Implementation Manual

The Interpersonal Theory of Suicide

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Section 1

Why the Interpersonal Theory of Suicide Should Be the Foundation of Your Suicide Risk Assessment, Treatment and Prevention Efforts

"In science, including psychology, a theory is a principle or idea that explains or solves a problem." The Interpersonal Theory does just that.

- There is significant empirical support for the Theory and it is consistent with the evidence. Chu et al. meta-analysis (2017), Psychological Bulletin.
- It is widely accepted as clinically useful. For example, it is the basis for the Suicide Prevention Lifeline, 988, protocol and training.
- The Theory explains things that could not be explained before it was articulated. For example, before the Theory there was no reasonable explanation for a reduction in suicide rates after 9/11 or during the recent pandemic. However, the Interpersonal Theory explains that people rally together during times of crisis, thus reducing feelings of failed belongingness and, in turn, the suicide rate.
- The Theory is useful because it considers the diversities of people who differ diagnostically and culturally while also pointing to the regularities in the mindsets of people in suicidal crisis. The Theory points to three regularities in particular: (1) perceived burdensomeness (the misperception that your death is worth more to others than your life), (2) thwarted belongingness (loneliness and social disconnection) and (3) capacity (which facilitates those thinking about suicide to act on their suicidal desire). Joiner points out, "…I am prepared to defend the view that 100% of suicides are characterized by the combination of learned fearlessness, perceived burdensomeness, and profound alienation from others…" Joiner, *Myths about Suicide*, Harvard University Press, 2010, p.193.
- The practical application of other risk assessment procedures can result in some clinicians asking a patient only about suicidal thoughts, while whether a patient admits to thoughts is not a good predictor of suicide attempts and deaths.
- A risk assessment based on the Theory includes inquiring about danger signs of imminent risk. "….it is imperative to assess acute and objective risk factors, which are time-limited and associated with an increased risk for suicide over

a period of hours to days, not months or years." Chu et.al. *Routinized assessment of suicide risk in clinical practice: an empirically informed update*, Journal of Clinical Psychology, 71 (12), 1186-1200.

- The Theory points to critical areas of focus during treatment.
- The Theory helps clinicians know when to intervene.
- Resources based on the Theory include clear guidelines for managing suicidal symptoms based on the determined level of suicide risk. Chu et.al. *Routinized assessment of suicide risk in clinical practice: an empirically informed update*, Journal of Clinical Psychology, 71 (12), 1186-1200.
- Despite significant effort by the behavioral healthcare industry, suicide deaths in the United States keep increasing from one year to the next.

Section 2

Implementation Procedure Checklist

The process of integrating the Interpersonal Theory of Suicide into your organization for suicide risk assessment and treatment purposes likely will require a number of steps. We suggest the following checklist of steps for your consideration and adaptation as appropriate for your staff.

- Establish a clinical committee to analyze the Interpersonal Theory by reviewing Dr. Joiner's videos and documents on the suicideprevention.MHRRG.com website. Following review of the materials, the committee could make recommendations to an executive management team concerning the best approach for integrating the Interpersonal Theory into the organization.
- The executive management team could review the clinical committee's recommendations, make changes as appropriate and schedule and supervise an implementation procedure.
- Decide the sequence for implementing the Theory by department.
- Train staff by having them review the videos and materials on the suicideprevention.MHRRG.com website. A template for creating a Relias course is available on the website.
- Incorporate into your electronic health record the risk assessment form, decision tree, and risk categories guidance documents, which are all downloadable from the suicide prevention website. The self-report measures on the site are intended to be completed by the client and can be scanned into the electronic health record when completed.
- If your organization is required by regulators or contract to use the Columbia Scale, we suggest adding to your electronic health record the questions in the risk assessment form which are not in the Columbia Scale. All of the questions in the Columbia six-question screening version are in the Interpersonal Theory risk assessment form.

Section 3

Summary of Videos -

Why People Die by Suicide
The Interpersonal Theory of Suicide

Suicide is a profound human tragedy. The more we can understand it, the more likely we are to prevent it.

Suicide in America

For at least the last two decades, suicide deaths in the United States have increased relentlessly despite significant effort by the behavioral healthcare community. In 2022, the CDC estimates that more than 49,000 people died by suicide in the United States. Internationally, however, there have been decreases in suicide deaths over the same two decades.

A culture of violence

There is something exceptional about the American experience. There is a dark side to American culture. Rugged individualism, which has generally served us well, is a part of the American culture.

However, sometimes being rugged can go too far and become brutal. Individualism can be exaggerated, resulting in alienation and isolation.

We have a culture of violence both in our media and in real life. Since the late 1970s, there has been a significant increase in brutal violence in the United States media, movies, and gaming.

Historically, the suicide rate has always been higher in older (60 to 65+) people. The generation which was in adolescence (born around 1965- ages 15, 18, 20) in the late 70s, when violence increased in the culture, has become the only American generation to exceed the older generation in suicide death rates.

The American relationship to violence is apparent in multiple ways, including suicide.

In 2018, there were more than 48,000 suicide deaths in the United States, which was a new high. In 2022, there was another increase to more than 49,000 suicide deaths.

A characteristic of suicide

Suicide is the only act involving both dying and killing a person, each of which we are deeply afraid of. We fear both death and killing. Even soldiers trained to kill, fear killing.

Suicide is a person causing harm (sometimes violent harm) to the same person, rather than another person. Matters bearing on violence and harm will influence suicide.

Harm of any sort is relevant to suicide. Accidental opioid deaths in the United States are a form of harm. The opioid addicted lifestyle inherently includes harm, sometimes perpetrating or being victimized by crime. Accidental opioid deaths are far more frequent in the United States than other countries. Similarly, homicide deaths in the United States far exceed other countries.

The pandemic and suicide deaths

In 2019, for the first time since the early 2000's, there was a dip in the U.S. suicide rate to the 47,000s. In 2020, during the global pandemic, risk factors for suicide increased, including stress, depression, anxiety, worry, loneliness, and isolation.

However, the increase in risk factors did not translate into increased suicide death rates. In 2020, there was another decrease in suicide deaths, by almost 1,000.

What explains the decrease in deaths combined with an increase in risk factors? Any disaster, such as the pandemic and the September 11 attack against the United States, results in people rallying together. That, in turn, causes the suicide rate to decrease. When people feel connected and cared for, suicide rates go down. On the other hand, when rates of loneliness, alienation and ostracism increase, the suicide rates also increase.

For many people, the pandemic increased connection and caring for others, and thus drove down suicide rates. Further, fear of death, which makes suicide very difficult to enact, is exacerbated during a disaster, while at the same time our embrace of life and health increases.

The demographics of suicide

Suicide deaths cluster in the older generation, 50+ 60+, while suicide deaths of younger people, teenagers and those in their early 20s, are historically lower.

Men have far more suicide deaths than women, at a rate of 3.5 to 1. About 80% of all suicides are in men.

In the United States, the highest suicide rates are in Native Americans and Alaskan native people, followed by white people. Other ethnicities, Black people and Hispanic people, have significantly lower suicide death rates.

Knowing these demographic factors is informative but not clinically helpful because they are not changeable. Clinically, we should focus on factors that are changeable, such as isolation and perceived burdensomeness.

Commonalities of the suicidal mind

Suicidal clients are likely to be lonely and emotionally distant. Their physical appearance may be indicative of something weighing on their mind. A behavioral sign for a clinician to look for is the "thousand-yard stare," which usually occurs when people are contemplating suicide in the near term.

Suicidal people feel hopeless, lonely, sad, and resigned. They feel that they don't belong and are alienated from others, even when physically present with others. Loneliness is a subjective state which does not depend on the number of people around.

Ambivalence is also an important feature of the suicidal mindset. There is an intense push and pull between wanting to die and wanting to live. Even in people who desperately want to die by suicide, there is evidence that they experience the push and pull between life and death. For example, the few people who have survived a jump from the Golden Gate Bridge often describe changing their minds in midair. Even people who can resolve ambivalence about murder, find that it is more difficult to resolve their ambivalence about suicide.

People determined to die by suicide realize how daunting a prospect it is and understand that they need to have a clear mind to enact suicide. For example, even committed drinkers stop drinking in the hours or days before suicide.

Suicidal people can appear very unemotional, with a flat affect, which contrasts with the monumental and violent actions they are considering.

And, at the same time they appear unemotional, they can be aroused physically, with a very low or nonexistent blink rate. The average human blink rate is once every three or four seconds, 10 times over 30 seconds. People contemplating

suicide may not blink at all in 30 seconds. Physical arousal tends to decrease blink rate. For example, we would expect a lower blink rate in people preparing to participate in a boxing match or to act in the theater. People anticipating violence to others or to themselves are physically aroused with a real concentration of thought on their death.

The Final Months

Psychological autopsies can reveal aspects of the suicidal mind and suicide warning signs. Despite significant diversities from one person to the next, there are clear commonalities, regularities, of the suicidal mind including: agitation, pacing (while at the same time sitting motionless for prolonged periods), diminished speech, unhealthy weight loss, insomnia, and a feeling that the person is a burden on others.

Paradoxically, a suicidal person can exhibit both arousal and shutdown parameters at the same time. Shut down parameters include not moving for prolonged periods, diminished speech, reduced eating, and cessation of alcohol intake.

The suicidal mindset is miserable and anguished. People stop eating and engaging in nurturing, life-giving activities. They withdraw from affectionate relationships and often do not talk.

They can reduce their movements, despite being agitated. They may exhibit severe affective states, such as outbursts of rage. Agitation can be manifested in pacing, grimacing, crying and wringing of hands. Phrases such as “I am crawling out of my skin” indicate clinically severe agitation.

Suicidal intent

A resolved intent to die in the near term, the coming days or hours, may be the single most information-rich risk factor. It is clinically useful to ask patients to rate their intent to die by suicide on a 0 to 10 scale. Many patients will likely be surprised and reply, “zero.” This behavioral reaction is informative. People may be quite surprised by the question and respond that they don’t have any intent to die. Another group may also indicate zero intent, but not be surprised, while being more comfortable with the idea of dying.

People may not always be truthful in response to clinical questions. Therefore, it is unwise for a clinician to pay attention to only one risk parameter. Look for other

channels of information. What do the client's family members say about risk factors? Do the family members corroborate what the patient is saying? What are the clinician's behavioral observations? Is the client clear-minded or confused? Is there something about the client's posture or facial expressions that seems concerning?

The nature of a patient's plans for enacting suicide is also information rich. If the patient intends to die, he or she will have a detailed plan. The patient will have decided on a method, a specific place and a specific object, such as a particular firearm, knife, rope or other ligature.

Understanding the suicidal mind- the suicidal mindset

The Interpersonal Theory of Suicide

It is clinically helpful to have a model that captures and formalizes the regularities of the suicidal mind. The Interpersonal Theory of Suicide does just that.

The Theory has been described as the most influential model of suicide since the 1800s. Scientific and practical evidence supports the Interpersonal Theory which is well validated in testing. Further, the Theory has been accepted as being clinically useful as it is the basis of the 988-crisis protocol nationwide.

If it is useful, a theory should explain things that could not be explained before the theory was articulated. For example, before the Interpersonal Theory there was no reasonable explanation for a reduction of suicide rates after 9/11 or during the recent pandemic. However, the Interpersonal Theory explains that people rally together during times of crisis, thus reducing feelings of failed belongingness and, in turn, the suicide rate.

The big questions

Why would someone want the highly undesirable outcome of a suicide death and intend to die? How do some people have the capacity to die by suicide? How are they capable? Why do they have the desire in the first place and who has the capacity to enact the desire?

In real life, people faced with the actual prospect of death by suicide, often flinch. We have an instinct to survive which protects us against danger. We are deeply afraid of death.

According to estimates of general population surveys, 10% or more of the population will experience serious suicidal ideation. In the United States, with a population of 330 million, 33 million people could have serious suicidal ideation. A much lesser number will actually die by suicide. Some people want to die by suicide, but they can't.

On the other hand, some people who do not want to die by suicide have the capacity.

Some occupations are more likely to attract people with capacity, people who are less afraid of harm, danger and death. For example, first responders, law enforcement personnel, firefighters, military personnel, physicians and surgeons.

Some people may be trained to be less afraid of death, such as in the military and medical school. But most individuals who have capacity will have it coming into their occupation.

Capacity is the ability to stare death down, such as running toward a fire. Capacity can be useful, even heroic, except when combined with a desire to die.

The Interpersonal Theory of Suicide is useful because it considers the diversities of people who differ diagnostically and culturally and points to the regularities in the mindsets of people in suicidal crisis. The Theory points to three regularities in particular: (1) perceived burdensomeness (the misperception that your death is worth more to others than your life), (2) thwarted belongingness (loneliness and social disconnection) and (3) capacity (which facilitates those thinking about suicide to act on their suicidal desire).

Suicidal people think that their feelings of burdensomeness and thwarted belongingness are permanent.

Capacity includes fearlessness of physical ordeal and increased tolerance of pain as well as practical ability (such as the ability to operate a firearm). Capacity overcomes our survival instinct. Relatively few people have capacity.

The Interpersonal Theory helps clinicians know when to intervene.

<u>Myths about suicide</u>

It is a myth that suicide is selfish. It can seem selfish from the perspective of the bereaved family member. But the decedent thinks he is doing others a favor because he is a burden.

Suicide is not cowardly. Rather, the decedent must stare down the mortal terror of death.

It is also a myth that most suicide decedents have been abusing alcohol up to the moment of death or are otherwise impaired. Anything that impairs focus makes suicide that much harder.

Clinical tools

The Interpersonal Needs Questionnaire (INQ) is a patient self-report measure for assessing suicidal desire. The INQ focuses on burdensomeness and failed belongingness.

The Acquired Capability for Suicide Scale- Fearlessness about Death (ACSS-FAD) is a patient self-report measure for assessing fearlessness about death.

Both measures have been rigorously and empirically tested.

Feelings of failed belongingness and perceived burdensomeness can be influenced by clinical intervention, but capacity resists change. Part of capacity is genetic. Means safety intervention is especially important as it addresses capacity.

In contrast, even small doses of caring and connection to address failed belongingness and perceived burdensomeness can have outsized positive effects.

Behavioral Activation is a planned approach to encourage patients to engage in activities that create caring and connection.

Psychiatric disorders

The single most lethal psychiatric condition in terms of suicide, along with opioid use disorder, is anorexia nervosa. Anorexia has a high degree of physicality and is, therefore, consistent with the Interpersonal Theory. The experience of the disorder would likely increase pain tolerance and decrease fear of death. Other relevant psychiatric disorders which confer increased risk are the mood disorders (including major depressive disorder and persistent depressive disorder), bipolar disorder, schizophrenia, and borderline personality disorder.

Alcohol

The role of alcohol in suicide is widely misunderstood. The data from meta-analysis demonstrates that at the time of death most suicide decedent's will likely have zero alcohol in their blood. The decedent may nonetheless have a significant history of

alcohol misuse. This is consistent with the Interpersonal Theory as decedents may conclude that alcohol use makes it more difficult to enact suicide.

Many people who attempt suicide can be misusing alcohol. Attempts, of course, are significantly different than death by suicide.

Suicide prevention- practical strategies

The single most important intervention to address capacity is means safety. It is the simple, common-sense idea to put distance and obstacles, both physical and/or psychological, between the at-risk person and the dangerous means or methods.

Means safety is one of the very few things we know that works for sure. For example, placing a firearm at a remove, such as by moving it a physical distance or using a gun lock, can reduce suicide risk.

Means safety myths

Some people believe that it is not realistic to create an effective means safety plan because it is not possible to address ubiquitous means, such as ligatures and overdose agents. However, dangerously suicidal people do not think in the abstract, they think about a specific item as a method. And they focus on this one object.

It is important for clinicians to follow up on means safety plans with the client at every contact.

Behavioral activation

Behavioral activation is an effective tool for reducing suicide risk. It is the determination to build into one's life activities that help to address suicidal feelings. Exercise is an effective antidepressant. For example, walking outside in the sunlight for 30 minutes every other day is one of the most effective treatments for mental health conditions.

Immersion in nature is also an effective way to address depression.

A key aspect of behavioral activation is the regularization and determination to socialize with others.

People may be skeptical about the effectiveness of behavioral activation. But clinicians should suggest to clients to at least try it out.

Treating insomnia

Cognitive Behavioral Therapy for Insomnia (CBTI) includes simple, down-to-earth concepts for addressing insomnia.

Pragmatic ways to address insomnia include:

- Reduce or eliminate caffeine or other stimulant use,
- Restrict activities that stimulate (like exercise) in the evening,
- Maintain a uniform wake up time,
- Do not take naps.
- Stimulus control: train the mind that bed means sleep. All activities that are not sleep, including being awake, should not be in bed. Sexual activity is an exception.
- Decatastrophization: the ordeal of not being able to sleep may feel like a catastrophe. Thinking that not sleeping is a catastrophe interferes with getting to sleep. Not sleeping enough for a night is not a disaster. It can be unpleasant and a major inconvenience, but it is not a catastrophe. Changing thoughts that being awake is a catastrophe will help people settle down to sleep.

Nightmares

Nightmares are an independent risk for suicidality.

For healthy adults, the average number of nightmares per year is 1 or 2. Those at risk for suicide may have nightmares once a week or once a month.

Imagery rehearsal therapy is an effective treatment for nightmares. Most nightmares involve the person being victimized. The therapy is to write out the image of being victimized, revise the image without the victimization and then repeatedly dwell on the new imagery.

Imagery rehearsal therapy is one of the most effective treatments for mental health.

Caring contacts

Humans are very gregarious and social. We need each other. The same brain centers which process physical pain also process ostracization. We are also very sensitive and responsive to expressions of love, care and support.

Studies demonstrate the efficacy for reducing suicide risk of simple caring letters, postcards or other contacts, including email and texts. The contact need not be personalized and can be automated. The contact should also comment on the availability of ongoing mental health care.

Caring contacts are effective because (1) they fill an important human need to feel cared about and (2) remind people about access to mental health care.

Intervention Guidance by Risk Categories

RISK CATEGORIES

LOW:

- A person with no identifiable suicidal symptoms
- A multiple attempter with NO other risk factors OR
- A non-multiple attempter 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

What to do if no current suicidal ideation:

- *Tell the client a variant on 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 9-1-1 or go to the ER."*
- *Give emergency numbers: including 1-800-273-TALK*
- *Continue to monitor risk in subsequent sessions (in case severity changes).*
- *Document activities in progress notes*

What to do if there is current suicidal ideation:

- Give emergency numbers
- Create a coping card (a crisis response plan)
- Symptom-matching hierarchy
- Document activities in progress notes

MODERATE:

- A multiple attempter with any other notable finding OR
- A non-multiple attempter with moderate to severe symptoms of the Resolved Plans and Preparation factor OR
- A non-multiple attempter 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

What to do:

- *Give emergency numbers*
- *Create a coping card (a crisis response plan)*
- *Symptom-matching hierarchy*
- *Consider mid-week phone check-in's*
- *Inform about existence of adjunctive treatments (e.g., medication)*
- *Increase social support:*
  - *Encourage client to seek support from friends/family;*
  - *Plan with client for someone to 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*

[Severe]	HIGH	[Extreme]

- A multiple attempter with <u>any</u> two or more other notable findings, OR
- A non-multiple attempter with moderate to severe symptoms of the Resolved Plans and Preparation factor and at least one other risk factor

- A multiple attempter with severe symptoms of the Resolved Plans and Preparation factor, OR
- A non-multiple attempter with severe symptoms of the Resolved Plans and Preparation factor and two or more other risk factors

What to do:

- *CONSULT a supervisor*
- *Consider emergency mental health options with supervisor*
- *Client should be accompanied and monitored at all times*
- *If hospitalization is not warranted, use steps from "moderate" category*
- *Document activities in progress notes*

Form Provided by Dr. Thomas Joiner, Florida State University, Dept. of Psychology

Section 5

Suicide Risk Assessment Form- Risk Factors

DANGER SIGNS

Talking about Suicide Social withdrawal	Agitation Weight loss	Insomnia Marked Irritability	Nightmares Extreme emotional states (e.g. rage)

Assess Suicidal DESIRE and IDEATION	Assess RESOLVED PLANS and PREPARATIONS	Assess OTHER SIGNIFICANT FINDINGS
• Have you been having thoughts or images of suicide (thoughts of images of killing yourself)? Tell me about that. • Do you think about wanting to be dead? • **THWARTED BELONGINGNESS**: Do you feel connected to other people? Do you live alone? Do you have someone you can call when you are feeling bad? (Are supporting relationships completely absent?) • **PERCEIVED BURDENSOMENESS**: Sometimes people think, "The people in my life would be better off if I were gone." Do you think that?	• **Duration** (look for pre-occupation): When you have these thoughts, how long do they last? • **Intensity**: How strong is your intent to kill yourself? 0 = not intense at all, 10 = very intense. • **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? • **Specified plan** (look for vividness, detail): Do you have a plan for how you would kill yourself? • **Means and opportunity**: Do you have the pills (or a gun, etc.)? Do you think you'll have an opportunity to do this? • Have you made preparations for a suicide attempt (e.g., buying pills) • Do you know when you expect to use your plan? • **Fearlessness**: **Thinking about suicide, do you feel afraid**? 0 = very afraid; 10 = not afraid at all	• **Precipitant Stressors**: Has anything especially stressful happened to you recently? (e.g., death of a loved one, divorce, major break-up, job loss)? • **Hopelessness**: Do you feel hopeless? • **Impulsivity**: When you are feeling badly, how do you cope? Sometimes when people feel badly, 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, or shoplifting)? • **Presence of psychopathology:** (rated by interviewer)

Depressive Symptom Index – Suicidality Subscale

Acquired Capability Scale (ACSS) Interpersonal Needs Questionnaire (INQ)

RISK CATEGORY			
LOW	MODERATE	SEVERE	EXTREME

ACTIONS TAKEN:

- Continue to monitor regularly
- Given Emergency numbers
- Scheduled mid-week phone check-in
- Provided info about adjunctive treatment
- Coping Card/Safety Plan
- Consulted Supervisor
- Other

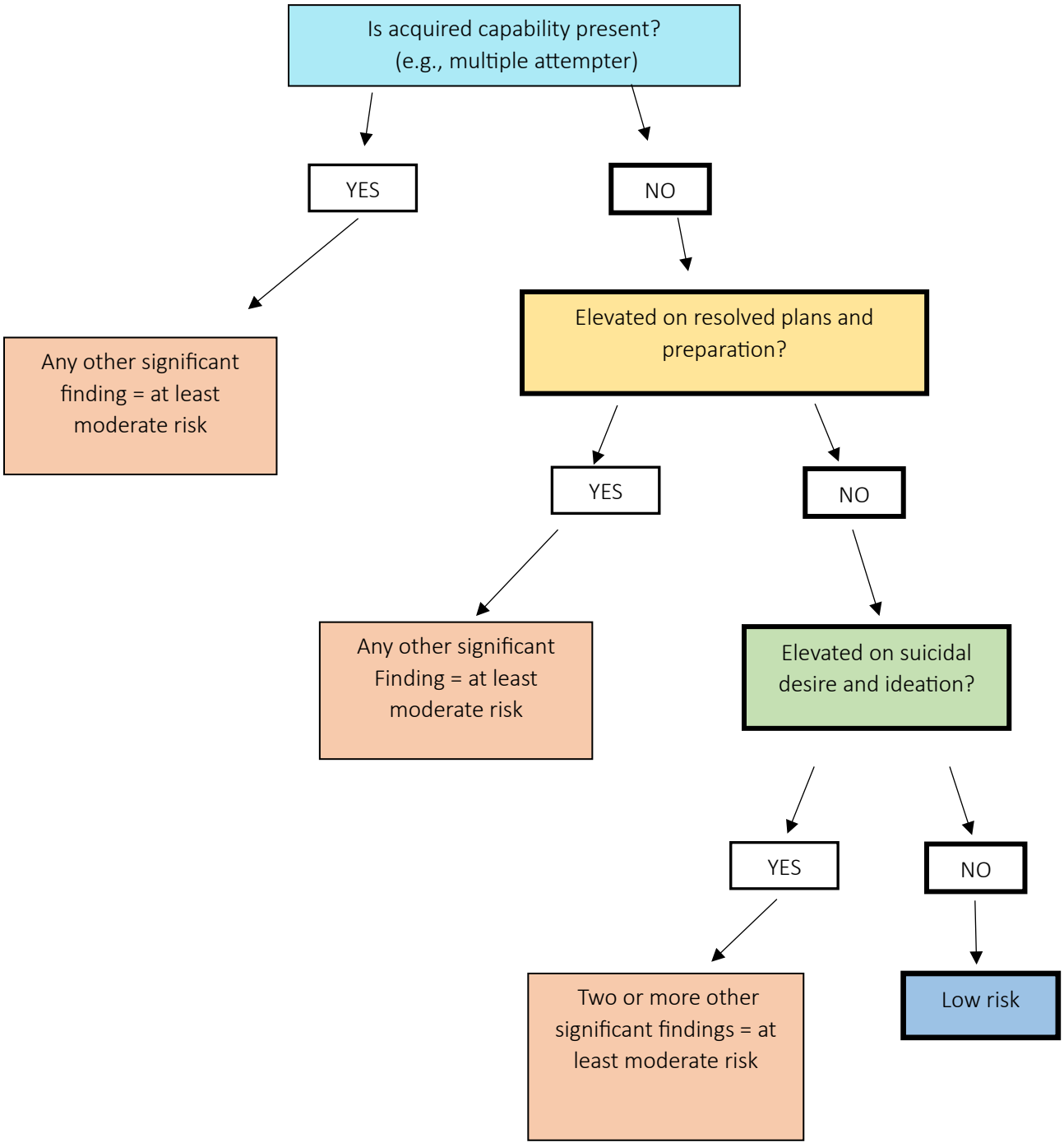
Form Provided by Dr. Thomas Joiner, Florida State University, Dept. of Psychology

Section 5

Suicide Risk Assessment- Decision Tree

DECISION TREE

(Joiner, Walker, Rudd, & Jobes (1999). Scientizing and routinizing the assessment of suicidality in outpatient practice. Professional Psychology: Research and Practice, 30, 1-7)



Section 7

Available & Downloadable Resources

The following documents based on the Interpersonal Theory of Suicide are available for free download from suicideprevention.MHRRG.com:

- risk assessment form
- decision tree
- treatment guidance by risk category
- self-report measure: Interpersonal Needs Questionnaire
- self-report measure: Acquired Capability for Suicide Scale