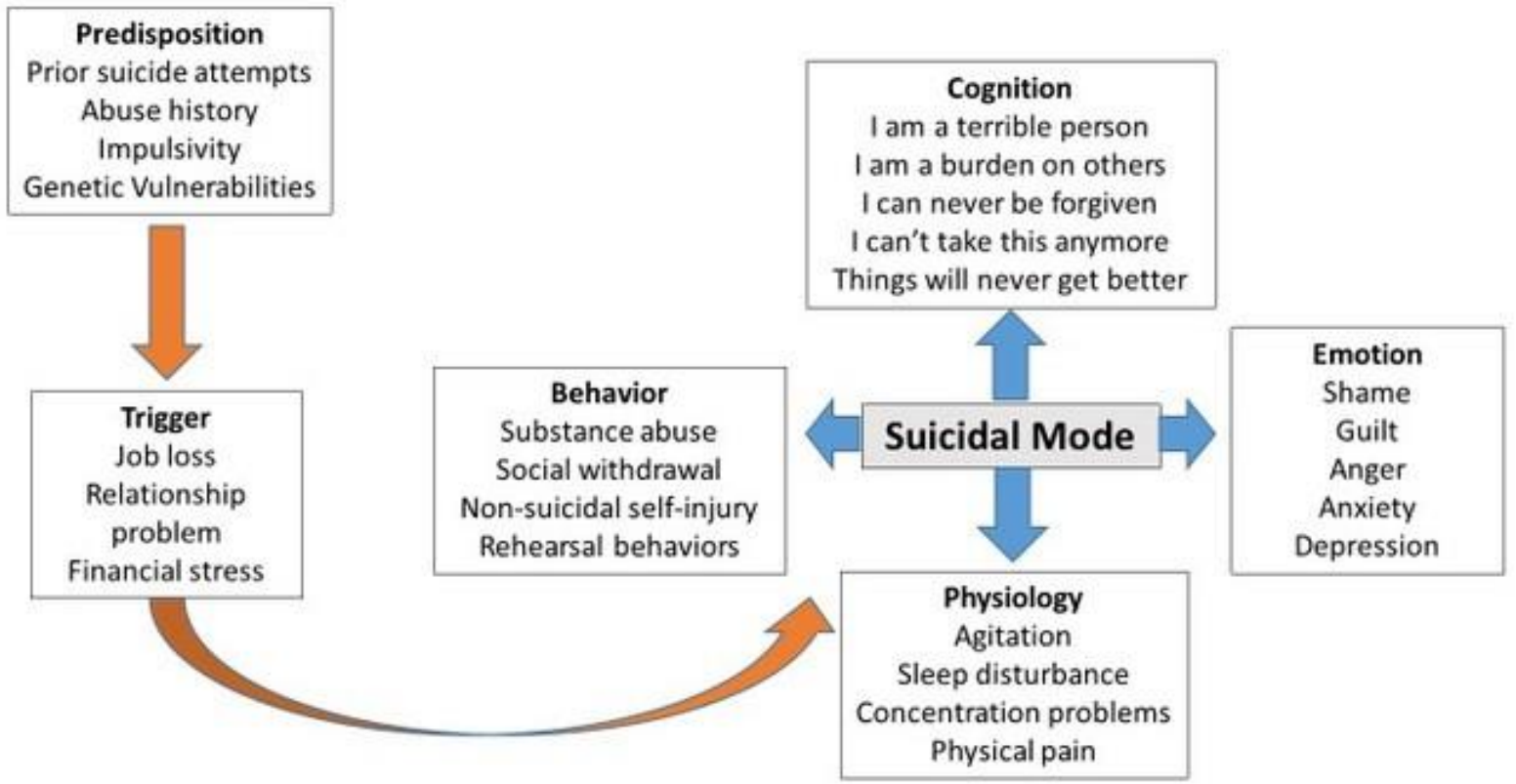
Suicidal Mode-Baseline



https://www.train.org/vha/course/1083785/

- Trait cognitive disturbances- relatively constant (per Beck)
- Baseline Risk Factors serve as vulnerabilities for acute risk factors

Suicidal Mode- ACUTE



- Trait cognitive disturbances, per Beck
- Hopelessness is expressed in both state and trait forms (chronic and acute)

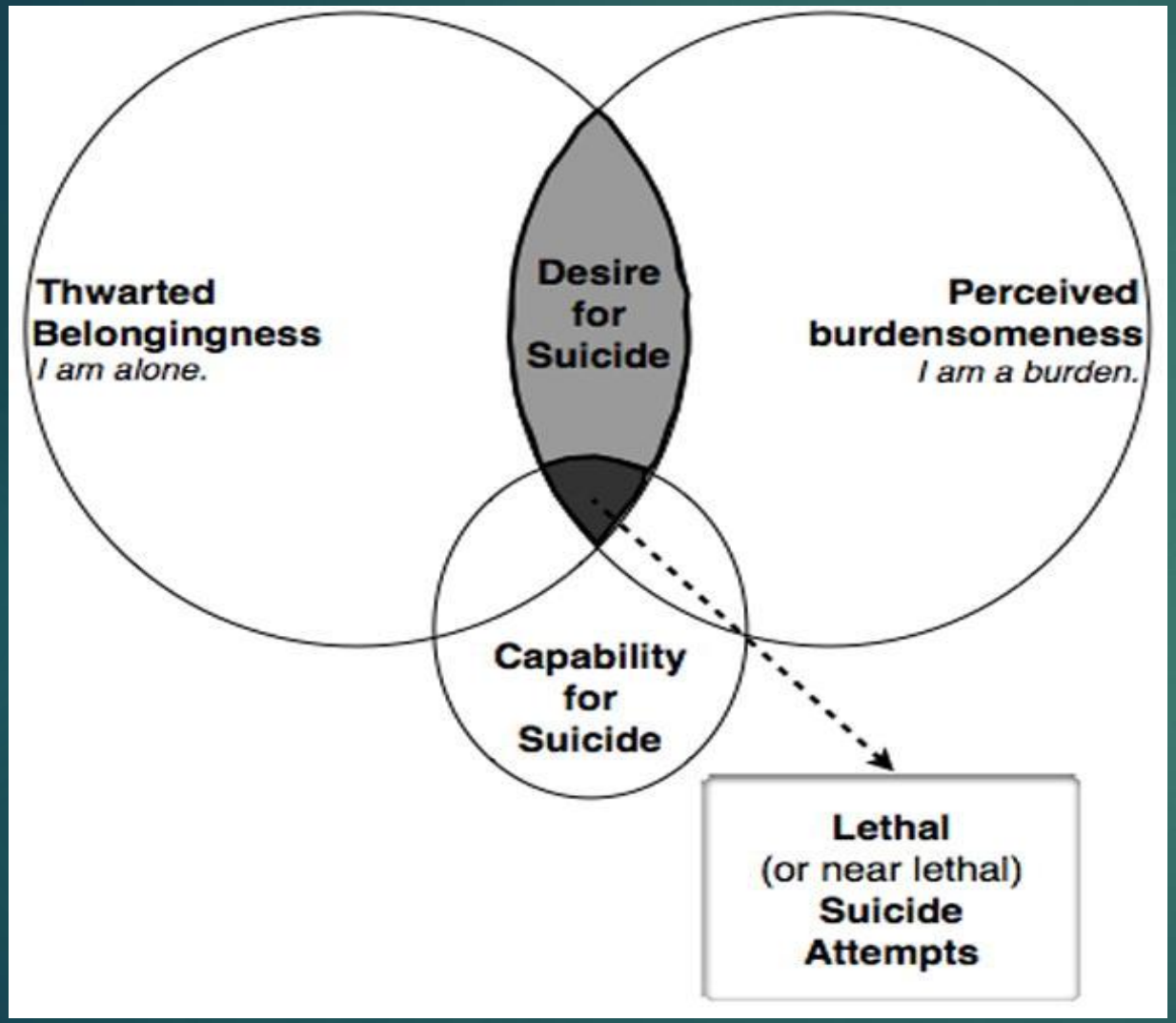
https://www.train.org/vha/course/1083785/

PTSD and the Suicidal Mode

- PTSD is the one disorder in which all domains are involved
  - Physically- agitation, sweating, panic, heart racing
  - Behaviorally- substance abuse, difficulty with interpersonal relationships
  - Emotionally- shame, guilt, anger
  - Cognitively- "I should have done something different…it's my fault they died."

- It's important, as a provider, to pay close attention to an individual's "set point" (stable risk) as well as changing dynamic risk, over time

Dr. Thomas Joiner's Interpersonal Theory of Suicide



Capability is acquired through life experiences. Fear of death is a natural and powerful instinct. One's fear of death is weakened when one is exposed to physical pain or provocative life experiences as these experiences often lead to fearlessness and pain insensitivity.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3130348/

Fact vs. Fiction

- PTSD is chronic and “uncurable.”
  - There are bodies of evidence that show that PTSD symptoms can be reduced to the point that a person can return to their normal past activities/lifestyle.

Fact vs. Fiction

- Everyone exposed to a traumatic event develops PTSD.
  - According to the Notional Center for PTSD, about 7-8 out of every 100 people exposed to trauma will develop PTSD.
  - Pre-existing risks and resiliency are some contributing factors.
  - The event itself, the duration of the event, the type of exposure, etc.

Fact vs. Fiction

- People who develop PTSD are weak. People who attempt suicide are weak
  - PTSD is not a character flaw. Some individuals who experience PTSD may have a genetic predisposition to anxiety — not unlike a genetic predisposition to heart disease. Others may develop PTSD because the trauma they experienced was particularly horrific, or because the traumatic experience lasted for a long time.
  - Suicide is not "the cowards way out"…"If you try to stare down death, it's going to be a struggle. It's going to be a fight. Our bodies are wired for survival, and even desperately suicidal people are in for quite a fight if they're going to try to enact suicide."

https://www.npr.org/templates/story/story.php?storyId=126365907

Fact vs. Fiction

- Triggers should be avoided for those with PTSD. You shouldn't ask a depressed person if they are suicidal.
  - Avoidance sustains PTSD symptoms- it can cause more acute reactions to triggers and actually increase symptoms related to PTSD
  - The strength of the traumatic memories will decrease with increased exposure
  - It's important to be direct and ask the question in a direct manner- it provides the person an opportunity to talk about how they are feeling- gives them permission.

Fact vs. Fiction

- Trauma therapy (Exposure or Cognitive Processing Therapy) is unsafe with individuals who have suicidal ideation.
  - Typically, emotional distress as a whole has increased, so there *may* be an increase in SI but as long as the individual sticks to the protocol and the ideation does not increase to a level of distress, trauma therapy can continue.

Treatment for PTSD, in relation to Suicidal Ideation

Clinical Presentation	Suggested Treatment Approach
No suicidal ideation or Suicidal ideation with low or no intent	Trauma-focused treatment
Suicidal ideation with moderate intent or Suicidal Planning (non-specific)	Trauma-focused treatment plus Safety Plan
Suicidal ideation with severe intent or suicidal preparation or rehearsal	Suicide-focused treatment followed by trauma-focused treatment

Treatment Options

- Brief Cognitive Behavioral Therapy: one study of active military personnel showed that 96% of those studied did not make an additional suicide attempt after just 3 months of therapy. This compares to 91% of those who did not attempt after "treatment as usual." After 2 yrs, these numbers change to 86% vs. 64%.

- Crisis Response Plan: Safety planning vs. Safety contract
  - 76% reduction, 4.9% attempted vs. 19%

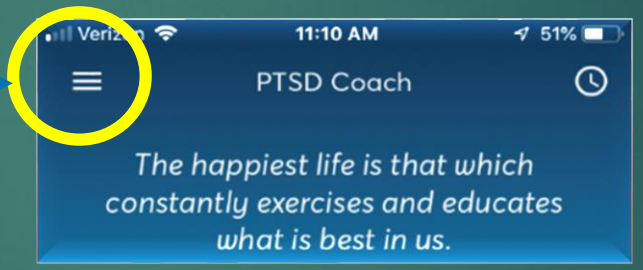
PTSD COACH

Download on the App Store

GET IT ON Google Play

To access the Safety Plan:

1. Download* and open PTSD Coach
2. Tap the lateral menu
3. Tap Safety Plan



*If you have previously downloaded PTSD Coach, you may need to update it from the App Store/Google Play. For some, it may update automatically.

National Center for PTSD website:
https://www.ptsd.va.gov/appvid/mobile/ptsdcoach_app.asp

VAMC Treatment Options

- Cognitive Behavioral Therapy for Insomnia and Imagery Rehearsal Therapy—Aimed at improving sleep and reducing night-mares.

- Cognitive Behavioral Conjoint Therapy for PTSD—Evidence-based therapy for couples that helps each partner improve relationship satisfaction and decrease the impact of PTSD symptoms on the relationship and other areas of life as a couple.

VAMC Treatment Options

- Cognitive Processing Therapy (CPT)— a specific type of cognitive behavioral therapy that has been effective in reducing symptoms of PTSD that have developed after experiencing a variety of traumatic events Evidence-based therapy that helps you gain a new way of handling thoughts that make you feel stuck. How we think influences how we feel and act, and CPT helps us become more able to challenge old ways of thinking.

- Prolonged Exposure (PE)—Evidence-based therapy that helps you approach things that cause you fear and discomfort, so you no longer find yourself avoiding things in daily life.

- Eye Movement Desensitization and Reprocessing (EMDR) - Evidence-based therapy that incorporates processing images, emotions, and negative thoughts associated with traumatic events. Involves bilateral stimulation/distraction to create dual awareness to help you process experiences and increase relaxation.

VAMC Treatment

- Medication Management—Medications can help manage sleep, anxiety, night-mares, etc. Per the APA…
  - Selective Serotonin Reuptake Inhibitors
    - The SSRIs sertraline and paroxetine are the only medications approved by the FDA for PTSD.
  - Venlafaxine is a conditionally recommended treatment for PTSD

Per the
VA/DoD CLINICAL PRACTICE GUIDELINE FOR MANAGEMENT OF POST-TRAUMATIC STRESS …..

Table I - 6 Pharmacotherapy Interventions for Treatment of PTSD

- Some benefit:
  - Mirtazapine
  - Prazosin (for sleep/nightmares)

- No benefit:
  - Benzodiazepines [Harm]
  - Tiagabine
  - Guanfacine
  - Valproate
  - Topiramate
  - Risperidone

https://www.healthquality.va.gov/guidelines/MH/ptsd/cpg_PTSD-FULL-201011612.pdf

Questions???

References

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