Using Interpersonal Theory to Become Suicide Savvy

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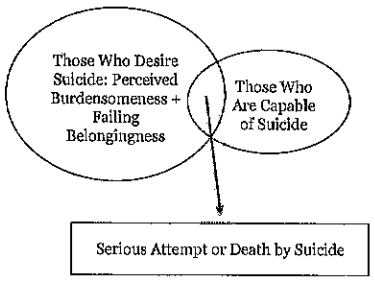
Overview of Presentation

- The Interpersonal Theory of Suicide
- Risk Assessment
- Intervention

Why Do People Die by Suicide?

- Because they develop both the desire and capability to do so
  - Acquired capability develops because they have been through enough pain that they have "habituated to the fear and pain of self-injury," which leads to loss of the self-preservation urge
  - Desire develops because of two co-occurring interpersonal problems:
    - Perceived burdensomeness
    - Failed belongingness

Interpersonal Theory of Suicide



Joiner, T. E. (2005). *Why People Die by Suicide* (p. 138). Cambridge, MA: Harvard University Press.

Acquired Capability

- Only those who have experienced enough past pain to habituate to the fear and pain of self-injury are capable of suicide
- The self-preservation urge is beaten back
- Previous self-injury is the most powerful habituation experience for future self-injury
- Capability does not necessarily include desire

Perceived Burdensomeness

- Low self-esteem
- Idea that one is flawed or defective
- Feeling that one's existence is a burden to family, friends, and society
- "My death will be worth more than my life"

Failed Belongingness

- Loneliness and social alienation
- Not an important part of a family, community of friends, or other valued group
- Feeling that one is not cared for

- Who can die by suicide?
  - "Those who, through habituation, have acquired the capability to enact lethal self-injury."
- Who would want to die by suicide?
  - "Those who perceive that they are a burden on loved ones and that they do not belong to a valued group or relationship."

Joiner et al. (2009, p. 6)

3 Steps of Risk Assessment

1. Gathering information from clients about
   - Suicidal desire
     - Perceived burdensomeness and failed belongingness
   - Acquired capability and resolved plans/preparation
     - Previous suicidal behavior and experiences of pain
   - Other domains shown by research to be related to suicide (e.g., stressors, hopelessness)
2. Determine the level of risk
   - Low, moderate, high-severe, or high-extreme
3. Select appropriate interventions

Step 1 of Risk Assessment: Gathering Information

- Let's take a closer look at the type of information to gather.
  - Step 1: Summary of Theory-Based Assessment Recommendations
- Let's look at an example of an assessment interview that covers these recommendations
  - Step 1: Assessment Interview

Case Application: Susan

Discussion #1

- For each of the three factors that explain why a person dies by suicide (i.e., failed belongingness, perceived burdensomeness, and acquired capability), list the elements in Susan's life that contribute to her risk of suicide.

Step 2 of Risk Assessment: Determining Level of Risk

- Two potential presentations of acquired capability
  - Multiple attempter
  - Nonmultiple attempter
- Level of risk
  - Low
  - Moderate
  - High (Severe)
  - High (Extreme)

Case Application: Susan

Discussion #2

- How would you define Susan's risk level (e.g., low, moderate, severe, extreme)?

Case Application: Susan

Discussion #3

- For each factor (i.e., failed belongingness, perceived burdensomeness, and acquired capability), list 2-3 therapeutic interventions to lower risk in that domain.

Step 3 of Risk Assessment: Choosing Interventions for the Level of Risk

- Once you decide a client's specific level of risk, you can select corresponding interventions
- The handout gives a list of interventions for the various levels of risk
- Next, we can focus on a few of the specific interventions
  - Eliciting social support
  - Crisis card
  - Symptom-matching hierarchy
  - Hope Kit

Eliciting Social Support

- Help clients garner support from family and friends
- If client believes no one cares, share that this has been a misperception for many people who die by suicide
- For clients hesitant to request support because of PB, ask them to think of times they helped others
- Ask to contact client's support person(s)

Crisis Card

- Write the crisis plan on a small card
- Crisis card should include
  - Mood regulation techniques
  - Pleasant activities
  - Emergency numbers to call if symptoms do not decrease

Introducing the Crisis Card

- "I'd like you and I to work together to come up with some steps you can take when you're upset and thinking about suicide. It can be hard to think clearly when you're feeling upset, so I'd like you to keep this card with you and pull it out if you start thinking about suicide" (Joiner et al, 2009, p. 96)

Creating the Crisis Card

- Include activities that helped the client cope with previous crises
- Keep the goals realistic for someone who is depressed and hopeless
- Choose activities that take the edge off intense feelings, distract him/herself from suicidal thoughts, and help him or her regulate mood
- Choose activities that involve ACTIVE engagement

Creating the Crisis Card (continued)

- List some activities that pertain to thwarted belongingness and perceived burdensomeness
  - Engage in duty-to-other roles
- Include a total of 6 to 7 pleasant activities on the card
- Us a bland index card and collaboratively write out the crisis plan
- Include emergency numbers to call if activities do not alleviate suicidal symptoms

Symptom-Matching Hierarchy

- Ask the client to list the most distressing symptoms
- Rank order the symptoms from most to least distressing
- Develop concrete and specific suggestions for alleviating each symptom
- Pay special attention to symptoms related to thwarted belongingness and perceived burdensomeness

Symptom-Matching Hierarchy (continued)

- Caution clients to start slow and remind them that the interventions may not work perfectly
- Make sure the suggested interventions are simple enough to be performed by someone in distress and by a novice client
- This intervention provides hope that their symptoms can be treated and shows them that they have some control over their symptoms (hopefully dispelling the notion that suicide is the only option)

Hope Kit

- Instruct the client to fill a small box with items that provide concrete reasons for living
- Fill with items that remind the client he or he is connected with others and makes a valuable contribution to the world
- Have the client place the box in a prominent area in the house
- Opening the kit during times of crisis may be helpful

References

- Joiner, T. E. (2005). *Why people die by suicide.* Cambridge, MA: Harvard University Press
- Joiner, T. E., Van Orden, T. K., & Rudd, M. D. (2009). *The interpersonal theory of suicide: Guidance for working with suicidal clients.* Washington, DC: American Psychological Association.
- Rudd, M. D., Joiner Jr., T. E., & Rajab, M. H. (2001). *Treating suicidal behavior: An effective, time-limited approach.* New York: Guilford Press.

Step 1: Summary of Theory-Based Assessment Recommendations

Failed belongingness

- The absence of caring, meaningful connections to others
- Absence of friends or relatives patient can call when upset
- Recent losses through death or divorce

Perceived Burdensomeness

- Statements that others would be better off if the patient were gone
- Statements that the patient is a burden on others
- Recent stressors involving a loss of self-competency (e.g., job loss)

Acquired capability

Experiences of pain and provocation

- Past suicide attempts (especially multiple attempter status)
- Aborted suicide attempts
- Self-injecting drug use
- Self harm (i.e., non-suicidal self-injury)
- Frequent exposure to, or participation in, physical violence

Current indicators

- High intent for suicide
- Fearlessness about suicide
- Long duration of ideation with preoccupation about suicide
- Highly detailed and vivid plan for suicide
- Specified time and place for suicide

From Joiner, T. E., Van Orden, T. K., & Rudd, M. D. (2009). *The interpersonal theory of suicide: Guidance for working with suicidal clients.* Washington, DC: American Psychological Association.

Step 1: Assessment Interview

Assess suicidal desire and ideation

1. Have you been having thoughts or images of suicide (thoughts or images of killing yourself)? Tell me about that.
2. Do you think about wanting to be dead?
3. Thwarted belongingness: Do you feel connected to other people? Do you live alone? Do you have someone you can call when you're feeling bad? (Are supportive relationships completely absent?)
4. Perceived burdensomeness: Sometimes people think, "The people in my life would be better off if I were gone." Do you think that?

Assess resolved plans and preparations

5. Duration (look for preoccupation): When you have these thoughts, how long do they last?
6. Intensity: How strong is your intent to kill yourself (0 = *not intense at all;* 10 = *very intense)*?
7. Past suicidal behavior: Have you attempted suicide in the past? How many times? Methods used? What happened (e.g., admitted to hospital)? Non-suicidal self-injury? Family history?
8. Specified plan (look for vividness, detail): Do you have a plan for how you would kill yourself?
9. Means and opportunity: Do you have the pills (or a gun, etc.)? Do you think you'll have an opportunity to do this?
10. Have you made preparations for a suicide attempt (e.g., buying pills)?
11. Do you know when you expect to use your plan?
12. Fearlessness: Thinking about suicide, do you feel afraid? 0 = *very afraid;* 10 = *not at all afraid.*

Assess other significant findings

13. Precipitant stressors: Has anything especially stressful happened to you recently (e.g., death of a loved one, divorce, major break-up, job loss)?
14. Hopelessness: Do you feel hopeless?
15. Impulsivity: When you're feeling bad, how do you cope? Sometimes when people feel bad, they do impulsive things to feel better. Has this ever happened to you (e.g., cutting your skin, drinking alcohol, running away, binge eating, promiscuous sex, physical aggression, shoplifting)?
16. Presence of psychopathology (rated by interviewer)

Risk category (circle):

Low Moderate Severe Extreme

Actions taken:

- ☐ Will continue to monitor regularly
- ☐ Given emergency numbers (including 1-800-273-TALK)
- ☐ Scheduled midweek phone check-in
- ☐ Provided info about adjunctive treatment
- ☐ Commitment-to-treatment statement
- ☐ Crisis card
- ☐ Consulted supervisor
- ☐ Other: _____
- ☐ Other: _____

Notes during the interview:

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Figure 2.4. Decision Tree Interview. Adapted from Joiner, T. E., Van Orden, T. K., & Rudd, M. D. (2009). *The interpersonal theory of suicide: Guidance for working with suicidal clients.* Washington, DC: American Psychological Association.

Interpersonal Theory of Suicide: Case Application

Susan is a 35-year-old Caucasian female. She presented for therapy with a diagnosis of Major Depressive Disorder, Recurrent, Severe. Client is taking an SSRI, sleep medication, and has a benzodiazepine her doctor prescribed to take as needed for "anxiety." She said she has a plan to kill herself, but she does not want to talk about it because she does not want her therapist to take steps to stop her. Susan has no children, and her husband recently filed for divorce despite her desire to continue the marriage. Susan has been living with her parents for the past few months, but just last week they relocated to Florida for new jobs. Susan's father died when she was young, and she does not have a close relationship with her mother. She said she is closer to her stepfather, but does not want to tell either of her parents that she is struggling with thoughts of suicide. Susan recently became unemployed because her company downsized. She has been looking for a job, but has no solid leads right now. Susan has not been socializing much with friends lately since she feels down. She has told one friend about her thoughts of suicide, and the friend has urged her to reconsider. Lately, Susan has been feeling like a burden to her parents since they have helped her financially. Susan said she attempted suicide about a year ago by taking a bunch of pills and drinking a lot of alcohol. She said she went to sleep after the overdose and was surprised to wake up and be "okay." Client refused to describe details of her present plan for suicide. Client said she has 5-6 glasses of wine on 4-5 nights per week.

- Discussion #1: For each of the three factors that explain why a person dies by suicide (i.e., failed belongingness, perceived burdensomeness, and acquired capability), list the elements in Susan's life that contribute to her risk of suicide.

- Discussion #2: How would you define Susan's risk level (e.g., low, moderate, severe, extreme)?

- Discussion #3: For each factor (i.e., failed belongingness, perceived burdensomeness, and acquired capability), list 2-3 therapeutic interventions to lower risk in that domain.

Two Potential Presentations of Acquired Capability

1. A multiple attempter
2. A nonmultiple attempter with three out of the following five symptoms
    - Single suicide attempt
    - Aborted suicide attempts
    - Self-injecting drug use
    - Self-harm (i.e., nonsuicidal self-injury)
    - Frequent exposure to, or participation in, physical violence

Step 2: Determining Level of Risk

Low

- A person with no identifiable suicidal symptoms
- An individual with acquired capability with no risk factors (including no suicidal ideation)
- An individual without acquired capability with suicidal ideation of limited intensity and duration, no or mild symptoms of the resolved plans and preparation factor and no or few other risk factors

Moderate

- An individual with acquired capability with any other notable finding (e.g., suicidal ideation, hopelessness)
- An individual without acquired capability with moderate to severe symptoms of the resolved plans and preparation factor
- An individual without acquired capability with moderate to severe symptoms of the suicidal desire and ideation factor (but mild or no resolved plans and preparation) and at least two other notable risk factors

High (severe)

- An individual with acquired capability with any two or more other notable findings
- An individual without acquired capability with moderate to severe symptoms of the resolved plans and preparation factor and at least one other risk factor

High (extreme)

- An individual with acquired capability with severe symptoms of the resolved plans and preparation factor
- An individual without acquired capability with severe symptoms of the resolved plans and preparation factor and two or more other risk factors

Figure 2.5. Decision Tree Step 2: Determining Level of Risk. From Joiner, T. E., Van Orden, T. K., & Rudd, M. D. (2009). *The interpersonal theory of suicide: Guidance for working with suicidal clients.* Washington, DC: American Psychological Association.

Step 3: Interventions for Each Level of Suicide Risk

Low-risk

No current suicidal ideation

- Tell the client a variant of the following: "In the event that you begin to develop suicidal feelings, here's what I want you to do. First, use the strategies for self-control that we will discuss, including seeking social support. Then if suicidal feelings remain, call [the emergency call person]. If, for whatever reason, you are unable to access help, or if you feel that things just won't wait, call 911 or go to the emergency room."
- Give emergency numbers, including that for the National Suicide Prevention Lifeline (1-800-273-TALK).
- Continue to monitor risk in subsequent sessions.
- Document activities and progress notes.

Current suicidal ideation

- Give emergency numbers.
- Create a crisis card.
- Complete a symptom-matching hierarchy.
- Document activities and progress notes.

Moderate risk

- Give emergency numbers.
- Create a crisis card.
- Complete a symptom matching hierarchy
- Consider midweek phone check-in's.
- Inform about existence of adjunctive treatments (e.g., medication).
- Increase social support.
    - Encourage to seek support from family and friends
    - Plan with client to have someone check in on him or her regularly.
    - Get client's permission for you to contact the person who will be checking in.
    - Document activities in progress notes.

High risk (severe and extreme)

- Consult with a supervisor if you are a trainee or with a colleague if you are not a trainee.
- Consider emergency mental health options.
- If hospitalization is not warranted, use suggestions from the Moderate Risk category.
- Document all activities in progress notes (including documentation that hospitalization was at least considered).

From Joiner, T. E., Van Orden, T. K., & Rudd, M. D. (2009). *The interpersonal theory of suicide: Guidance for working with suicidal clients.* Washington, DC: American Psychological Association.

Crisis Card

When I'm upset and thinking of suicide, I'll take the following steps:
Step 1: [pleasurable activity or therapy skill]
Step 2: [pleasurable activity or therapy skill]
Step 3: [pleasurable activity or therapy skill]
Step 4: Repeat all of the above.
Step 5: If the thoughts continue, get specific. If I find myself preparing to make a suicide attempt, I'll call [insert number of emergency call person] or the National Suicide Prevention Lifeline (1-800-273-TALK).
Step 6: If I still feel suicidal and do not feel like I can control my behavior, I'll call 911 or go to the emergency room.

Figure 3.2. Crisis card. From *Treating Suicidal Behavior: An Effective, Time-Limited Approach,* by M. D. Rudd, T. E. Joiner Jr. and M. H. Rajab, 2001, p.168. New York: Guilford Press.

Symptom-Matching Hierarchy

1. Insomnia → sleep hygiene (i.e. go to bed at the same time each night and wake up at the same time each day, limited caffeinated beverages, do not take naps during the day, and do not spend more than 20 minutes in bed if unable to sleep).
2. Anhedonia or sadness → behavioral activation (refer to the Pleasant Events Schedule)
3. Agitation → relaxation, exercise
4. Loneliness → behavioral activation with an interpersonal focus (e.g., go to church, call a friend or family member)
5. Hopelessness → engage in pleasant activities
6. Anxiety → exercise, distract yourself by engaging and engrossing activity (e.g., work a crossword puzzle)

From Joiner, T. E., Van Orden, T. K., & Rudd, M. D. (2009). *The interpersonal theory of suicide: Guidance for working with suicidal clients.* Washington, DC: American Psychological Association.