Moderator: Okay, our next presenter is Lisa Brenner who is a board certified…

Lisa Brenner: That’s okay.

Moderator: Everybody knows who Lisa is.

Lisa Brenner: No but I don’t want to spend time on that [laughter].

Moderator: Her presentation is two promising evidence based interventions for suicide prevention among Veterans with TBI. Please.

Lisa Brenner: Thank you. Thanks all. I am so psyched that this is being streamed. So I should also say this is all me, not the VA today, even though we are all VA today, which is lovely actually.

So I started my career as a clinician. I actually spent ten years being a clinician in the VA before I became a researcher so really tying this to the needs and wants and desires of the patients, as we heard, is really important.

This is from one of the qualitative interviews we did, “It took a while before I realized when I started thinking about things and realizing I was going to be like this for the rest of my life, it gives me a really down feeling and makes me think, ‘Why should I be around like this for the rest of my life?’”

This is the slide for those of you in the room who maybe are a little more junior or just getting started in research. Pick an area that not everybody is doing. It is really easy to become a world expert if there is only three publications in suicide and TBI. The great news is really that this work has exploded over time and more and more groups are getting engaged and so if this interests you, we are still not at the point where we are at the thousands on this side so I hope I hear from you if you are interested in this line of research.

The other thing that is really important to me is how we measure outcomes and outcomes. This is a plug for the self-directed ions classification system. It is a classification system that I know all of you are using in the VA because it is mandated and it does—it operationalizes all terms associated with suicide and suicide behavior and suicidal thinking. Resources about this are on our website so I just want to highlight this.

I also want to highlight what TBI is or isn’t. So a TBI is an injury event with an alteration in consciousness. That is it. If you have a history of TBI, you have an injury of an alteration in consciousness. The problem is the alteration in consciousness could be I had my bell rung to I am in a persistent vegetative state hence you see all of the confusion we have been having in the VA and outside the VA for a long, long time about TBI. It is many things under this umbrella.

Today, I am going to be talking about primarily moderate to severe TBI. Those would be the TBIs that were less frequently received in Iraq and Afghanistan. More than 80% more, more, more of all TBIs are mil, which is synonymous with concussion.

So I am talking today more about the kinds of brain injuries that would be expecting to have persistent symptoms and that people would have lifelong needs associated with their TBI. That being said, I wish it was that simple. There is challenges around multiple mild TBIs, there are challenges around many, many, many things. Mild TBI is called more of a PTSD so I wish it was that simple, clearly it is not.

Okay, so these are just my few slides to try to convince you that TBI and suicide is a problem. It is a problem. This is really the Seminole study that was done overseas where they also have big databases and what they found is mild, moderate, or severe persistent risk for suicide. You can see they had up to 15 years of follow-up. There was still increased risk for suicide, death by suicide in those with TBI.

We did the very same study in the VA. I am not going to go through all of the details of this. This is just the convincing you part. This is something that you should be thinking about and again, it went on for quite some time.

We also did control for psychiatric history. Psychiatric symptoms are a symptom of TBI and so we actually controlled for part of what we would expect to see and still found that across mild, moderate, and severe history of TBI was still a risk factor for suicide.

I know you can’t see this because I want you to go get the paper, which I am happy to send to you. What I want to show you here is just a very, very high rates of psychiatric comorbidities in all of these individuals. I know you can’t see it. It is a very high risk of psychiatric comorbidity in those who died by suicide, those who didn’t die by suicide, mild TBI, moderate, and severe TBI.

So if you have folks on your caseload or if you have mental health practitioners and they think that they are not working with folks that have a history with TBI they are in fact not correct. That is a different talk for a different day but many, many folks—we actually found about a third of folks—actually about a half—a third to half of folks who are seeking mental health or homeless services have a history of TBI and about a third of those have moderate to severe TBI. Again, the implications of that are huge and again, for a different day.

So strategies for intervention. Though we know this is a huge problem, until very recently there was one randomized clinical trial with a total of 17 people in it worldwide to address this issue in clinical practice and that trial was conducted by this colleague, Graham Simpson, who is in Australia. Graham has also done tons of great work around hopelessness as a risk factor for people who have TBI and this hopelessness is in about 35% of people with moderate to severe TBI have persistent hopelessness and this goes on for a long time. If you do suicide research or are interested in suicide prevention, you know hopelessness is one of the predictors of death by suicide.

Graham really though long and hard about how can we get a little bit upstream about something we see and he developed this intervention called Window to Hope. I am not going to get too far into it but Graham did in fact have a positive TBI trial in a moderate to severe population of TBI, which in itself is a miracle. His primary outcome was using the Beck hopelessness scale, which is something that is in the mental health package that all of you can encourage people to be using.

It is a small group intervention and by small group I mean two or three people and the therapist so there is peer-to-peer interaction but plenty of time and space to actually go over content. Mechanistically, the idea is if you can decrease hopelessness you are gong to decrease suicidal ideation and suicide attempts. Ten sessions. I am not going to go through all of this but this should look very familiar to you in that it is very common CBT like skills that we are teaching problem solving skills and posttraumatic growth.

There are specific aims of the program in terms of trying to help maintain a sense of hopefulness after a TBI, learning how you are thinking and how the activities you engage in may be contributing to hopelessness, dealing with life’s problems, so the problem solving, and then looking at ways to rebuild your life.

This is the window, the four paned window, using lots of pneumonic and teaching strategies and lots of repetition because people do have memory problems and also having homework and things like behavioral activation that we know works in many, many populations but also works with these folks.

I have just given you a sense of all of the different kinds of things. So I thought, “This is awesome, we should do this for Veterans,” and we did. We got a grant from the Suicide Military Research Consortium.

This is our masculine window. If you have heard me talk about this before you might know that the DoD did not appreciate the feminine window that Graham had picked. This is our more masculine window but after the fact it does look like it is looking up to heaven, which is probably not the best for suicide prevention but we did many, many four paned windows on the internet and that was the best we found.

So just a few things to highlight, and this was really, really hard, it took a lot of work, we screened so many people but we wanted to be really clear that people had moderate to severe TBI and had sufficient hopelessness so they actually could improve and I think a lot of times when a trial is going badly, you think, “Could I move it down to three—eight hopelessness, seven hopelessness, six, five, four.” We didn’t and we had a positive trial so that is a take-home message, to just hang in there and keep looking for the right cohort.

What we found was very similar to what Graham—we had a waitlist of twelve so this is \_\_\_\_\_[00:08:21] times two and they maintained it three months. This is baseline, beginning of the treatment, now, so it had a significant affect.

So hopelessness decreased across both. We also say that the hopelessness decreased not just in a statistically significant manner but in a clinically significant manner. People moved down on the Beck hopelessness scale in a way that we like.

Also, this was a lot of work and not tons of individuals in but we did also have some changes on depression and not as many changes on ideation interestingly.

Okay, and then we have the nice qualitative data that said—and again I don’t have time for all of this today but again this was not just one intervention but a multitude that I can combine and use separately pertaining to my issues around decisions and problem solving when I have problems with my thought process. Somebody else really took away, “I know that ending my life is not the answer now. Take a deep breath and then it feels good.” So this idea of infusing hope.

The other intervention—this is like my entire life’s work in 15 minutes by the way—okay so another intervention was driven. This was an R&D funded study. Anybody that is familiar with the IO family test, you have five trials and you should improve over time. We had four groups. This is the group that had TBI and a suicide attempt. You can see that they stopped trying. They just didn’t engage in the past at all. In terms of suicide prevention, that is not what you want to see, right? If somebody has kind of cognitive rigidity and thinks, “I don’t even know what to do. The only thing is to kill myself,” that is not what we are looking for.

Interestingly, folks with TBI alone did much, much better on this and engaged. People with suicide attempts alone did much, much better and engaged in the task. So it makes me think a lot of questions of, can folks like this—independently, if you hand somebody a safety plan and say, “Go home and use it,” without any structure and support around that, is that going to work.

So that was our thinking with this. Here is TBI, cognitive deficits, hopelessness, given stressful life event, \_\_\_\_\_[00:10:22] problem solving and a patient who thinks suicide is the only option and has made a suicide attempt. So we developed a second intervention. What it is is it pairs problem solving strategies with safety planning and this is the same safety planning everybody in the VA is using.

Every week there are activities that we do but at the end of each group, we always return to the safety planning activity and what you see now, being the neuropsychologist in me, now I wish I had done different colored pencils, you know the Ray Osra if you do different colored pencils for each part, I wish I would have done different colored pencils for each session because these safety plans were meager at the beginning and by the end much more expanded upon and also much more—people knew them much more and talked about them in session and were meaningful and personal to the people but it couldn’t happen in just a few minutes or even 20 minutes for these folks.

These are the kinds of things we focus on, really problem solving ability so their stress. If you have too much stress it breaks and if you have problem solving skills and a crisis response plan, you can have other alternatives rather than a suicide attempts. Again lots of pneumonic and things, lots of repetition, stuff that we do all the time with folks, identifying triggers, lots of very concrete worksheets around warning signs and unhopeful thinking. I just had the same concept. We had a different pneumonic for this that I actually didn’t really like and we were going around with Veterans in the groups—one of the groups and they were like, “How about PASTA?” I was like, “That is genius.” I love PASTA because actually a Veteran thought of it and that to me is just—what could be better than that?

And then focusing on this action plan around a suicide attempt and how do you cope. Pairing these two things together this was a feasibility, acceptability study so not an RCT. We had really interesting mixed group. I ran a group with a much older Vietnam Vet and a an OEFI and I was like, “Oh, is this going to go good?” it went amazing, they were great together.

The attendance—I should say the attendance for all of these groups was amazing. We did reminder phone calls, we helped people coordinate and be in. So if you think people with a history of severe TBI can’t come to treatment or won’t come to treatment or don’t get it, they will if you provide them the scaffolding that they need and they can benefit from cognitive behavioral interventions. These studies aren’t the only ones that suggest that.

Again, lots of nice qualitative data. “I know that I am not going to make harebrained decisions, I am going to use some of the coping skills that we learned here.” The reinforcement of the pause button to take time and analyze the problem and think of possible solutions. As you remember, that was the big problem, that people weren’t thinking of possible solutions and I think that is the most important part of the class. I hope you do too.

Just to end with, “Talk to a professional,” this is the same person who the beginning quote was from, “That’s what you guys are professionally trained to deal with, people with problems like mine. Left to myself, I would probably kill myself but that didn’t feel right so I turned to you guys.” I think the idea is if we are going to have these folks in our clinic, which I have data to support you do, we need to know how to treat them and we need to have interventions that work for them.

That is all I have for you today. I just want to highlight several resources too, things about the self-directive ions classification system. Also MIRECC podcast, if you don’t know that MIRECC has a podcast that I actually really love. I listen to it on my laptop or on twitter and we hope we see you on twitter or we see you listening to our podcast and if you have suggestions for other things, resources, we have tons of resources on here, we would love to hear from you.

Thanks for the funders and everybody who did this work. It was—obviously this has been a ton of work. That’s it. Thank you.

Moderator: Thank you. Questions, I think we have time for a question or two.

Unidentified Female: Yeah so a lot of this stuff seems very basic, CBT, depression, anxiety, like the components. Can you give a little bit more details on what was modified for this TBI population? Was it just more repetition or making things simpler?

Lisa Brenner: It was more repetition, smaller groups, having some kind of information about their TBI and how their TBI might impact woven throughout in the small group format. We got very, very detailed manuals for both of these and I was obsessed with—anybody who actually believed—I shouldn’t say this because I know how hard implementation is, but if you know CBT skills or know problem solving therapy skills and know safety planning and, here is the clincher, are willing to follow the manualized directions—I think that is the harder problem—most people can do this.

We are actually having really hard time figuring out how to disseminate the first intervention and then get funding for the second because the other problem is that—and I really resonate with this, are we going to teach clinician to do 50 different interventions and then what do we do about that? There is probably not enough people with moderate to severe TBI in any mental health clinic at any one time to have a person who is really dedicated to that or—I can imagine the scheduling.

So do we put these online? How do we start to think about disseminating the one and then getting funding for the other?

Unidentified Female: Okay, thank you.

Moderator: Okay, thank you very much.