

USING THE
INTERPERSONAL THEORY
OF SUICIDE TO GUIDE
RISK ASSESSMENT,
CRISIS MANAGEMENT,
AND INTERVENTION
WITH SUICIDAL CLIENTS

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Holding the rope



Overview

1. Background on suicidal behavior:
 - Facts and Myths
2. Overview: The Interpersonal Theory of Suicide
3. Theory-informed work with suicidal patients:
 - Risk Assessment
 - Crisis Management/Safety Planning
 - Treatment for Suicidal Behaviors
 - The therapeutic alliance
 - Prevention approaches

BACKGROUND: FACTS & MYTHS

Epidemiology of Suicide:

Prevalence

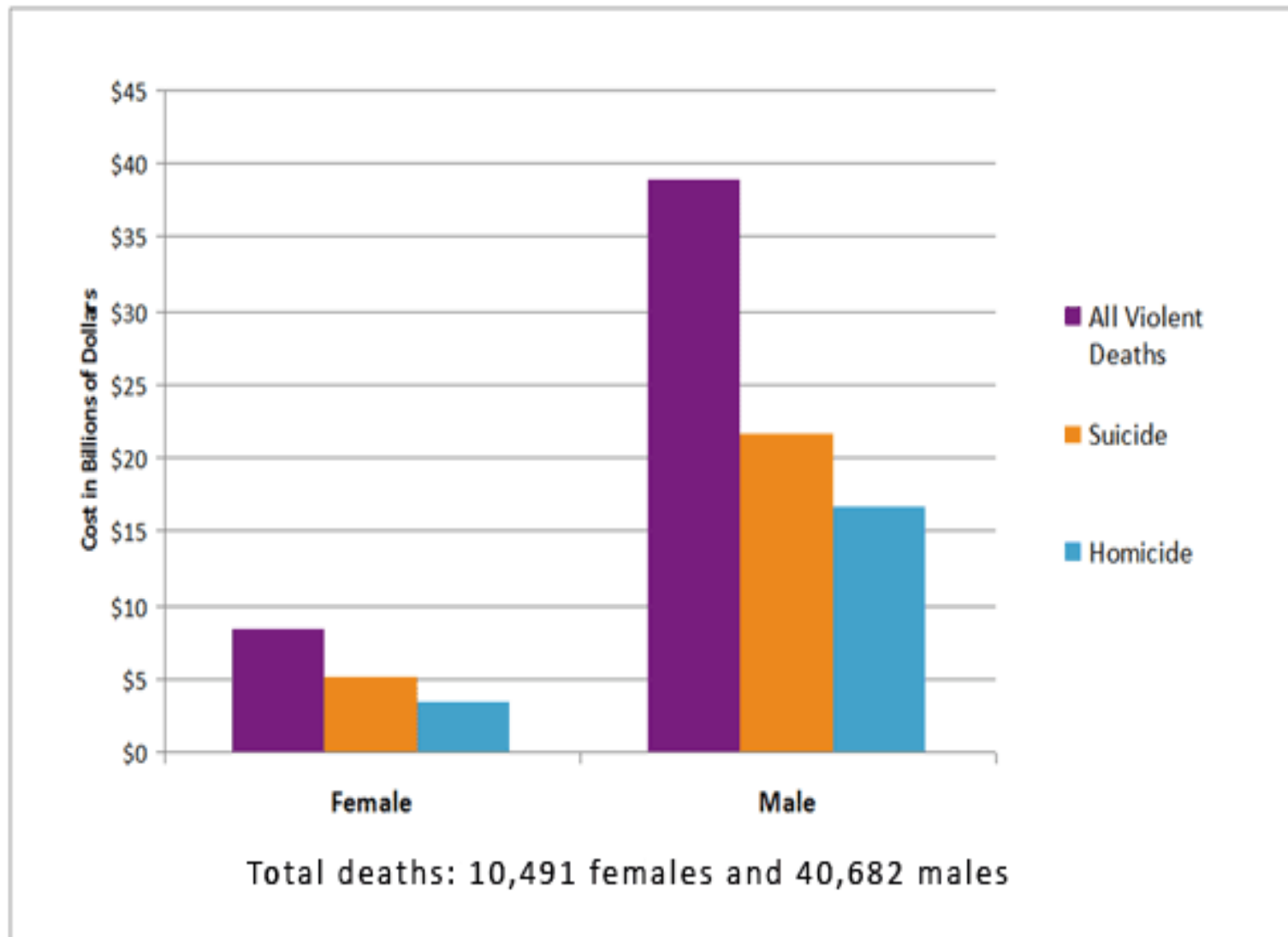
- Suicide deaths each year in the U.S.:
 - approximately 30,000+ people die by suicide
 - In 2009: 36,909; rate = 12.0 per 100,000
 - about 1 every 14 minutes & about 101 per day
 - 10th leading cause of death.
 - More common than death by homicide (15th).
- For every death, there are 25 attempts, for a total of around 750,000 U.S. attempts per year (not individuals but attempts).
 - 100-200 attempts per each death (for young)
 - Only 4 to 1 for older adults

Epidemiology of Suicide:

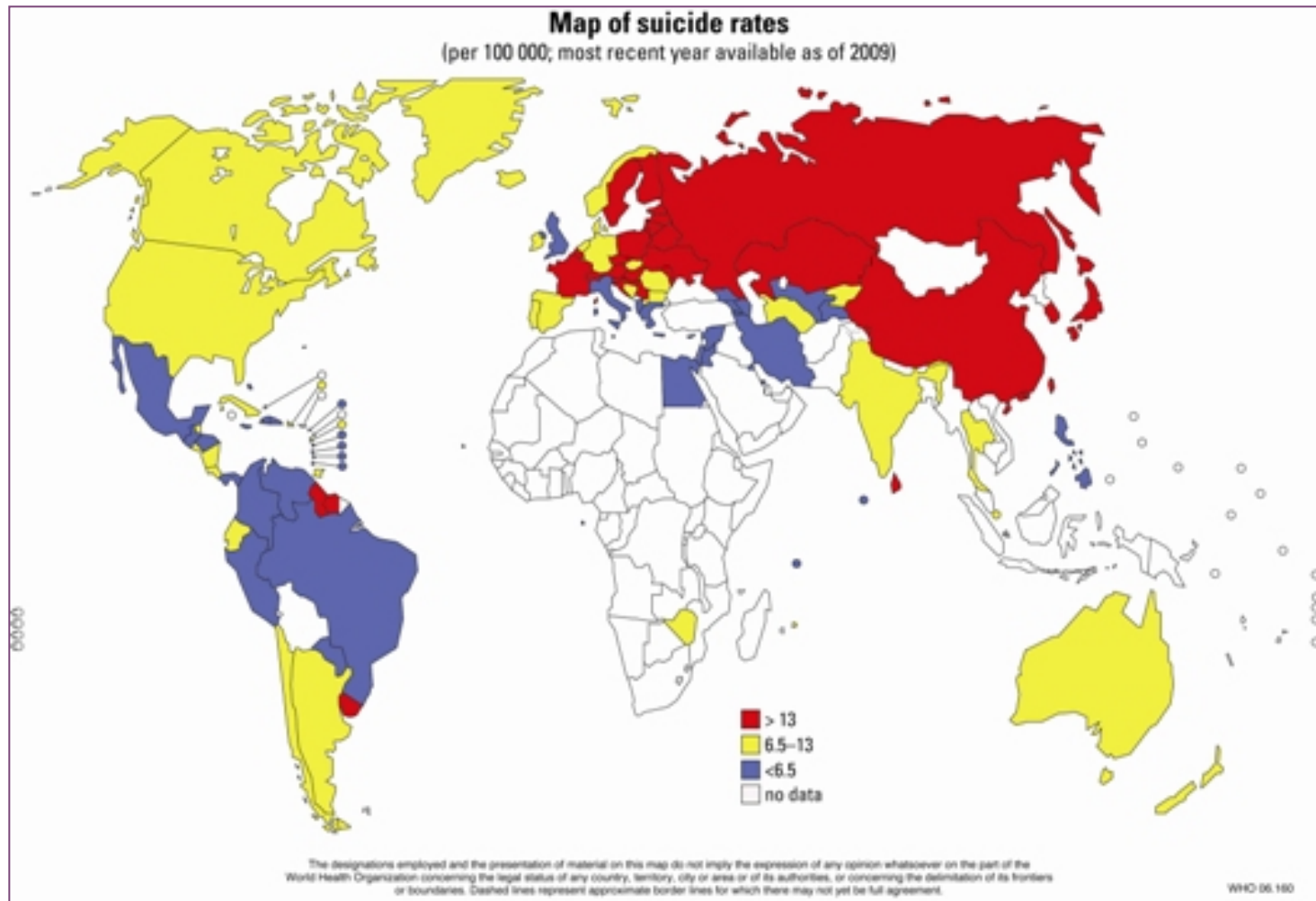
Gender

- Suicide deaths (in the USA):
 - 29,089 men died by suicide in 2009
 - About 80 men per day
 - **Rate: 19.2 per 100,000**
 - Particularly high rates for white males: 212.6
 - 7,820 women died by suicide in 2009
 - About 21.4 women per day
 - **Rate: 5.0 per 100,000**
- Non-lethal attempts
 - More common among women (in USA): 3 female attempts for each male attempt.
- Gender pattern is not universal: China & India

Combined Medical and Work Loss Costs, 2005 (CDC)

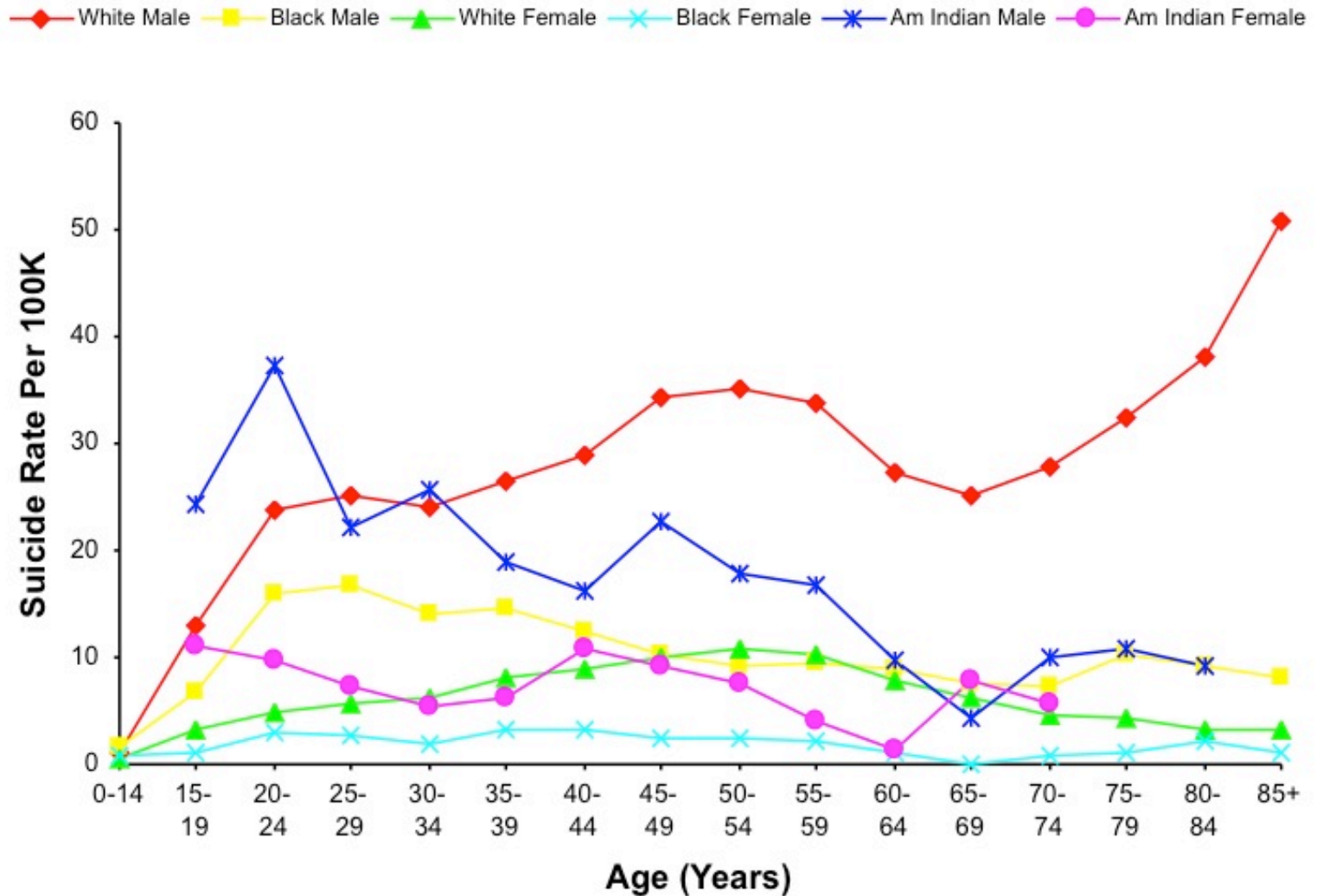


A global problem



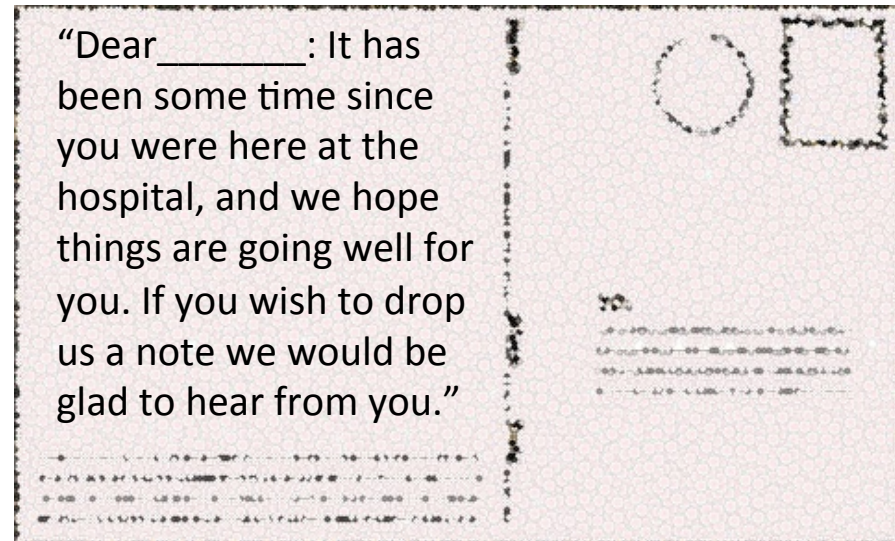
World Health Organization (2009). Data available at: http://www.who.int/mental_health/prevention/suicide/suicideprevent/en/index.html

A problem across the lifespan



An under-studied problem

- U.S. Preventive Services Task Force:
 - Routine screening for suicide risk not recommended¹
- Only **two** randomized controlled trials (RCT's) w/ effects on suicide deaths.
 - Caring Letters²
 - SUPRE-MISS³
- Common ingredient?
 - Connections to providers or peers



¹ U.S. Preventive Services Task Force. Screening for Suicide Risk: Recommendation and Rationale. May 2004. , 2004.

² Motto JA, Bostrom AG. A randomized controlled trial of postcrisis suicide prevention. *Psychiatric services* 2001;52(6):828-33.

³ Fleischmann A, Bertolote JM, Wasserman D, De Leo D, Bolhari J, Botega NJ, et al. Effectiveness of brief intervention and contact for suicide attempters: a randomized controlled trial in five countries. *Bulletin of the World Health Organization* 2008;86(9):703-9.

A problem of social disconnectedness

□ Indices of social isolation in later life:

- **Loss of a spouse**
(Conwell et al, 1990; Erlangsen et al, 2004)
- **Loneliness**
(Rubenowitz et al, 2001)
- **Interpersonal discord**
(Harwood et al, 2006; Beautrais, 2002; Duberstein et al, 2004)
- **Low social support**
(Turvey et al, 2002)
- **Fewer people in whom to confide**
(Miller, 1978)
- **Less community engagement**
(Duberstein et al, 2004)
- **Living alone**
(Waern et al, 2002; Barraclough, 1971)



An often misunderstood problem

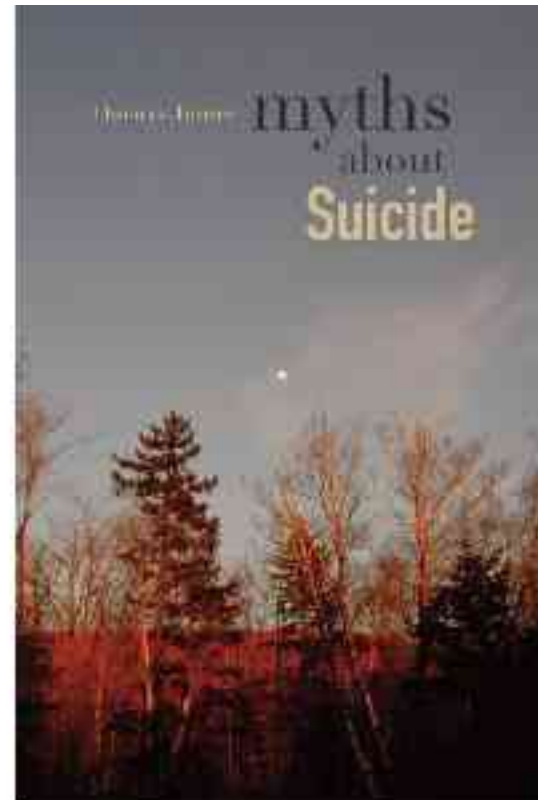
Myths & Misunderstandings

- “People who talk about it don’t do it.”
- “If someone is prevented from suicide at one place, they’ll just go somewhere else to do it.”
- “Mentioning suicide plants the idea in someone’s head.
- “People kill themselves on impulse.”

An often misunderstood problem

Myths & Misunderstandings

- Talk of the Nation (NPR)



THERE IS NOTHING SO PRACTICAL
AS A GOOD THEORY...

What's the use of a good theory?

- Provides full understanding, which, in turn:
 - focuses clinicians' existing tool set.
 - provides partial answer to bereaved people's question, why?

Why Do People Die by Suicide?

- Most psychological theories tell us it's because *people feel bad*.
 - Hopelessness
 - Depression
 - Psychache



Theories of Suicide

- Anger Turned Inwards (Freud, 1920)
- Hopelessness (Beck, 1974)
- Escape (Baumeister, 1991)
- Psychache (Schneidman, 1993)
- **Interpersonal Theory of Suicide (Joiner, 2005)**

Why Do People Die by Suicide?

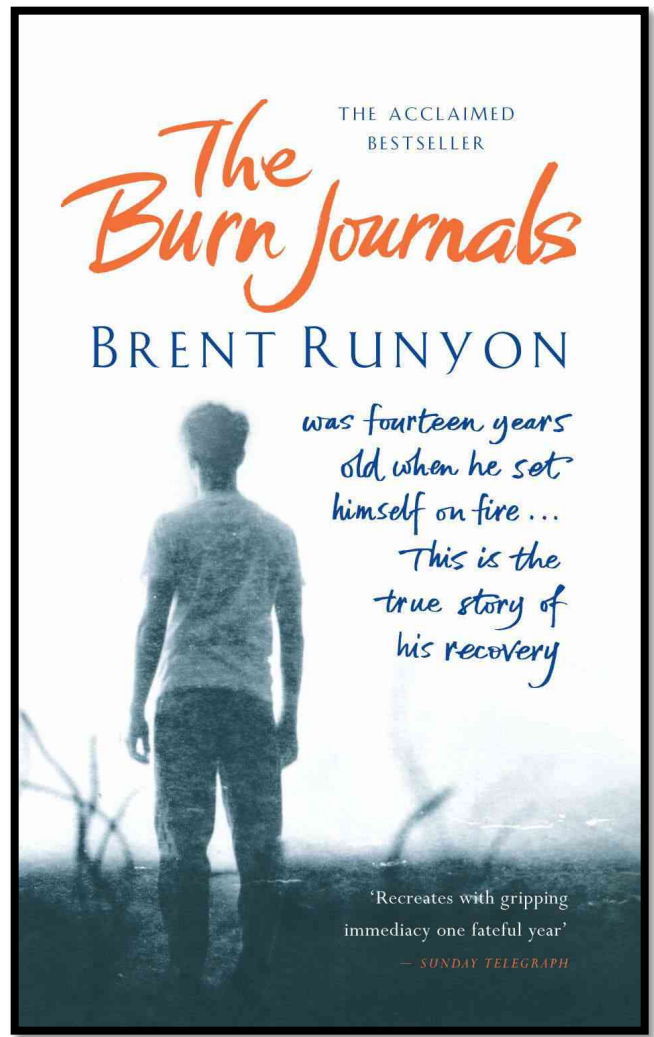
- Most theories fall short. Can't explain facts about suicide.
 - More men die by suicide than women...
 - Except in China.
 - Yet more women attempt (but survive).
 - Especially in late-life.
 - Almost everyone who dies by suicide met criteria for a mental disorder.
 - Yet the vast majority of those with mental disorders will not attempt or die by suicide.

How the Interpersonal Theory of
Suicide is *different*:

People die by suicide because
they *want to* **and** because they
are *able to*.

Acquired Capability

***Dying by
suicide is
not an
easy thing
to do.***

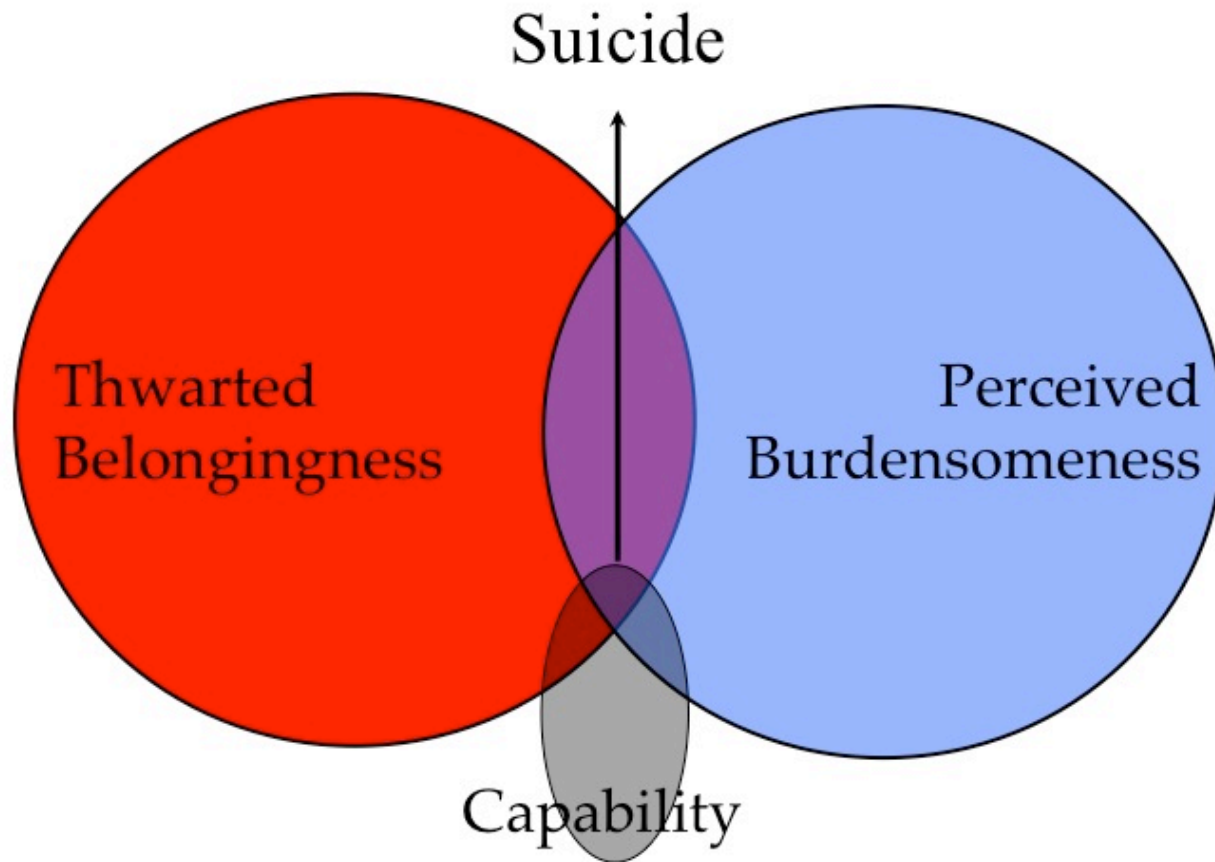


***People must
acquire the
capability to
die by
suicide.***

“I wonder why all the ways I’ve tried to kill myself haven’t worked. I mean, I tried hanging; I used to have a noose tied to my closet pole. I’d go in there and slip the thing over my head and let my weight go, but every time I started to lose consciousness, I’d just stand up. I tried to take pills. I took 20 Advil one afternoon, but that just made me sleepy. And all the times I tried to cut my wrist, I could never cut deep enough. That’s the thing, your body tries to keep you alive no matter what you do.”

Acquired Capability for Suicide

Why People Die by Suicide: *The Interpersonal Theory of Suicide*



Acquired capability

- Case #7 was described as being socially isolated when she attempted suicide with an unknown quantity and type of pain medication and also opened her wrist arteries. This action led to some degree of unconsciousness, from which she awoke She then threw herself in front of a train, which was the ultimate cause of her death. (Holm-Denoma et al., 2008)

The Acquired Capability *to Enact Lethal Self-Injury*

- With repeated exposure, one habituates –
 - the “taboo” and prohibited quality of suicidal behavior diminishes,
 - and so may the fear and pain associated with self-harm.
- Relatedly, opponent-processes may be involved.

Acquired capability: FEAR

- To die by suicide, you must *lose some of the fear* associated with suicidal behaviors.
- We aren't born with the capability to stare down death.



Acquired capability: PAIN

- To die by suicide, you must also be able to ***tolerate the pain*** involved in suicidal behavior.
 - repeated ***practice*** and ***exposure***,
 - get used to the physically painful aspects of self-harm

How does someone acquire the capability for suicide?

- Habituation & activation of opponent processes.

(Solomon & Corbit, 1974)

- Scary things become less scary
- Painful things become less painful.



How does someone acquire the capability for suicide?

- **Direct pathway: *previous suicide attempts***
 - Intensity of current ideation³
 - Future non-lethal attempts⁴
 - Lethal attempts⁵
- **Indirect pathway: *painful & provocative events***
 - Childhood abuse
 - Prostitution
 - Self-injecting drug use

Empirical Evidence

- Lethality of method and seriousness of intent increase with attempts.
- People who have experienced or witnessed violence or injury have higher rates of suicide – prostitutes, self-injecting drug abusers, people living in high-crime areas, physicians.
- Those with a history of suicide attempt have higher pain tolerance than others.

Empirical Evidence: “Kitchen Sink”

- The model predicts an association between past and future suicidality, even beyond strong covariates like mood disorder status, family history of psychopathology, etc..
- In four samples (U.S. suicidal outpatients, Brazilian inpatients, U.S. college students, & U.S. geriatric inpatients), this prediction was supported.

Joiner et al. (2005). *Journal of Abnormal Psychology*.

Empirical Evidence: *Childhood Physical/Sexual Abuse*

- The theory predicts: childhood physical abuse → future suicidality
 - physical abuse will be stronger than that between verbal/emotional abuse and suicidality, because physical/sexual abuse involves more physical pain.
- This is in fact the finding in the National Comorbidity Survey data set. Joiner et al. (2006). *Behaviour Research & Therapy*.
 - Childhood physical/sexual abuse predicts lifetime number of suicide attempts controlling for a host of strong covariates like personal and family psychopathology, and for verbal/emotional abuse.
 - Verbal/emotional abuse was not predictive of later suicidal behavior.

Professions with Elevated Suicide Rates

- Physicians
 - Especially high risk for overdose on medicines, often taken from work¹
- Military personnel
 - Male veterans 2x's as likely to die as non veterans²
 - recent rise in the rate of suicide among active duty military service members

Research on Acquired Capability

Previous
Suicide
Attempts



Acquired capability

Painful &
provocative
events



Acquired capability

Research Methods

Painful & Provocative Events

- Promiscuous sex
- Shot a gun
- Contact sports
- Jumped from tall places
- NSSI
- Piercings

Acquired Capability for Suicide Scale

- “Things that scare most people don’t scare me
- “I can tolerate a lot more pain than most people.”

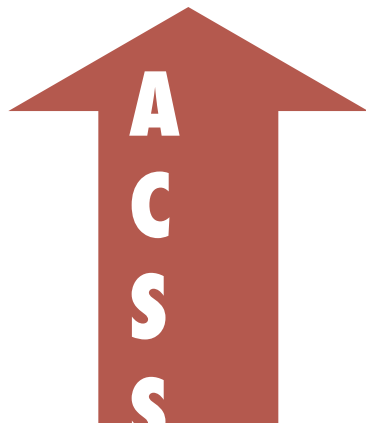
Research Results



Zero attempts

Single attempts

Multiple attempts



$sr = .26$

Painful & Provocative Events

The Documentary *The Bridge*

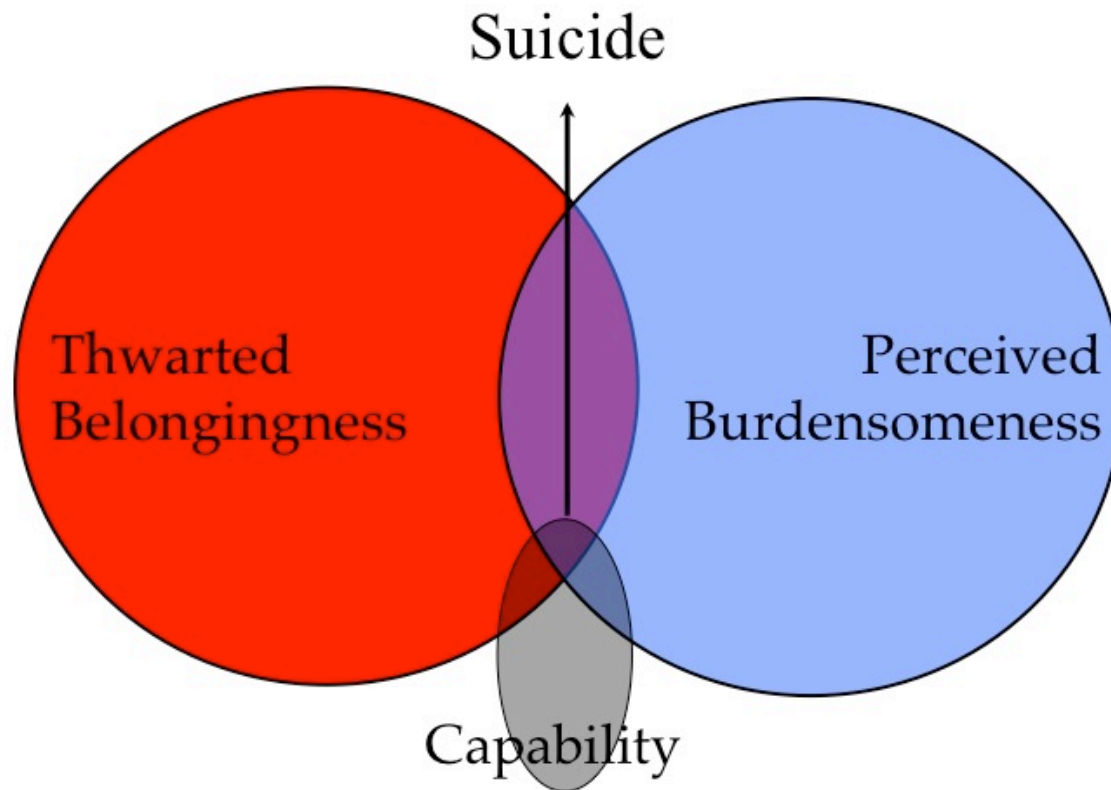
- Photographer saves someone who is pondering jumping from the Golden Gate Bridge.



Desire for Suicide

Why people desire suicide

Another way the theory is different: what form does the emotional pain take?



Thwarted belongingness

□ Psychache

- “stems from thwarted or distorted psychological needs” (Shneidman, 1996)

□ The need to belong (Baumeister & Leary, 1995):

- positive
- frequent, proximal
- perceptions of care

***Feeling connected and cared about
can be lifesaving***

Thwarted belongingness:

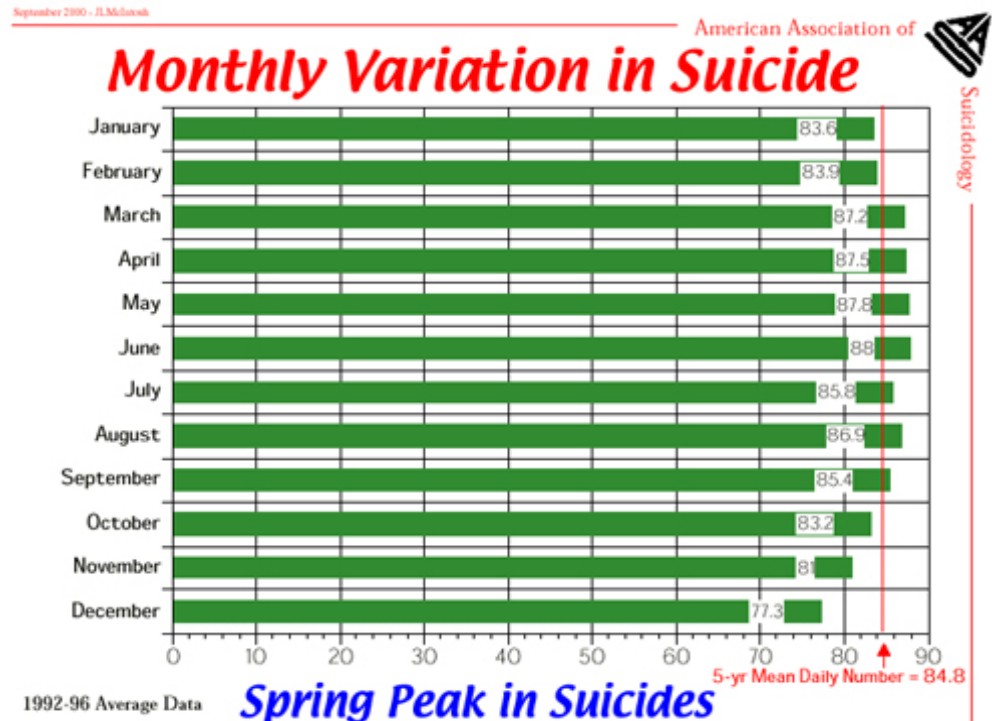
- ❑ Living alone, unmarried
- ❑ Few social supports
- ❑ Lack of confidant
- ❑ Loneliness
- ❑ Social withdrawal
- ❑ Loss
- ❑ Family conflict



“I don’t
belong
anywhere
or with
anyone.”

Thwarted belongingness: *Empirical Evidence*

- Seasonal variation
- Psychological autopsy
- “Pulling together”
 - Sports fans & camaraderie
 - National disasters & shared experience



Perceived burdensomeness

- Self-perceptions of incompetence
- Misperception: A liability for others
 - My existence burdens family, friends, society
 - Mental calculation: “my death will be worth more than my life to family, friends, society, etc.”

Perceived Burdensomeness: Anecdotal Evidence

- Burn victim mentioned earlier:

*"I felt my mind slip back into the same pattern of thinking I'd had when I was fourteen [when he attempted suicide]. **I hate myself.** I'm terrible. I'm not good at anything. **There's no point in me hanging around here ruining other people's lives.** I've got to get out of here. I've got to figure out a way to get out of my life."*

Perceived burdensomeness

- Physical illness
- Functional impairment
- Unwanted, expendability in children
- Low self-esteem
- Unemployment
- Incarceration



“I am a burden on others”

Perceived burdensomeness

Construct definition & early studies

- Self-perceptions of incompetence
- Misperception: A liability for others
 - My existence burdens family, friends, society
 - Mental calculation: “my death will be worth more than my life to family, friends, society, etc.”
- Initial study:
 - Single item on burden:
 - I do not think that my relatives would be happier if I were gone.
 - I think that my relatives would be happier if I were gone.
 - I am sure that my relatives would be happier if I were gone.
 - Burden associated with:
 - Age
 - Current Suicidal Ideation
 - Greater number past attempts
 - Beyond depression, hopelessness.

Perceived burdensomeness:

Empirical Evidence

- Suicide deaths
 - Suicide notes
 - Psychological autopsy
- Non-lethal suicide attempts
- Severity of suicidal ideation
 - Older and younger adults

Perceived burdensomeness *in older adult primary care patients*

- Predicting severity of suicidal ideation (GSIS-SI)
 - Age
 - Gender
 - Self-rated health
 - Hopelessness
 - Loneliness
 - Depression
 - Perceived burden
- Greater perceived burdensomeness → greater suicide ideation
 - Only burden & loneliness significant
 - No gender interaction

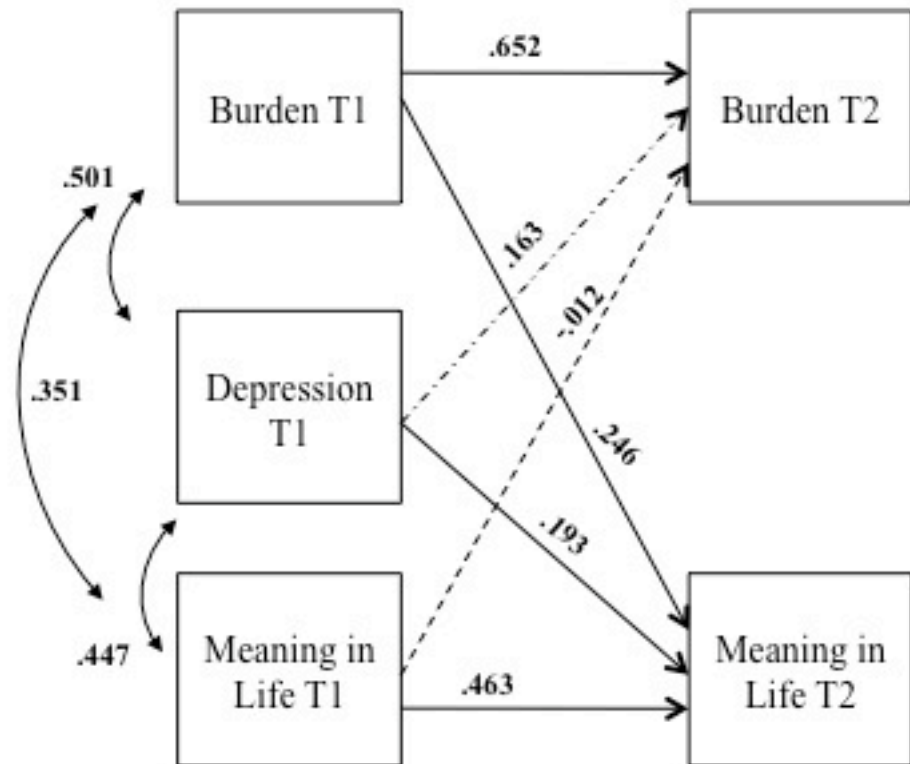
Perceived Burdensomeness May Reduce Meaning In Life

□ Sample: n =65

- Age 60+
- At an outpatient geriatric psychiatry clinic
- Either mood, anxiety, or adjustment disorder

□ Measures

- INQ = perceived burdensomeness
- PHQ-9 = depression severity
- GSIS-ML = meaning in life



Interpersonal Needs Questionnaire

Assessing thwarted belonging & perceived burden

Interpersonal Needs Questionnaire

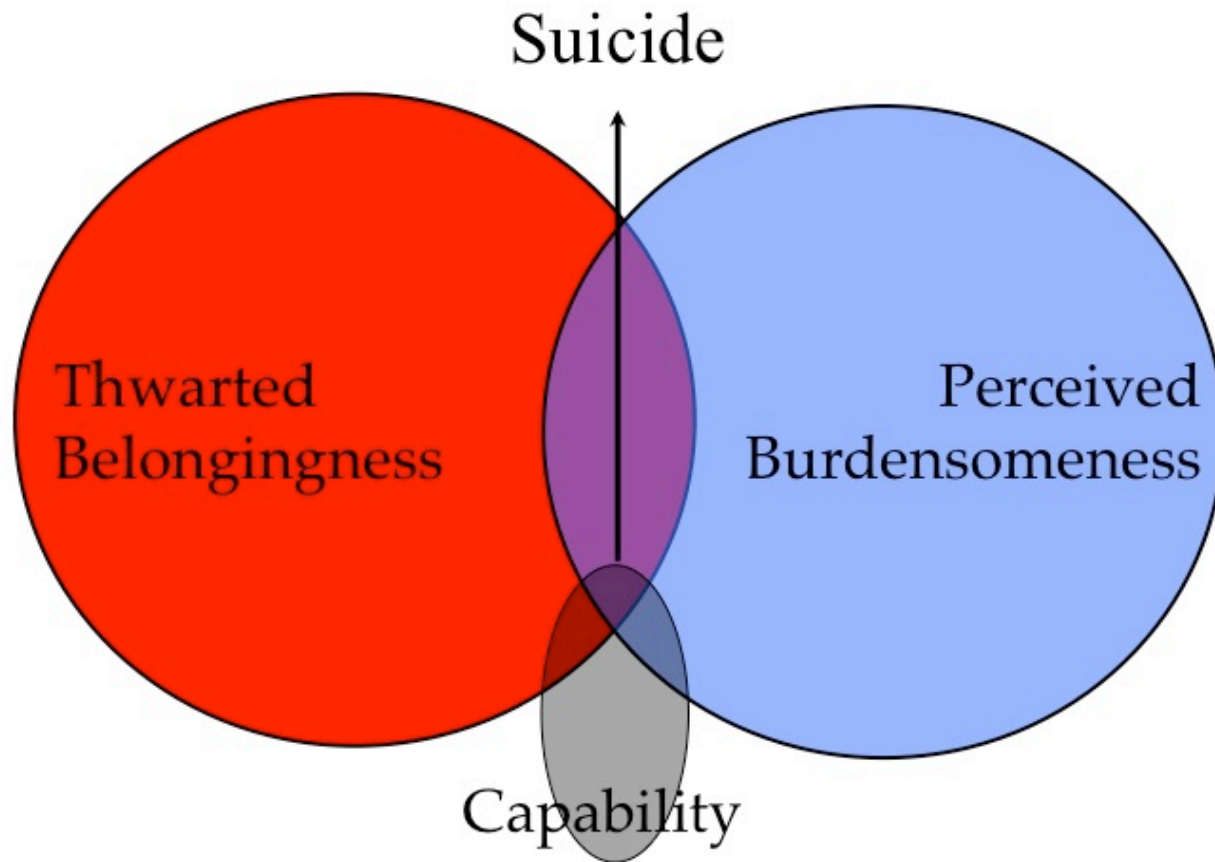
The following questions ask you to think about yourself and other people. Please respond to each question by using your own current beliefs and experiences, NOT what you think is true in general, or what might be true for other people. Please base your responses on how you've been feeling recently. Use the rating scale to find the number that best matches how you feel and circle that number. There are no right or wrong answers: we are interested in what *you* think and feel.

1	1	2	3	4	5	7
Not at all true for me			Somewhat true for me			Very true for me

1. These days the people in my life would be better off if I were gone
2. These days the people in my life would be happier without me
3. These days I think I am a burden on society
4. These days I think my death would be a relief to the people in my life
5. These days I think the people in my life wish they could be rid of me
6. These days I think I make things worse for the people in my life
7. These days, other people care about me
8. These days, I feel like I belong
9. These days, I rarely interact with people who care about me
10. These days, I am fortunate to have many caring and supportive friends
11. These days, I feel disconnected from other people
12. These days, I often feel like an outsider in social gatherings
13. These days, I feel that there are people I can turn to in times of need
14. These days, I am close to other people
15. These days, I have at least one satisfying interaction every day

Note. Items 7, 8, 10, 13, 14, and 15 are reverse coded.

Greatest risk: Presence of all three factors

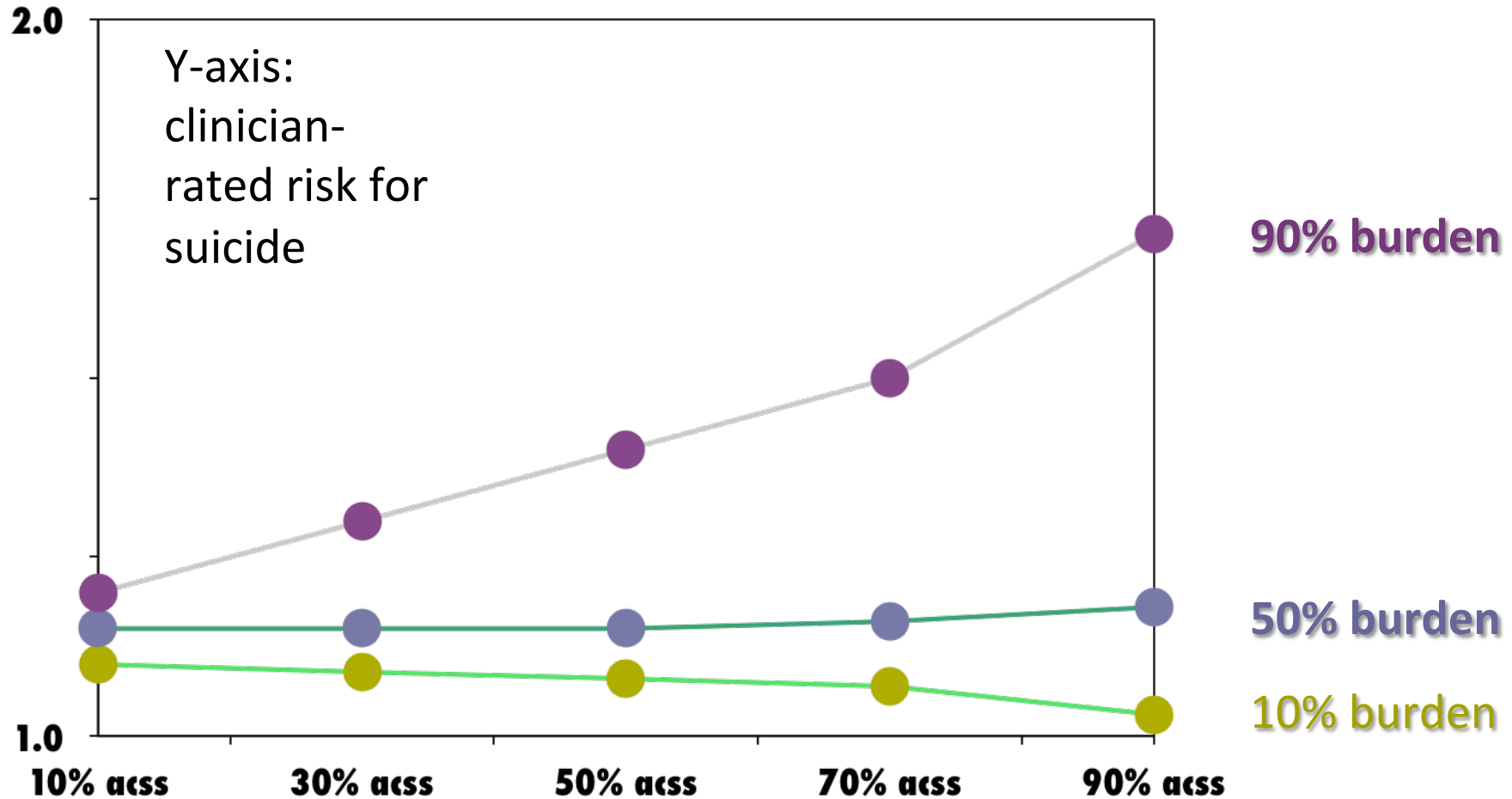


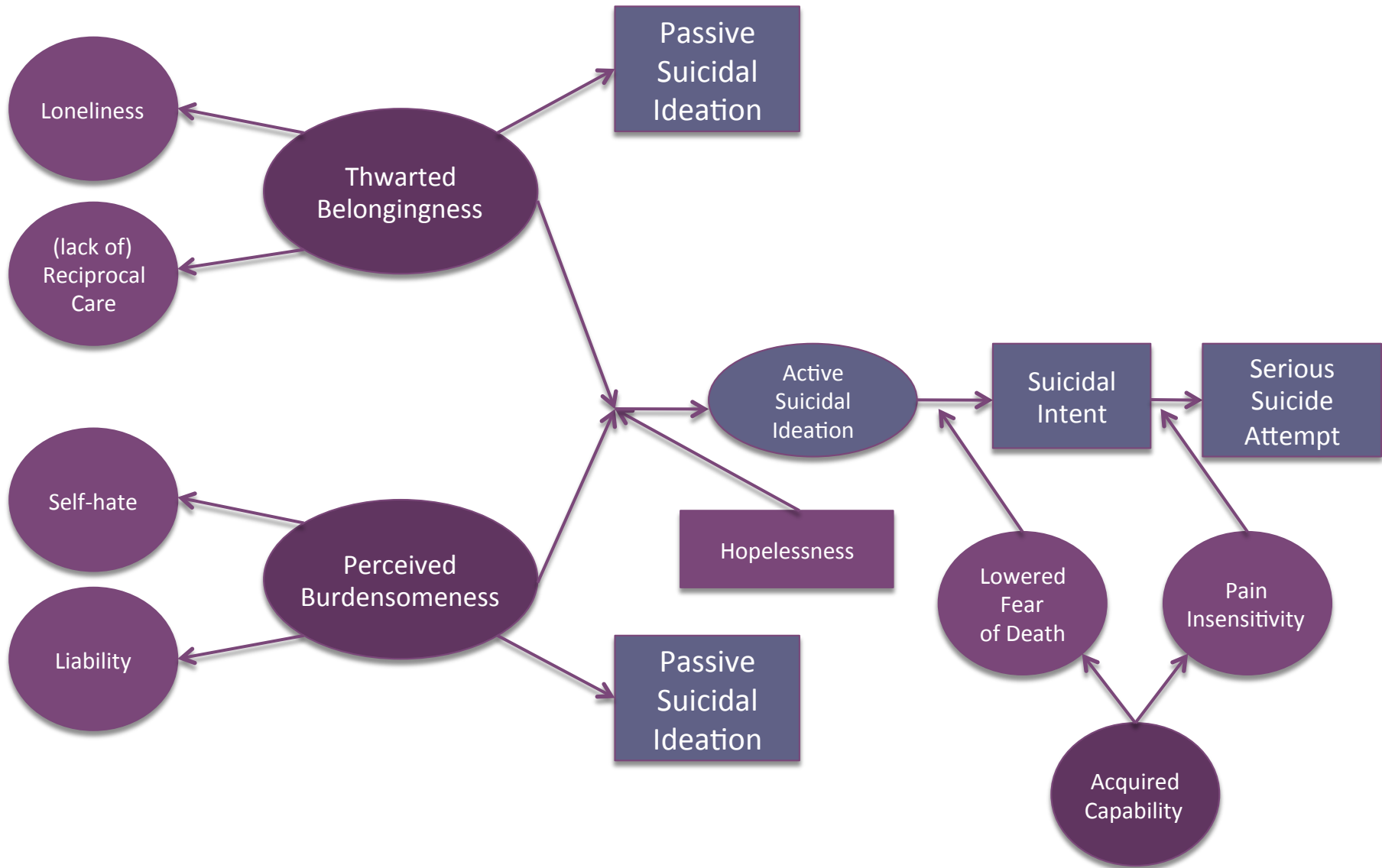
[Thomas Joiner on Dr. Phil](#)

Ingredients for both desire & capability are necessary for suicide risk to elevate

- Hypothesis: Outpatients with higher self-perceived acquired capability will be rated at higher risk for suicide by clinicians, but *only* when accompanied by perceived burdensomeness
 - “I am a burden on the people in my life.”
 - Acquired capability for suicide isn’t destiny. Must be accompanied by desire to die.

Acquired capability X burdensomeness





(Van Orden, Witte, et al., 2010, *Psychological Review*)

Case example

Emotional pain & death ideation

- 80 y/o retired social worker
 - Divorced 8 years ago
 - Lives alone, independent senior housing
 - Moved to Rochester to be near adult children
 - Macular degeneration, knee pain
- Chief complaint: “I see years of nothingness ahead.”
- Referred by PCP b/c increase in depression & anxiety, social withdrawal
 - Referred to me for psychotherapy, after endorsed wanting to die with her psychiatrist.
 - “I don’t want to live anymore and it seems logical I should feel that way.”

Older adult case example:

Thwarted belonging & perceived burden

- **Thwarted belongingness:**
 - “I’ve had difficulty making friends since I moved here about a year ago.”
 - “I don’t belong anywhere”
 - Communal dinner each night: “I think I’m driving everyone nuts.”
 - Spending time with adult children: “I was sitting around their place feeling like I don’t have a place...”
- **Perceived burdensomeness:**
 - “I’m a burden, but I try not to be. I’ve made life more difficult for my son and daughter in law here.”
- **Positive social connections *not completely absent*:**
 - “I want to kill myself but I can’t do that to my family.”

The role of mental disorders

*“People who kill themselves, though, are influenced in doing so by mental illnesses, and these illnesses themselves are widely misunderstood, subject to many myths. **But make no mistake, they're forces of nature. They're grave. They're severe, just like heart disease, cancer and stroke. They kill a million people every year through suicide worldwide.**”*

--Thomas Joiner, PhD on *Talk of the Nation*

Axis I and II Psychopathology

Integrated with theory

- Disorders that share features of burdensomeness, low belongingness, and acquired ability (fearlessness, resolve re: suicide) are most likely to involve suicidality.
- Mental disorders are more distal in the development of suicidal crises

Axis I and II Psychopathology

Mood disorders

- Major Depressive Disorder
 - ~10% mortality due to suicide
- Bipolar disorder,
 - mortality estimates are 10-15% for bipolar I, same for bipolar II.

Axis I and II Psychopathology

Anxiety disorders

- Mortality estimates are less clear here
 - fearfulness is an issue
 - comorbidity with major depression (e.g., GAD and major depression share genetic risk).
 - Anxiety can be very painful and can instill hopelessness.

Axis I and II Psychopathology

Schizophrenia

- Mortality estimate: around 10%,
 - delusional self-hatred, or delusional burdensomeness (Joiner, Gencoz, Gencoz, Metalsky, & Rudd, 2001).

Axis I and II Psychopathology

Substance use disorders

- mortality estimate approaches 10%
 - impulsivity is an issue.
 - Perhaps indirect role for impulsivity, as well as a direct role

Axis I and II Psychopathology

Borderline Personality Disorder

- 10% mortality estimate.
 - At least 50% with at least one severe attempt in the past.
 - Some evidence that past attempt is more predictive of completed suicide in this group vs. other diagnostic group.
 - The unfortunate reputation for manipulation/gesturing can misguide clinicians.

Axis I and II Psychopathology

Treatment Planning

- These diagnostic issues are key in terms of treatment planning:
 - for someone who is repeatedly suicidal, a therapy that primarily targets suicidality is probably best;
 - whereas, for someone who becomes suicidal for the first time in context of a major depressive episode, a therapy primarily targeting depression may be best (more on this when treatment is discussed).

Risk assessment & management

RISK ASSESSMENT

Theory-informed risk assessment

- Objective:
 - not alarmist,
 - not dismissive



Risk Factors vs. warning signs

- Risk factors:
 - Often long-standing and unchanging (e.g., gender)
 - Predispose individuals to suicidal behavior
- Warning signs:
 - Dynamic & proximal
 - Indicate presence of current suicidal crisis

Warning Signs

American Association of Suicidology

IS

Ideation
Substance Abuse

PATH

Purposeless
Agitation
Trapped
Hopelessness

WARM

Withdrawal
Anger
Restlessness
Mood changes

Suicide Risk Assessment:

Risk Factors (>15 studies)

- Mental disorders
- Previous suicide attempts
- Social isolation
- Physical illness
- Unemployment
- Family conflict

Suicide Risk Assessment:

Risk Factors (6-15 studies)

- Family history
- Impulsivity
- Incarceration
- Hopelessness

Suicide Risk Assessment:

Risk Factors (5 or fewer studies)

- Agitation or sleep disturbance
- Childhood abuse
- Exposure to suicide
- Homelessness
- Combat exposure
- Self-esteem, shame

What to assess? Organized by theory

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



What to assess? Organized by theory

- 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)



What to assess? Organized by theory

□ 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

What to assess? Organized by theory

- Acquired Capability
 - 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

Acquired capability

Two potential presentations

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

Suicide risk assessment frameworks

- Formalized procedures that provide structured ways to assess signs and symptoms of current and more long-standing risk.
 - Indications of what signs and sx's to assess & what questions to ask
 - How to combine info on past & current sx's to determine current risk
 - What actions to take
- GOAL: establish degree of current risk, including if clear & imminent risk so that appropriate clinical actions are taken.



Risk Assessment Frameworks

- The Collaborative Assessment and Management of Suicidality (CAMS; Jobes, 2006)
- Chronological Assessment of Suicidal Events (CASE; Shea, 2002)
- U. of Washington Risk Assessment Protocol (UWRAP; Linehan et al., 2000)
- The Suicide Risk Assessment Decision Tree (Joiner et al., 1999)

Columbia Suicide Severity Rating Scale

<http://www.cssrs.columbia.edu/>

- Wish to be dead:
 - “Have you wished you were dead or wished you could go to sleep and not wake up?”
 - Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up.
- Passive/death ideation. Is it pernicious?

Columbia Suicide Severity Rating Scale

<http://www.cssrs.columbia.edu/>

□ Suicidal thoughts:

- “Have you actually had any thoughts of killing yourself?”
- General, non-specific thoughts of wanting to end one’s life/commit suicide
- E.g., “I’ve thought about killing myself” without thoughts of ways to kill oneself/associated methods, intent, or plan.

Columbia Suicide Severity Rating Scale

<http://www.cssrs.columbia.edu/>

- Suicidal Thoughts with Method (without Specific Plan or Intent to Act):
 - Have you been thinking about how you might do this?
 - Person endorses thoughts of suicide and has thought of at least one method during the assessment period.
 - This is different than a specific plan with time, place or method details worked out.
 - E.g., “I thought about taking an overdose but I never made a specific plan as to when, where or how I would actually do it....and I would never go through with it.”

Columbia Suicide Severity Rating Scale

<http://www.cssrs.columbia.edu/>

- Suicidal intent (without specific plan):
 - “Have you had these thoughts and had some intention of acting on them?”
 - Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as opposed to, “I have the thoughts but I definitely will not do anything about them.”

Columbia Suicide Severity Rating Scale

<http://www.cssrs.columbia.edu/>

- Suicidal intent specific plan:
 - “Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?”
 - Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out.

Columbia Suicide Severity Rating Scale

<http://www.cssrs.columbia.edu/>

- Complete intensity ratings:
 - Frequency
 - Duration
 - Controllability
 - Deterrents
 - Reasons for ideation (interpersonal vs. escape pain)

(C-SSRS)

Posner, Brent, Lucas, Gould, Stanley, Brown, Fisher, Zelazny, Burke, Oquendo, & Mann
 © 2008 The Research Foundation for Mental Hygiene, Inc.

RISK ASSESSMENT VERSION

Instructions: Check all risk and protective factors that apply. To be completed following the patient interview, review of medical record(s) and/or consultation with family members and/or other professionals.			
Suicidal and Self-Injurious Behavior (Past week)		Clinical Status (Recent)	
<input type="checkbox"/>	Actual suicide attempt	<input type="checkbox"/>	Lifetime
<input type="checkbox"/>	Interrupted attempt	<input type="checkbox"/>	Lifetime
<input type="checkbox"/>	Aborted or Self-Interrupted attempt	<input type="checkbox"/>	Lifetime
<input type="checkbox"/>	Other preparatory acts to kill self	<input type="checkbox"/>	Lifetime
<input type="checkbox"/>	Self-injurious behavior without suicidal intent	<input type="checkbox"/>	Lifetime
Suicidal Ideation (Most Severe in Past Week)		<input type="checkbox"/>	Hopelessness
<input type="checkbox"/>	Wish to be dead	<input type="checkbox"/>	Major depressive episode
<input type="checkbox"/>	Suicidal thoughts	<input type="checkbox"/>	Mixed affective episode
<input type="checkbox"/>	Suicidal thoughts with method (but without specific plan or intent to act)	<input type="checkbox"/>	Command hallucinations to hurt self
<input type="checkbox"/>	Suicidal intent (without specific plan)	<input type="checkbox"/>	Highly impulsive behavior
<input type="checkbox"/>	Suicidal intent with specific plan	<input type="checkbox"/>	Substance abuse or dependence
Activating Events (Recent)		<input type="checkbox"/>	Agitation or severe anxiety
<input type="checkbox"/>	Recent loss or other significant negative event	<input type="checkbox"/>	Perceived burden on family or others
	Describe:	<input type="checkbox"/>	Chronic physical pain or other acute medical problem (AIDS, COPD, cancer, etc.)
		<input type="checkbox"/>	Homicidal ideation
<input type="checkbox"/>	Pending incarceration or homelessness	<input type="checkbox"/>	Aggressive behavior towards others
<input type="checkbox"/>	Current or pending isolation or feeling alone	<input type="checkbox"/>	Method for suicide available (gun, pills, etc.)
Treatment History		<input type="checkbox"/>	Refuses or feels unable to agree to safety plan
<input type="checkbox"/>	Previous psychiatric diagnoses and treatments	<input type="checkbox"/>	Sexual abuse (lifetime)
<input type="checkbox"/>	Hopeless or dissatisfied with treatment	<input type="checkbox"/>	Family history of suicide (lifetime)
<input type="checkbox"/>	Noncompliant with treatment	Protective Factors (Recent)	
<input type="checkbox"/>	Not receiving treatment	<input type="checkbox"/>	Identifies reasons for living
Other Risk Factors:		<input type="checkbox"/>	Responsibility to family or others; living with family
<input type="checkbox"/>		<input type="checkbox"/>	Supportive social network or family
Other Protective Factors:		<input type="checkbox"/>	Fear of death or dying due to pain and suffering
<input type="checkbox"/>		<input type="checkbox"/>	Belief that suicide is immoral; high spirituality
		<input type="checkbox"/>	Engaged in work or school
Describe any suicidal, self-injurious or aggressive behavior (include dates):			

Very Brief Self-Report Measure

- A brief self-report measure (Joiner, Pfaff, & Acres, Behaviour Research & Therapy, 2002).
- Likely similar to other good scales (e.g., the Beck Suicide Scale), but many of these are costly; this one is free.

Depressive Symptom Inventory

Statement 1	Statement 2	Statement 3	Statement 4
Group One:			
I do not have thoughts of killing myself	Sometimes I have thoughts of killing myself.	Most of the time I have thoughts of killing myself	I always have thoughts of killing myself.
Group Two:			
I am not having thoughts about suicide.	I am having thoughts about suicide but have not formulated any plans.	I am having thoughts about suicide and am considering possible ways of doing it.	I am having thoughts about suicide and have formulated a definite plan.
Group Three:			
I am not having thoughts about suicide.	I am having thoughts about suicide but have these thoughts completely under my control.	I am having thoughts about suicide but have these thoughts somewhat under my control.	I am having thoughts about suicide but have little or no control over these thoughts.
Group Four:			
I am not having impulses to kill myself.	In some situations I have impulses to kill myself.	In most situations I have impulses to kill myself.	In all situations I have impulses to kill myself.
Group Five:			
I have never attempted suicide.	I have attempted suicide once.	I have attempted suicide two or more times.	

Mood Scale (PHQ)

I am now going to ask you some questions regarding your emotional health.

In the <u>past two weeks</u> , how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
a. Little interest or pleasure in doing things	0	1	2	3
b. Feeling down, depressed, or hopeless	0	1	2	3
c. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
d. Feeling tired or having little energy	0	1	2	3
e. Poor appetite or overeating	0	1	2	3
f. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
g. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
h. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
i. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

j. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult
at all

Somewhat
difficult

Very
difficult

Extremely
difficult

Total Score PHQ: _____

PHQ-9

Question “i”

- If any positive response, FOLLOW-UP
 - determine passive vs. active ideation
 - “In the last 2 weeks, have you had any thoughts of hurting or killing yourself?”
 - If yes = active suicidal ideation, FOLLOW-UP

- There are routinized screeners designed to be used to follow-up the PHQ-9 suicide item.
 - Option: the *P4 Screener for Assessing Suicide Risk*

P4 Screener

□ Think about acquired capability:

- Past attempt
- Plan
- Probability

• (Dube et al., 2010)

Figure 1. P4 Screener for Assessing Suicide Risk^{a,b}

Have you had thoughts of actually hurting yourself?
 NO YES

 4 Screening Questions ←

1. Have you ever attempted to harm yourself in the past?

NO YES

2. Have you thought about how you might actually hurt yourself?

NO YES → [How? _____]

3. There's a big difference between having a thought and acting on a thought. How likely do you think it is that you will act on these thoughts about hurting yourself or ending your life some time over the next month?

- a. Not at all likely _____
 b. Somewhat likely _____
 c. Very likely _____

4. Is there anything that would prevent or keep you from harming yourself?

NO YES → [What? _____]

Risk Category	Shaded ("Risk") Response	
	Items 1 and 2	Items 3 and 4
Minimal	Neither is shaded	Neither is shaded
Lower	At least 1 item is shaded	Neither is shaded
Higher		At least 1 item is shaded

^aP4 is a mnemonic for the 4 screening questions: *past* suicide attempt, *suicide plan*, *probability* of completing suicide, and *preventive* factors. ©Copyright 2010 Kurt Kroenke, MD.

^bAny individual who responds "yes" to a question about thoughts of self-harm is asked 4 additional questions—the 4 P's on past history, plan, probability, and preventive factors. Shaded responses are those that are more concerning for suicidal ideation.

P4 Screener

Figure 1. P4 Screener for Assessing Suicide Risk^{a,b}

Have you had thoughts of actually hurting yourself?

NO YES

4 Screening Questions ←

1. Have you ever attempted to harm yourself in the past?

NO YES

2. Have you thought about how you might actually hurt yourself?

NO YES → [How? _____]

3. There's a big difference between having a thought and acting on a thought. How likely do you think it is that you will act on these thoughts about hurting yourself or ending your life some time over the next month?

a. Not at all likely _____

b. Somewhat likely _____

c. Very likely _____

4. Is there anything that would prevent or keep you from harming yourself?

NO YES → [What? _____]

Risk Category	Shaded ("Risk") Response	
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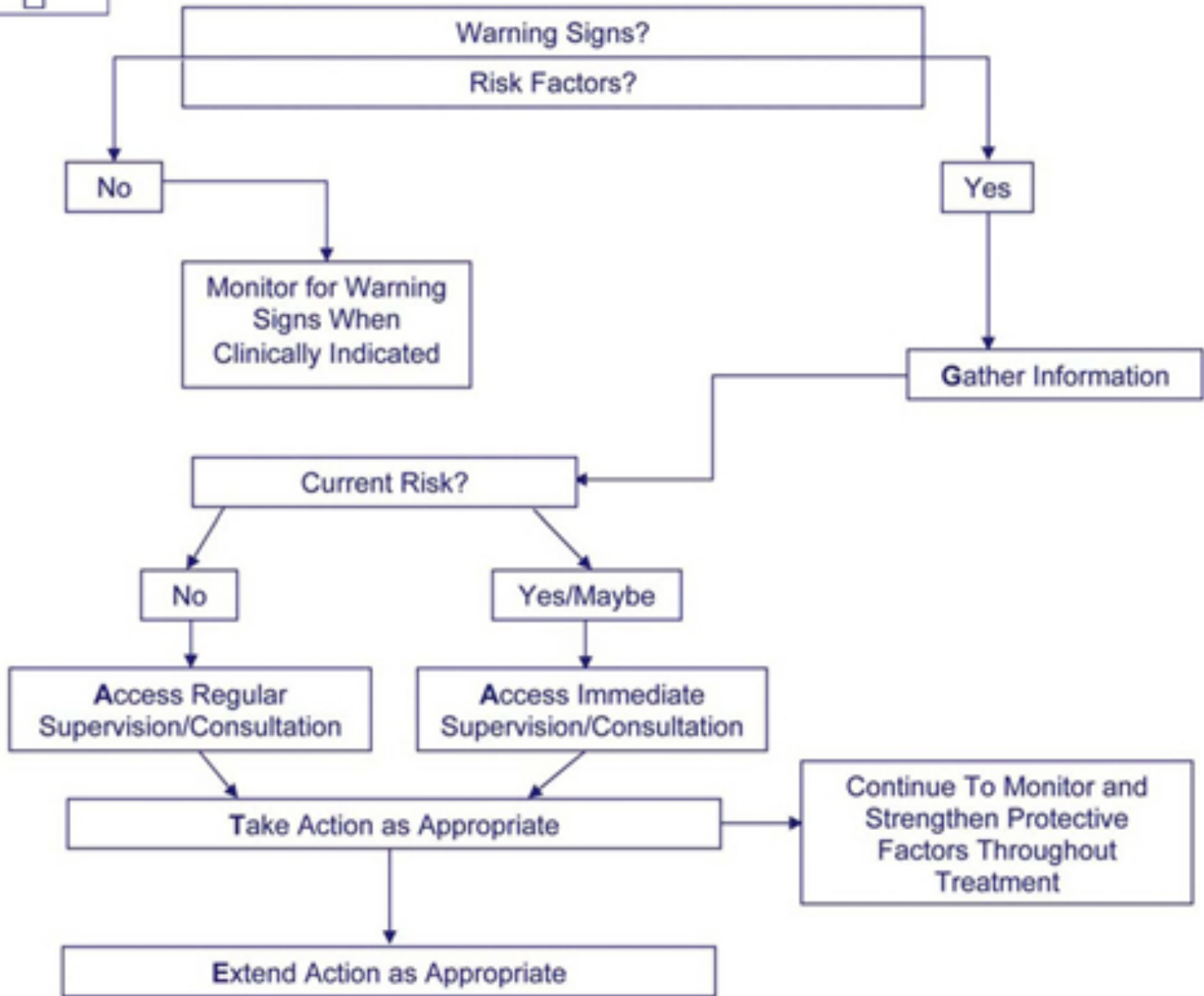
^bAny individual who responds "yes" to a question about thoughts of self-harm is asked 4 additional questions—the 4 P's on past history, plan, probability, and preventive factors. Shaded responses are those that are more concerning for suicidal ideation.

TIP-50: Treatment Improvement Protocol (TIP) Series, No. 50

- Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment
 - SAMHSA
 - <http://www.ncbi.nlm.nih.gov/books/NBK64022/>
 - GATE: Procedures for Substance Abuse Counselors
 - Gather information
 - Access supervision
 - Take responsible action
 - Extend the action
 - Training videos on YouTube



Figure 1.1
Decision Tree
How to Address Suicidal Thoughts and Behaviors
in Substance Abuse Treatment



Other risk assessment resources

- American Association of Suicidology:
 - <http://www.suicidology.org/web/guest/current-research>
 - A Review of Suicide Assessment Measures for Intervention Research with Adults and Older Adults [PDF]
 - A Review of Suicide Assessment Measures for Intervention Research with Youth [PDF]

Suicide Risk Decision Tree

Joiner et al (1999)

Joiner, Van Orden, Witte, & Rudd (2009)

Toward a Risk Assessment Framework

- Two Most Important Areas:
 - History of Previous Attempt/Fearlessness
 - Nature of Current Suicidal Symptoms
- Regarding **nature of current suicidal symptoms**, two concepts are important.
 - The first is what we've termed Resolved Plans & Preparation (Developed Plan for Suicide, Sense of Courage & Competence to Commit Suicide, Opportunity, Intensity/Duration of Ideation).

What to assess? Data suggests...

- Past attempts, esp multiple attempts
- Worst point SI
- Suicidal desire and ideation versus resolved plans and preparation
 - **Desire/ideation:** absence reasons for living; wish to die; frequency of ideation; wish not to live; passive attempt; desire for attempt; talk of death/suicide
 - **Resolved plans & preparations:** sense of courage to make an attempt; competence to attempt; availability of means/opportunity; specificity of plan; preparations; duration of SI; intensity

Resolved Plans & Preparations

- This symptom cluster includes
 - Vivid, detailed, long-lasting ideas about suicide
 - A sense of competence about suicide
 - A sense of **fearlessness** about suicide.
 - Well-developed plans

Dangerous set of symptoms

Toward a Risk Assessment Framework

- The other concept is what we've termed Suicidal Desire (Desire for Death, Frequency of Ideas and so on).
- Both of these concepts represent serious things, but relatively speaking, the Resolved Plans & Preparation symptoms are more dangerous than the Suicidal Desire & Ideation factor.

Desire for Death

- This symptom cluster includes
 - Vague and fleeting ideas about suicide
 - Statements like “would be better off dead.”
 - No well-developed plans

Still worrisome set of symptoms,
but **RELATIVELY** less dangerous
in terms of imminent risk.

Toward a Risk Assessment Framework

- The idea of the Risk Assessment Framework is:
 - Other Risk Factors (e.g., Substance Abuse, Marked Impulsivity, Personality Disorder, others discussed above) Are Interpreted In Light of: Two Main Areas Assessment
 - History of Previous Attempt/Fearlessness
 - Nature of Current Suicidal Symptoms).
- This relieves somewhat the “laundry list” problem.

The Framework

- NOTE: “Other significant finding” means the list of suicide risk factors, things like severe recent negative life events, marked hopelessness, deteriorating health, loneliness, and so on.
- “Moderate Risk” refers to risk categories, such as None, Mild-Moderate, Severe, and Extreme.
 - A multiple attempter with one other significant finding would be in the mild-moderate category;
 - a multiple attempter with two other significant findings would be in the severe category;
 - a multiple attempter with three or more other significant findings would be in the extreme category.

Suicide Risk Assessment Decision Tree

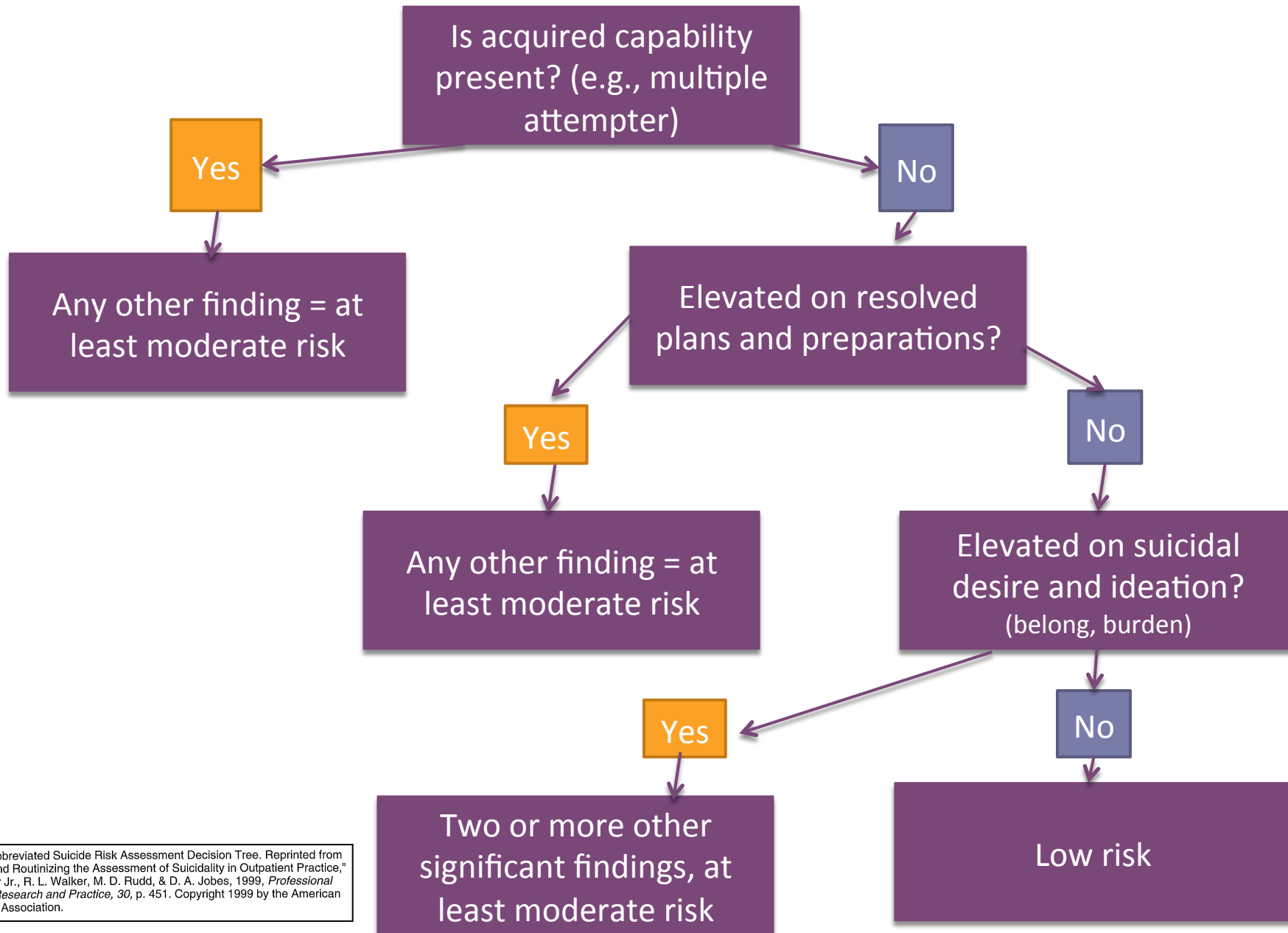


Figure 2.3. Abbreviated Suicide Risk Assessment Decision Tree. Reprinted from "Scientizing and Routinizing the Assessment of Suicidality in Outpatient Practice," by T. E. Joiner Jr., R. L. Walker, M. D. Rudd, & D. A. Jobes, 1999, *Professional Psychology: Research and Practice*, 30, p. 451. Copyright 1999 by the American Psychological Association.

Low risk

- A person with no identifiable suicidal symptoms
 - An individual with Acquired Capability with NO other risk factors (including NO suicidal ideation)
 - An individual without Acquired Capability with suicide ideation of limited intensity and duration, no or mild symptoms of the Resolved Plans and Preparation factor AND no or few other risk factors
-

Case example: Low risk

Samantha is a 20-year-old White female who presented for therapy after the break-up of a long-term relationship. During intake, Samantha noted that she wanted help for her “serious abandonment issues” and stated that she often “jumped from one relationship to another.” Samantha noted that she “can’t be alone” and that she had suffered from these problems over the past 5 years. Samantha had no prior treatment history. Samantha did not meet criteria for an Axis I disorder, though she exhibited some symptoms of binge eating disorder. Samantha met criteria for Borderline Personality Disorder. Samantha had no history of engaging in self-injurious behaviors and denied current and past suicidal ideation.

Risk factors? Why low risk?

Moderate risk

- An individual with Acquired Capability with any other notable finding (e.g., suicidal ideation, hopelessness, etc.)
- 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.

Case example: Moderate risk

- 80 y/o retired social worker
 - Divorced 8 years ago, Lives alone, independent senior housing; Macular degeneration, knee pain
- Chief complaint: “I see years of nothingness ahead.”
- Referred by PCP b/c increase in depression & anxiety, social withdrawal
 - Referred to me for psychotherapy, after endorsed wanting to die (to her psychiatrist).
 - “I don’t want to live anymore and it seems logical I should feel that way.”

Risk factors? Why moderate risk?

High Risk

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

Case example: High risk

Megan is a 37-year-old White female who presented for treatment of depression. She reported that she had been depressed her entire life. As a teenager, Megan abused alcohol and drugs including speed, marijuana, and LSD, and received inpatient substance use treatment at the age of 18. Shortly thereafter Megan joined Alcoholics Anonymous and has not used alcohol or drugs since that time. Megan attempted suicide twice, once by overdose and once by carbon monoxide poisoning, and cut herself in several locations once while in substance use treatment. Megan was diagnosed with major depressive disorder (MDD), dysthymia, and BPD. She scored in the severe range on the BDI (31) and reported frequent suicidal ideation but denied suicidal intent. Megan also reported difficulties in her romantic relationship and indicated that she had no close friends. In addition, she reported that she had been unable to maintain employment due to difficulty communicating with others.

Risk factors? Why high risk?

The Framework

- Framework has to be used together with common sense.
- The framework appears to be general across populations, with minor amendments as needed.

Children & adolescents

- Information from both child and parents
 - “expendable child” research
 - “I don’t matter”
 - Loneliness and bullying
 - Adolescents: contagion
 - Asking doesn’t cause SI
-

Older Adults

“My work is done.
Why wait?”

George Eastman

March 14, 1932

Age 77

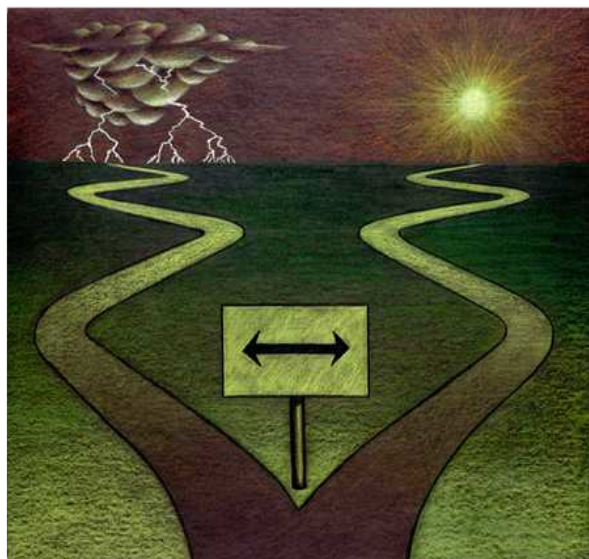


Developmental Trajectories: *Risk & Resilience*

Suicide in late-life is not an expected or “normal” response to the stresses of aging

• Risk

- psychiatric illness
- social disconnectedness
- functional impairment
- physical illness
- pain



• Resiliency

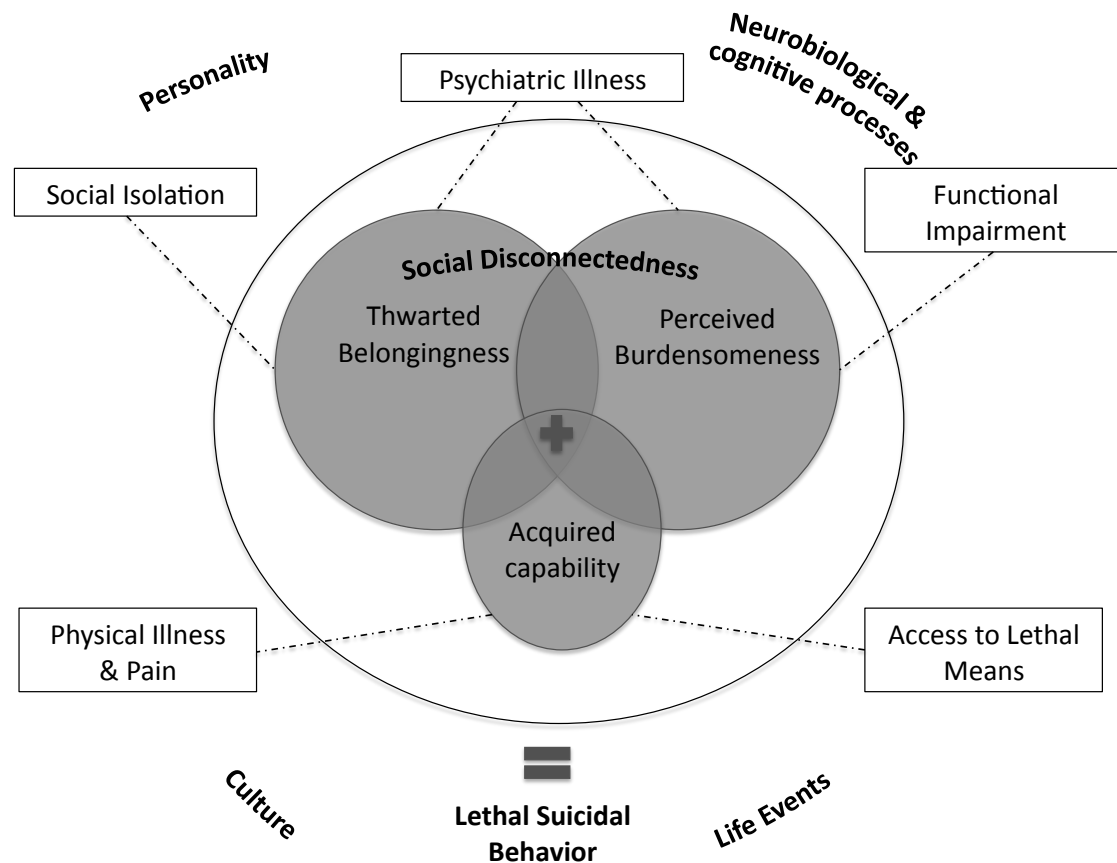
- Positive emotions
- Emotion regulation
- Closeness in relationships

Charles & Carstensen (2010) ;
Gatz et al. 1996

RISK FACTORS FOR SUICIDE AMONG OLDER ADULTS

- Depression – major depression, other
- Prior suicide attempts
- Co-morbid general medical conditions
- Often with pain and role function decline
- Social dependency or isolation
- Family discord, losses
- Personality inflexibility, rigid coping
- Access to lethal means

Hypotheses: *The theory applied to Older Adults*



Extended Case example

“Aaron” is a 68-year old divorced, white male, who lives with an opposite sex roommate in his home in a suburb of a mid-sized city. He was referred to a geriatric mental health outpatient clinic for psychotherapy after an inpatient hospitalization for suicide ideation with a plan to shoot himself with a pistol. The psychiatrist on the inpatient unit noted that the patient’s depressed mood and acute anxiety appeared to be caused by both recent and chronic psychosocial stressors, including conflicts with his adult sons and grief over the loss of his parents. For these reasons, and the fact that Thomas’ mood improved rapidly while on the unit, the psychiatrist did not initiate psychotropic medications during the inpatient stay. At his first appointment at the outpatient clinic, the social worker completing the intake referred him for IPT, which was conducted with the first author. Thomas agreed to an evaluation for the suitability of IPT and agreed to the time-limited nature of the treatment.

Extended Case example

The DSM-IV diagnoses most appropriate to Aaron's presentation at the start of outpatient therapy were Depressive Disorder Not-Otherwise-Specified (with criteria met for Minor Depression) and Anxiety Disorder Not-Otherwise-Specified (with some criteria met for Generalized Anxiety Disorder).

Regarding standardized assessment measures, at the first evaluation session, the IPT therapist administered the Patient Health Questionnaire-9 (PHQ-9; Kroenke, Spitzer, & Williams, 2001) and GAD-7 (Spitzer, Kroenke, Williams, & Lowe, 2006); Thomas' score on the PHQ-9 was a two, and he endorsed depressed mood and feeling bad about himself over the previous two weeks. Similar to his score on the PHQ-9, Thomas' score on the GAD-7 at intake was a 5. For both scales, the therapist hypothesized that the scores underestimated Aaron's degree of symptomatology.

Extended Case example

Aaron described his reason for seeking therapy as the presence of overwhelming stress in his life. He described conflicts between himself and his adult sons in the month prior to the psychiatric inpatient stay; he found the disputes devastating because of his intense desire for a close-knit family. He also stated that both of his parents died in the previous year, and that the stress with his sons had kept him from grieving the loss of his parents. He indicated the presence of depressed mood beginning after the death of his mother, as well as difficulty falling asleep, mild decrease in energy, and decreased appetite, all of which improved during inpatient hospitalization. Aaron noted that two weeks prior to the ED visit, his sons stopped speaking to each other – a stressor that Thomas described as the straw that broke the camel’s back.

Extended Case example

Aaron was an only child who grew up on his parents' small farm. He recalled living far away from other children and that he spent most of his childhood with his parents and their friends or playing by himself. He reported great pride in his career as a state trooper and on-going involvement in a state trooper association after his retirement 15 years prior. He divorced after 20 years of marriage shortly after he retired. Aaron stated that the reason for the divorce was the couple's decision to move to a southern state after his retirement – a decision that his wife was happy about and he was not. Aaron reported that he was treated for depression with fluoxetine after the move south. Aaron stated that the move drove them apart, and eventually, he moved back north and the couple divorced. He described their ongoing relationship as amicable and respectful, noting that they spoke regularly about their concerns regarding one of their sons who had a chronic medical illness.

Extended Case example

In the second evaluation session, Aaron completed the Interpersonal Needs Questionnaire, a self-report instrument designed to measure the key constructs of the Interpersonal Theory of Suicide (Van Orden et al., 2010)—thwarted belongingness and perceived burdensomeness. Thomas endorsed feeling “disconnected from others” and “lonely” as “somewhat true for me” on the scale. When the therapist asked Aaron to think back to how he was thinking and feeling the day he went to the hospital, Thomas endorsed two items assessing perceived burdensomeness as “very true for me” — “the people in my life would be better off if I were gone” and “I make things worse for the people in my life.” Thomas stated that his duty as a father was to keep a tight knit family and that when his sons stopped speaking he felt like they would be better off without him.

Extended Case example

Another key assessment area within the Interpersonal Theory of Suicide is the degree to which an individual may possess the acquired capability for suicide. Given Aaron's familiarity with and fondness for guns, as well as the presence of several guns with ammunition in his home, the therapist hypothesized that Aaron had an elevated level of acquired capability, which therefore would need to be addressed clinically.

Extended Case example: risk level

- When presented to ED:
 - Current suicidal ideation (desire/ideation or resolved plans)?
 - Acquired capability?
 - Thwarted belong/burden?
 - Other risk factors?
- What level?
 - I (retrospectively) rated him as HIGH (SEVERE)

Extended Case example: risk level

- When presented for therapy:
 - Current suicidal ideation (desire/ideation or resolved plans)?
 - Acquired capability?
 - Thwarted belong/burden?
 - Other risk factors?
- What level?
 - I rated him as MODERATE, and noted that regular assessments were essential as his risk could elevate if stressors increased.

Your patients

- Take 5 minutes and think about your caseload.
 - Briefly describe the presentation of a patient who is (or has been):
 - Low risk
 - Moderate risk
 - High risk
 - What did you do to manage risk?
-

VIP mnemonic

- V is for voluntary hospitalization – mention it.
- I is for intensify treatment – more frequent, additional treatments, etc.
- P is for phone check-ins.

No Suicide Contracts

- What about no suicide contracts? Agreement to follow “coping card” may be better, because it tells people what to do instead of what not to do.
- In one study, 41% of clinicians using contracts had patients die by suicide or severely attempt while on contract (Kroll, 2000, Am. J. Psychiat.).

I, _____, agree to make a commitment to the treatment process.
I understand that this means that I have agreed to be actively involved in all aspects of treatment, including

- attending sessions (or letting my therapist know when I can't make it);
- setting goals;
- voicing my opinions, thoughts, and feelings honestly and openly with my therapist (whether they are negative or positive, but most important, my negative feelings);
- being actively involved during sessions;
- completing homework assignments;
- experimenting with new behaviors and new ways of doing things; and
- implementing my crisis response plan when needed.

I also understand and acknowledge that to a large degree a successful treatment outcome depends on the amount of energy and effort I make. If I feel like treatment is not working, I agree to discuss it with my therapist and to attempt to come to a common understanding as to what the problems are and to identify potential solutions. In short, I agree to make a commitment to living.

Signed: _____

Date: _____

Witness: _____

*Figure 3.1. Commitment-to-treatment statement. From *Treating Suicidal Behavior: An Effective, Time-Limited Approach*, by M. D. Rudd, T. E. Joiner Jr., and M. H. Rajab, 2001, p. 180. New York: Guilford Press. Copyright 2001 by The Guilford Press. Reprinted with permission.*

Commitment to Treatment Contract

Recommendations for Documentation

□ Document:

- That you conducted a proper risk assessment
- Risk category
- Actions taken to prevent suicide based upon risk



Prevention/Treatment Implications

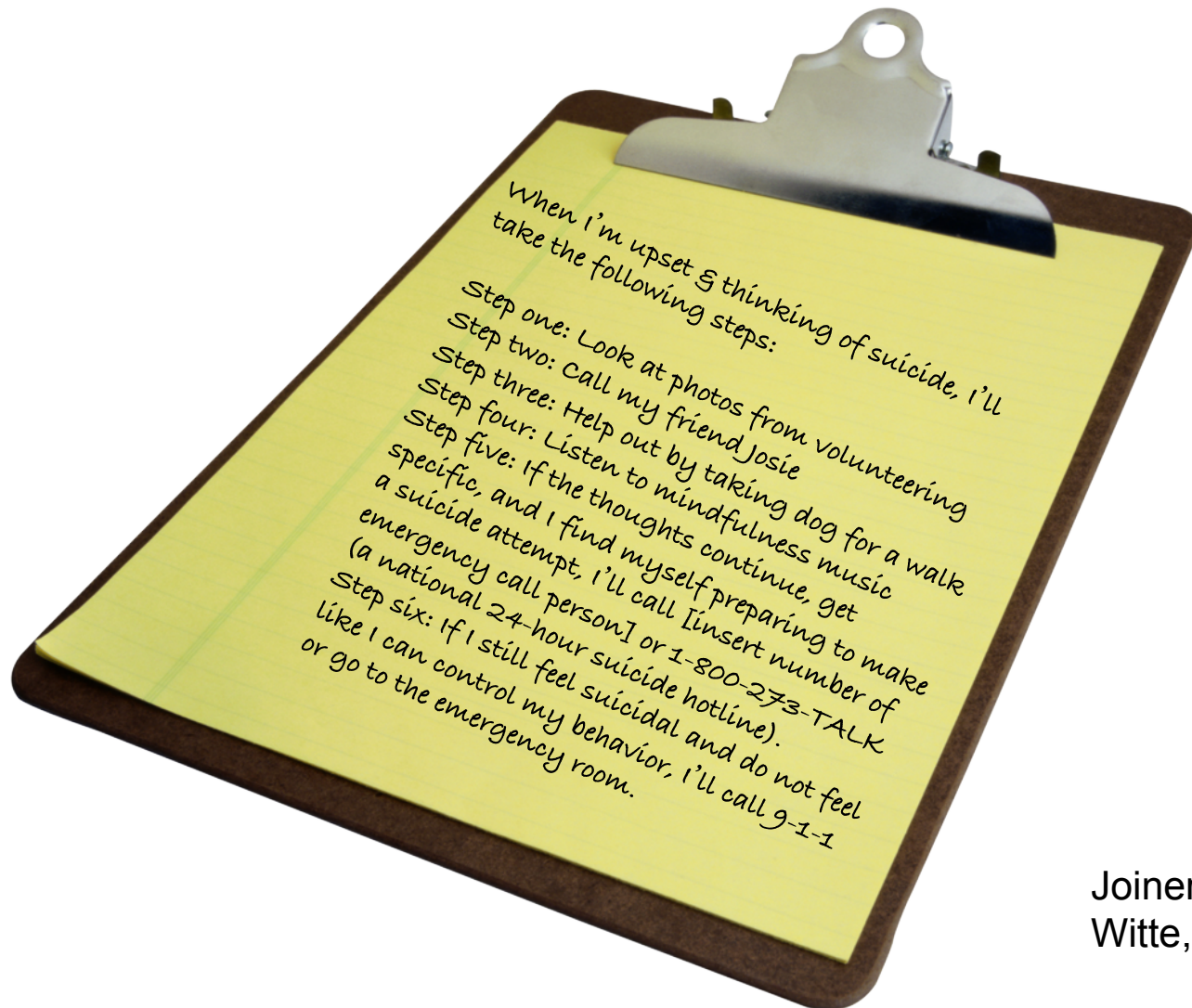
- The model's logic is that prevention of “acquired ability” OR of “burdensomeness” OR of “thwarted belongingness” will prevent serious suicidality.
- Belongingness may be the most malleable and most powerful.

Theory-informed Crisis Intervention & Risk Management

Taking Action to Address Risk

Coping card

Increase connections & contributions



Joiner, Van Orden,
Witte, & Rudd (2009)

Symptom Matching Hierarchy

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, limit 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; Marra, 2004, pp. 150–154)
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 in an engrossing activity (e.g., work a crossword puzzle)

Using the theory clinically

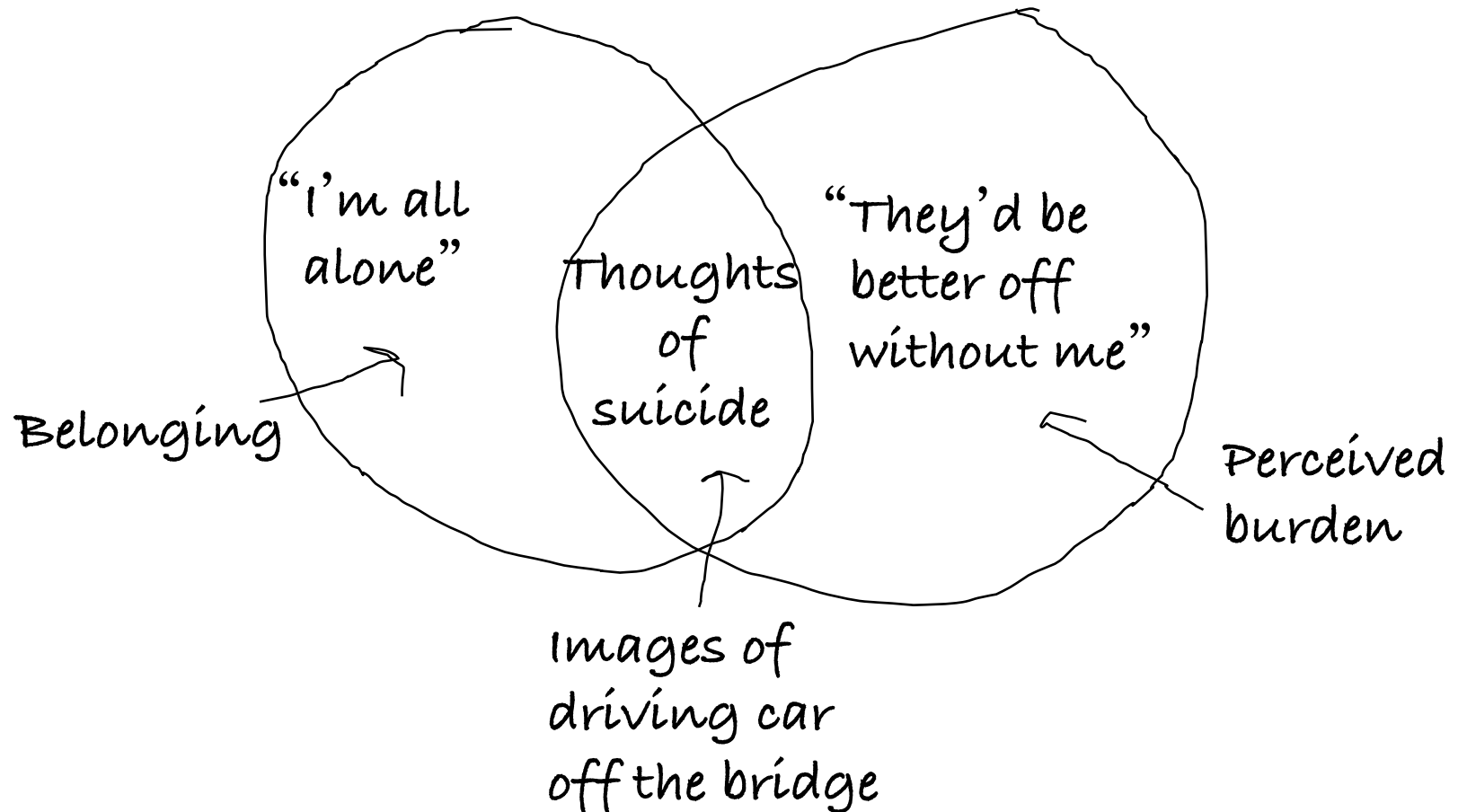
Initial formulation

"After talking with you today, I believe I have a better sense of what you're going through. You've experienced a lot of turmoil lately in relationships, and this has left you feeling lonely, like you don't belong and that you don't have a contribution to make, but instead that you're a burden on others.

These are painful feelings. Feeling like you don't belong and that you're a burden often go hand in hand with thinking about suicide, not just for you, but for other people too. This means you and I will need to keep an eye out for these feelings.

Using the theory clinically

Psychoeducation



Using the theory clinically

Initial formulation

The treatment I'm proposing will involve you and I questioning some of the thoughts you have that you don't belong or that you have little to contribute; we'll examine these thoughts in light of the objective evidence, and decide together whether they are accurate. The treatment will also involve examining and changing behaviors that lead you to feel ineffective and that you don't belong.

Overall, this approach tends to work for people who are thinking about suicide, and it will take regular effort on both of our parts. We're in this together, and if we both try very hard, positive changes and relief are realistic to expect."

Interventions

No current Suicidal ideation

- “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 9-1-1 or go to the emergency room.
- Give emergency numbers, including 1-800-273-TALK
- Continue to monitor risk in subsequent sessions
- Document activities in progress notes

Low/mild risk but current SI

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

Moderate risk

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

High risk

- Consult with a supervisor if you are a trainee or with a colleague if you are not a trainee
- Consider emergency mental health options & mention voluntary hospitalization to pt
- If imminent risk, client should be accompanied and monitored at all times
- If hospitalization is not warranted, use suggestions from “moderate” category
- Document all activities in progress notes (including documentation that hospitalization was at least considered)

TREATMENT OF SUICIDAL IDEATION AND BEHAVIORS

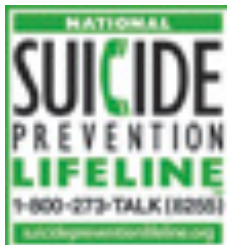
Pulling It All Together

- If suicidality is primary, essentially regardless of what's going on on Axes I/II,
 - then a treatment focused on suicidality is indicated, for the simple reasons of decreasing dangerousness, and the fact that progress with regard to suicidality (e.g., using problem-solving, emotion regulation, cognitive restructuring) is very likely to benefit whatever else is going on diagnostically (e.g., mood or anxiety disorder; personality disorder).

Targets in Treatment

- Thwarted belonging → Increase belonging
- Perceived burden → Increase a sense of contributing
- The first two are more malleable, however important to block acquired capability
 - Model & teach planfulness (block impulsivity, & further habituation)

Positive social connections can save lives!



1-800-273-TALK (8255)
suicidepreventionlifeline.org

Dialectical Behavior Therapy (DBT)

RCT's of DBT w/an effect on
suicide attempts:

- Koons et al. (2001)
- Linehan et al. (1991)
- Linehan et al. (1993)
- Linehan et al. (2006)
- Verheul et al. (2003)

What is DBT?

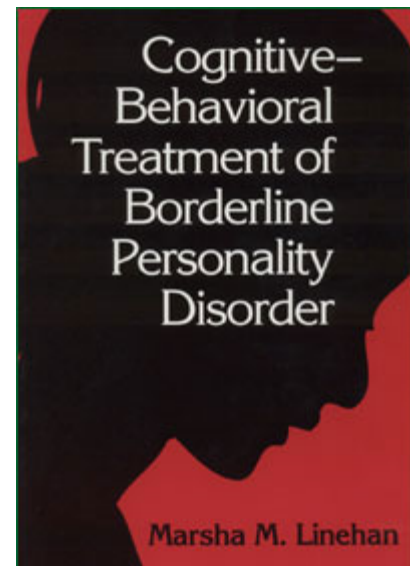
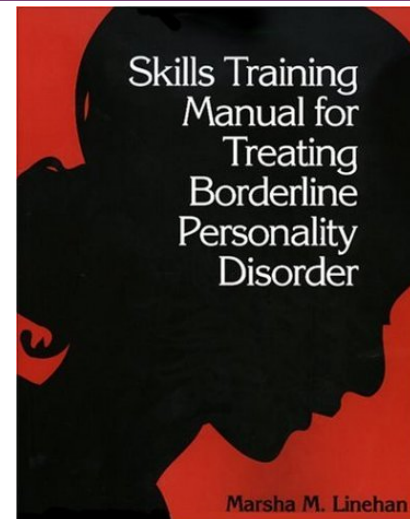
- A treatment that reduces suicide attempt rates by 50% as compared to treatment by nonbehavioral experts (Linehan et al., 2006, *Arch Gen Psychiatry*;63:757-766)
 - Reduces hospitalization for suicide ideation
 - Reduces ED visits
 - Less likely to drop out of treatment
- A cognitive-behavioral therapy designed to treat emotion regulation difficulties & suicidal behavior.
 - Effective for Borderline Personality Disorder
 - Replication—suicide attempts
 - Modification for children (Miller) & older adults (Lynch)



What is DBT?

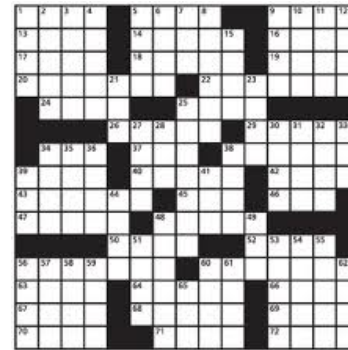
“DBT is JAZZ” –Alec Miller, PsyD

- Individual Therapy:
motivation to live & use skills
- Skills Group: block impulsivity
 - Mindfulness
 - Interpersonal Effectiveness Skills
 - Emotion Regulation
 - Distress Tolerance
- Consultation Team:
belongingness for therapists
- Skills Coaching via Telephone:
competence & belonging for pt's



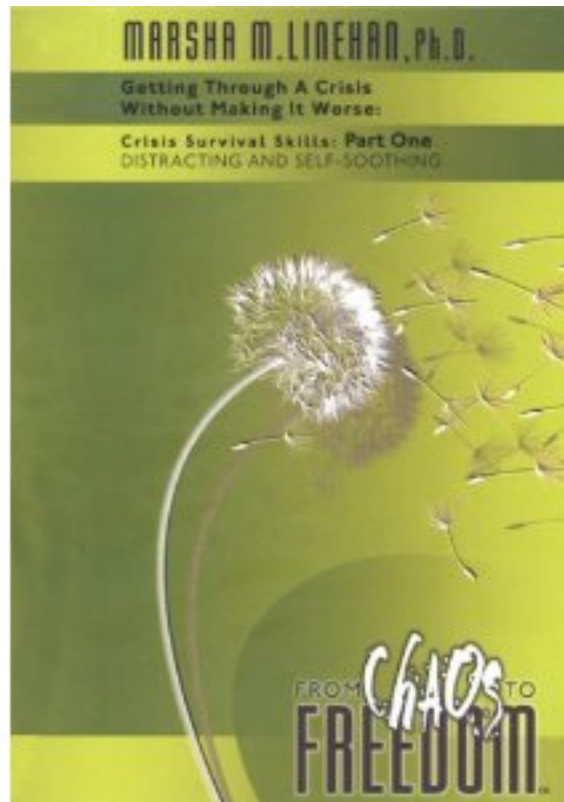
Crisis Survival Strategies: DISTRACT

- Activities
- Contributing
- Comparisons
- opposite Emotions
- Pushing away
- other Thoughts
- intense other Sensations



Crisis Survival Strategies: Rationale

- Getting through a crisis without making it worse



Crisis Survival Strategies: SELF-SOOTHE

- Vision
- Hearing
- Smell
- Taste
- Touch



Crisis Survival Strategies:

PROS of TOLERATING DISTRESS

- Feeling proud
- Not hurting others emotionally
- Building up confidence
- Not missing out on future joy



Problem Solving Therapy

RCT's of PST w/an effect on suicide attempts:

- Rudd, Rajab et al.(1993);
- Salkovskis, Atha, & Storer (1990)

Hawton et al. meta-analysis:

- Depression
- Hopelessness
- Life problems

Problem Solving Therapy (PST)

- Two “strands”:
 - Nezu & colleagues (for mental health clinics)
 - Arean & Hegel & colleagues (Primary care, older adults)
- Resources:
 - IMPACT
 - Thomas book

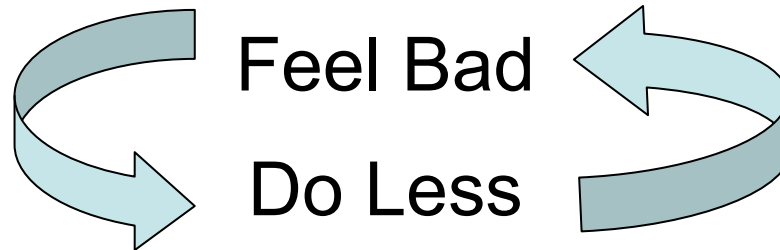
Quick Reference

The Seven Steps of Problem Solving Treatment (PST)

1. Define and Break Down the Problem
 - *a clear and specific description of the problem*
2. Establish a Realistic Goal
 - *identify how things will be different once the problem is solved*
 - *state goal in measurable terms*
3. Generate Possible Solutions
 - *think of all possible solutions*
 - *be creative*
4. Evaluate the solutions
 - *advantages/disadvantages; pros/cons*
5. Choose the Best Solution
 - *the solution that is most doable*
 - *the solution that is likely to succeed*
6. Identify the Steps to Implement the Solution
 - *how to put the solution to action?*
 - *How, what, when?*
7. Evaluate the Outcomes
 - *success in carrying out action steps?*
 - *If not, what were the obstacles?*

Ciechanowski et al.
(2004). JAMA, April 7,
2004—Vol 291, No. 13

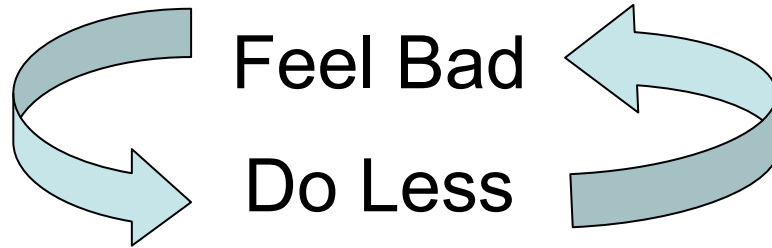
Pleasant Activity



- Depressed people often engage in fewer pleasurable activities than do non-depressed people. Having a lack of pleasurable things to do causes a person to become depressed and because they are depressed, they are less likely to seek out pleasant events.
- Think of something you could do that is pleasurable.
- Commit to doing one of those.
- Put on your PEARLS worksheet.

Ciechanowski et al.
(2004). JAMA, April 7,
2004—Vol 291, No. 13

Social and Physical Activity



- People who are involved in social activities at least two times each week have less depression than those who are not engaged in social activities.
- Engaging in physical activity for 20 minutes a day, 5 times a week, decreases depression and improves health.
- Think of something you can do that is social or physical (exercise or movement of some kind).
- Commit to doing one of these during the upcoming week.
- Put it on your PEARLS worksheet.

Ciechanowski et al.
(2004). JAMA, April 7,
2004—Vol 291, No. 13



PEARLS Worksheet

Progress Review from Last Session:
(use additional sheet if needed)

Participant Name:
Date:
Visit #:

1. Problem:

2. Goal:

3. Possible solutions:	4. Solution Evaluation	
	<i>Advantages</i>	<i>Disadvantages</i>
a.	a.	a.
b.	b.	b.
c.	c.	c.
d.	d.	d.

5. Solution Choice:

6. Steps to Achieve Solution:

I. _____

II. _____

III. _____

IV. _____

V. _____

VI. _____

Activity Planning

Pleasant:

Physical:

Social:

Target problems that cause low belonging or feelings of burdensomeness. Also, means restriction.

Ciechanowski et al. (2004). JAMA, April 7, 2004—Vol 291, No. 13

Resources

Learning PST

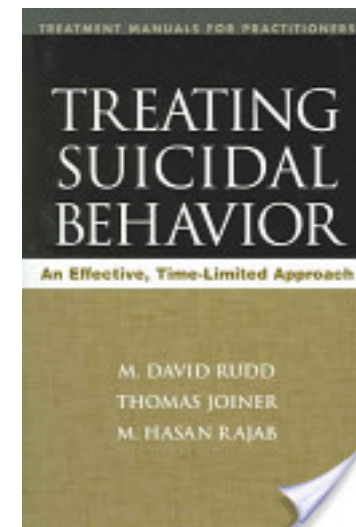
□ PEARLS

- <http://www.pearlsprogram.org/>

□ IMPACT

- <http://impact-uw.org/>

- ### □ Rudd, Joiner, & Rajab (2004). Treating Suicidal Behavior: An Effective Time-Limited Approach.



Cognitive Therapy

RCT's of CT w/an effect
on suicide attempts:

- Brown et al. (2005)

Cognitive Therapy for the Prevention of Suicide Attempts

A Randomized Controlled Trial

Gregory K. Brown, PhD

Thomas Ten Have, PhD

Gregg R. Henriques, PhD

Sharon X. Xie, PhD

Judd E. Hollander, MD

Aaron T. Beck, MD

- Subjects:
 - n=120
 - Age 18 to 66
 - 61% female.
- Results:
 - 50% less likely to re-attempt suicide during f/u (18 mos)
 - No effect on SI
 - Less depression
 - Less hopelessness
- 10 session CT

IN 2002, SUICIDE WAS THE FOURTH leading cause of death for adults between the ages of 18 and 65 years with approximately 25 000 suicides for this age group in the United States.¹ As recommended by the *National Strategy for Suicide Prevention*, one public health approach for the prevention of suicide involves identifying and providing treatment for those individuals who are at high risk for suicide.²

Attempted suicide is one of the strongest risk factors for completed suicide in adults. A meta-analysis of follow-up mortality studies estimated that individuals who attempted suicide were 38 to 40 times more likely to commit suicide than those who had not attempted suicide.³ Prospective research also has supported the validity of attempted suicide as a risk factor for eventual suicide.⁴⁻⁷

Empirical evidence for treatments that effectively prevent repetition of suicide attempts is limited.⁸ Randomized controlled trials of individuals who have attempted suicide have used intensive follow-up treatment or intensive case management,⁹⁻¹¹ interpersonal psy-

Context Suicide attempts constitute a major risk factor for completed suicide, yet few interventions specifically designed to prevent suicide attempts have been evaluated.

Objective To determine the effectiveness of a 10-session cognitive therapy intervention designed to prevent repeat suicide attempts in adults who recently attempted suicide.

Design, Setting, and Participants Randomized controlled trial of adults (N=120) who attempted suicide and were evaluated at a hospital emergency department within 48 hours of the attempt. Potential participants (N=350) were consecutively recruited from October 1999 to September 2002; 66 refused to participate and 164 were ineligible. Participants were followed up for 18 months.

Intervention Cognitive therapy or enhanced usual care with tracking and referral services.

Main Outcome Measures Incidence of repeat suicide attempts and number of days until a repeat suicide attempt. Suicide ideation (dichotomized), hopelessness, and depression severity at 1, 3, 6, 12, and 18 months.

Results From baseline to the 18-month assessment, 13 participants (24.1%) in the cognitive therapy group and 23 participants (41.6%) in the usual care group made at least 1 subsequent suicide attempt (asymptotic z score, 1.97; $P = .049$). Using the Kaplan-Meier method, the estimated 18-month reattempt-free probability in the cognitive therapy group was 0.76 (95% confidence interval [CI], 0.62-0.85) and in the usual care group was 0.58 (95% CI, 0.44-0.70). Participants in the cognitive therapy group had a significantly lower reattempt rate (Wald $\chi^2 = 3.9$; $P = .049$) and were 50% less likely to reattempt suicide than participants in the usual care group (hazard ratio, 0.51; 95% CI, 0.26-0.997). The severity of self-reported depression was significantly lower for the cognitive therapy group than for the usual care group at 6 months ($P = .02$), 12 months ($P = .009$), and 18 months ($P = .046$). The cognitive therapy group reported significantly less hopelessness than the usual care group at 6 months ($P = .045$). There were no significant differences between groups based on rates of suicide ideation at any assessment point.

Conclusion Cognitive therapy was effective in preventing suicide attempts for adults who recently attempted suicide.

JAMA. 2005;294:563-570

www.jama.com

chotherapy,¹² or cognitive behavior therapy.¹³ Several studies supporting the efficacy of cognitive behavior therapy or problem-solving therapy for reducing suicide behavior^{13,14} have highlighted the need for randomized controlled trials with sufficient power to detect treatment differences.¹⁵

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Corresponding Author: Gregory K. Brown, PhD, Department of Psychiatry, University of Pennsylvania, 3535 Market St, Room 2030, Philadelphia, PA 19104 (gregbrow@mail.med.upenn.edu).

For editorial comment see p 623.

Self-Control Regulation Interpersonal Psychotherapy (SCRIPT)

Self-Control Regulation Interpersonal Psychotherapy: A SCRIPT for Beginning Therapists in the Treatment of Borderline Personality Disorder

Kimberly A. Van Orden, Kathryn H. Gordon,
Carla Counts-Allan, Lisa M. James, Kelly M. Caron,
and Thomas E. Joiner, Jr.
Florida State University

The efficacy of Dialectical Behavior Therapy (DBT; Linehan, 1993a) in the treatment of borderline personality disorder has been well established. A modification of the standard DBT protocol is presented, tailored to meet the unique constraints of an outpatient community mental health clinic training clinic. The program involved participation in two treatment modalities: weekly individual therapy (50 minutes) with a trainee therapist utilizing Self-Control Regulation Interpersonal Psychotherapy (SCRIPT; Cukrowicz & Joiner, 2005) and a weekly DBT skills training group (2 hours per week). Rationale for the modifications includes the hypothesized ease of trainability for the techniques of SCRIPT compared to individual DBT. In the current treatment program, the cornerstone of SCRIPT, situational analysis, is implemented (instead of chain and solution analyses used in the standard DBT protocol) as a means of skill acquisition and generalization. Patients completed treatment components for 1.5 years. Results indicate a 24-point global assessment of functioning increase for Patient 1, a 15-point increase for Patient 2, and a 30-point increase for Patient 3. These data support the feasibility and potential effectiveness of this DBT modification for graduate student training clinics.

The efficacy of Dialectical Behavior Therapy (DBT; Linehan, 1993a) in the treatment of borderline personality disorder has been well established through a series of six randomized-controlled trials (RCTs; Linehan, Armstrong, Suarez, Allmon, & Heard, 1991; Linehan et al., 2006; Linehan et al., 2002, Linehan et al., 1999; Koons et al., 2001; Verheul et al., 2003). These studies investigated the efficacy of DBT as described by the treatment manuals (Linehan, 1993a, 1993b). This treatment, which

Cognitive Behavioral Analysis System of Psychotherapy (CBASP)

- ASSUMPTION: Not getting what we want in interactions with other people leads to depression & interpersonal problems.
- Situational Analysis
 - Focusing on the veracity of thoughts may not be necessary, rather, focus on whether thoughts/behaviors are HELPFUL or HURTFUL in terms of clients getting what they want.
 - Target problems of belonging and burden for suicidal clients
- http://www.psychotherapybrownbag.com/psychotherapy_brown_bag_a/2009/04/cbasp-how-to-treat-chronic-depression.html

SCRIPT/ SCRIPT-BPD

- Tailoring the treatment to fit the therapist population
 - A “simple” treatment for “complex” problems
- Core techniques:
 - Situational analysis from CBASP
 - McCullough, J. P. (2000). *Treatment for chronic depression: Cognitive Behavioral Analysis System of Psychotherapy (CBASP)*. New York: Guilford.
 - Motivational Interviewing & principles of Self-Determination Theory
 - (If needed): DBT skills

Principles of SCRIPT

1. Interpersonal Problems are a central target
 - Core feature of PD's & suicide risk
 - Situational Analysis & DBT Interpersonal Effectiveness Skills
2. Motivation for Treatment is a central target
 - Self-Determination Theory (Ryan & Deci, 2000) integrated with techniques of Motivational Interviewing (Sheldon, Williams, & Joiner, 2003)
3. Increasing self-control is a central target
 - Basic social psychology research on motivation (Baumeister et al), self control muscle

Situational Analysis vs. Chain analysis

Situational Analysis

- Linchpin is the client's goal
- Not in chronological order
- Elicitation & remediation phase

Chain Analysis

- DETAILS
- Chronological order
- Linchpin is behavior/ thought functionally related to problematic behavior
- Followed by Solution Analysis

Situational Analysis – Step One

1. Situation
2. Interpretation of the situation (what did you think?)
3. Behaviors (what did you do?)
4. Desired outcome - What did you want to happen in this situation?
5. Actual outcome - What actually happened?
6. Does your DO = AO?

Situational Analysis – Step Two

1. Did your thought, _____ help or hurt you in getting your desired outcome of _____?
2. Did your behavior _____ help or hurt you in getting your desired outcome of _____?
3. How could you talk back to your thought or change your behavior so that you would be more likely to get your DO of _____?
4. If nothing will increase the likelihood of getting the DO, it might be an unattainable DO.

Role Play of Situational Analysis

A situation in which a client became suicidal or engaged in suicidal behavior. What was happening in the hours/minutes before?

I will be the therapist the first time around. Then break into pairs and try out Situational Analysis and I'll walk around if you have questions.

THERAPEUTIC STANCE/PROCESS

Foster connection & competence

Foster connection & competence

- Terri Wise video:
- <http://www.youtube.com/watch?v=rIXRavVgxJY>

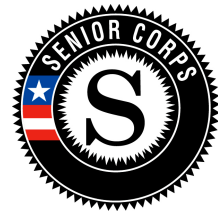
PREVENTION

Strengthening Belongingness

- New CDC vision: Promote connectedness
 - The degree to which a person or group is socially close, interrelated, or shares resources with other persons or groups
 - Between individuals
 - Between individuals/families and community organizations
 - Among community organizations and social institutions

The Senior Connection

A Randomized Trial of Companionship



Randomized controlled Trial

- CDC: promotion and strengthening of connectedness at personal, family, and community levels.
- Our goal:
 - to reduce late life suicide-related morbidity and mortality
 - leveraging the resources and expertise of the aging services provider network (ASPN)
 - address unmet social needs of community-dwelling older adults.
- Intervention conditions:
 - peer companionship intervention
 - vs. CAU in primary care.

Senior Corps Peer Companions



**WHY
PEOPLE
DIE
BY
SUICIDE**

Thomas Joiner



**THE INTERPERSONAL
THEORY OF SUICIDE**
GUIDANCE FOR WORKING
WITH SUICIDAL CLIENTS

Thomas E. Joiner Jr., Kimberly A. Van Orden,
Tracy K. Witte, and M. David Rudd

Thank you for your attention!

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