INTRODUCTION: THE INTERPERSONAL THEORY OF SUICIDE—CONCEPTS AND EVIDENCE

Therapists are often frightened when working with suicidal patients. In fact, a national survey of therapists found that the most frequently reported fear (endorsed by 97% of the sample) was the possibility of a patient dying by suicide (Pope & Tabachnick, 1993). A memoir describing a near-fatal mountaineering accident provides an apt metaphor: Joe Simpson (1988) told the story of how he and his climbing partner, Simon, were tethered together and both near death some 20,000 feet in the air. Simon literally held Joe's life in his hands. Conditions became such that to save his own life, Simon had to cut the ropes, leaving Joe to face almost certain death. Working with suicidal clients can feel like holding the ropes, with the weight of someone's life in one's hands and no way to help. In our view, this need not be the case: Equipping clinicians with knowledge about suicidal behavior can be a powerful tool—a lifesaving tool.

The purpose of this book is to demystify clinical work with suicidal patients by grounding this work within a model of suicidal behavior, the interpersonal theory of suicide (Joiner, 2005). The theory is ambitious in that it attempts a comprehensive and empirically defensible answer to the question, Why do people die by suicide? Initial indications of the theory's attempt to comprehensively answer this question are favorable (described later), but

of course time will tell. This book does not focus on the question of the ultimate scientific fate of the theory; it focuses instead on issues that we argue have been resolved, such as aspects of suicidal behavior that heretofore have not received adequate attention—indeed, in some theories have received no mention whatsoever—and that nonetheless are necessary for a full understanding of the phenomenon. The theory's emphasis of these constructs allows clinical work with suicidal patients a new level of rigor and focus.

In the current book, we illustrate how the theory can be used to improve clinical care for suicidal patients. Our framework places the therapist in a role much like that of a mountaineering guide: A skilled guide knows the terrain; is comfortable handling crises; teaches clients skills to get up the mountain; and most important, places clients' safety as the number one priority. However, guides are not always tethered to their clients. Guides do not assume complete responsibility for their clients' lives, nor do they claim to be able to perfectly predict the weather. Clinical guides working with suicidal patients must be skilled and knowledgeable but not omnipotent. The current book is meant as a "guidebook" of sorts that illustrates how to conduct clinical work with suicidal patients grounded in the interpersonal theory.

In the following sections, we briefly describe the theory, summarize some anecdotal and empirical evidence relevant to the theory, and then foreshadow the book's emphasis on clinical issues by discussing the theory's guidance for some issues regarding the psychotherapy of suicidal behavior.

THE INTERPERSONAL THEORY OF SUICIDE

Why do people die by suicide? Because they can, and because they want to—because they develop both the desire and the capability to do so. This may seem a flip and superficial answer, even a crass one, but if the theory were to be summarized in less than 10 words, this would be a reasonable choice. Of course, 10-word theories are uncommon and usually do not amount to much (although we are impressed with $E = mc^2$). Among other problems, this laconic answer leaves open many profound questions, such as, What differentiates those who can from those who cannot die by suicide? Whatever this quality is, how does it develop over time in people's lives? Among those who want to die by suicide, what are the key constituents of the desire for death—Emotional pain? Hopelessness? Depression? What?

Regarding the issue of who can die by suicide, the theory asserts a fact that we believe is obvious after a moment's reflection and yet has been very neglected in past work, namely, that lethal self-injury is associated with so much fear and/or pain that few people are capable of it. A very important point is that this fact applies even to most of those who have ideas about and the desire for suicide; even they are daunted by the prospect.

We feel that this is only as it should be—humans (and other organisms too) are not designed for self-destruction. On the contrary, evolution has seen to it that self-preservation is an ancient and profoundly powerful force. It is nature's most powerful mandate, except "be fruitful and multiply," and of course survival can be viewed as a means to the end of reproduction.

According to the interpersonal theory, the only ones who are capable of death by suicide are those who have been through enough past pain and provocation (especially involving, but not limited to, intentional self-injury) to have habituated to the fear and pain of self-injury, so much so that the self-preservation urge can be beaten back. As we show, the self-preservation instinct is too strong to be eliminated altogether; it will always rear its head. It usually prevails, but there are a select few who are able to stare it down, and these few have acquired this dangerous capability, according to the theory, through getting used to pain and fear. It is important to emphasize that although previous self-injury (especially self-injury with the intent to die) is the most powerful habituation experience when it comes to decreasing fear and pain about future self-injury, it is not the only such experience. In varying degrees, any fear- and/or pain-inducing experience—including injury, accidents, violence, daredevil behaviors, and exposure to violence and injury through combat or work as a physician, to list a few examples—may be that habituation experience.

These kinds of experiences produce, through habituation, the *acquired capability* to enact lethal self-injury, an idea that is crucial to the theory and that we believe is necessary to a full understanding of suicidal behavior, despite the fact that it has not been rigorously included in previous theories of suicidal behavior. A mountain guide would likely keep a closer eye on a client demonstrating no fear of daunting slopes on the mountain, as fear can be life saving by alerting climbers to potential danger. Similarly, we advise clinicians working with patients who demonstrate lowered fear and tolerance of self-harm to keep a closer eye on these patients with regard to suicide risk.

A crucial point of the theory, however, is that capability does not necessarily entail desire. Those who become expert in the martial arts have the capability to inflict physical harm on others, but aside from self-defense, they do not desire to do so, and so do not. Physicians have the knowledge and the capability to inflict harm on others, but except in the service of treatment and cure (e.g., surgery, chemotherapy), they do not desire to do so, and so do not (although, as we point out later in this introduction, they appear to use their knowledge and capability at above-average rates to harm themselves). Similarly, there are many people who have become fearless and have gotten used to pain to the degree that they have the capability to inflict lethal self-harm, but they do not desire to do so, and so do not. Only those with both the capability and the desire are at risk, according to the theory.

This leads us to the concept of suicidal desire. Apart from the capability for suicide, who would want to die by suicide? The theory's answer is those who experience the sustained co-occurrence of two interpersonally relevant states of mind, perceived burdensomeness and failed belongingness.

Perceived burdensomeness is a self-view that includes low self-esteem but goes beyond it. The idea is that one is defective or flawed such that not only one's self is brought down but, even worse, one's existence burdens family, friends, and society. This view produces the crucial mental calculation that "my death will be worth more than my life to family, friends, society, and so on." It is essential to note that although suicidal people believe this calculation to be true, it represents a potentially fatal misperception. Also, as we discuss later, this is the one concept in the suicide literature that can tie together virtually all suicide-related phenomena, ranging from conventional deaths by suicide in humans, to suicide terrorism in humans, to self-sacrifice in fire ants and lions. And it is a view, like the acquired capability concept, that has not been adequately developed in past theories of suicidal behavior.

Failed belongingness is roughly, although not perfectly, synonymous with loneliness and social alienation. It is the experience that one is alienated from others, not an integral part of a family, circle of friends, or other valued group. When people simultaneously experience perceived burdensomeness and failed belongingness—that is, when they feel their care for others is inconsequential or even harmful and that they themselves are not cared for—the theory asserts that this cuts all important ties to life and that the desire for death therefore develops.

The three factors previously noted—acquired capability, perceived burdensomeness, and failed belongingness—are proposed as answers to the questions of who can die by suicide and who would want to. Who can? Those who, through habituation, have acquired the capability to enact lethal self-injury. Who wants to? Those who perceive that they are a burden on loved ones and that they do not belong to a valued group or relationship. Those who both can and want to are at highest risk of serious suicide attempt or lethal self-injury.

As shown in Figure 1, a fairly large number of people develop the desire for suicide; indeed, anyone working in inpatient psychiatry or a mood disorders clinic will attest to this. And relatively large numbers of those people have developed the capability for suicide. Crucially, however, there are relatively few people in the dangerous zone of overlap; it is these people, according to the theory, who are at greatest risk of serious suicidal behavior.

Empirical and Anecdotal Evidence Relevant to the Theory

In the sections that follow, we provide a brief review of empirical and anecdotal evidence in support of each of the theory's main constructs: acquired

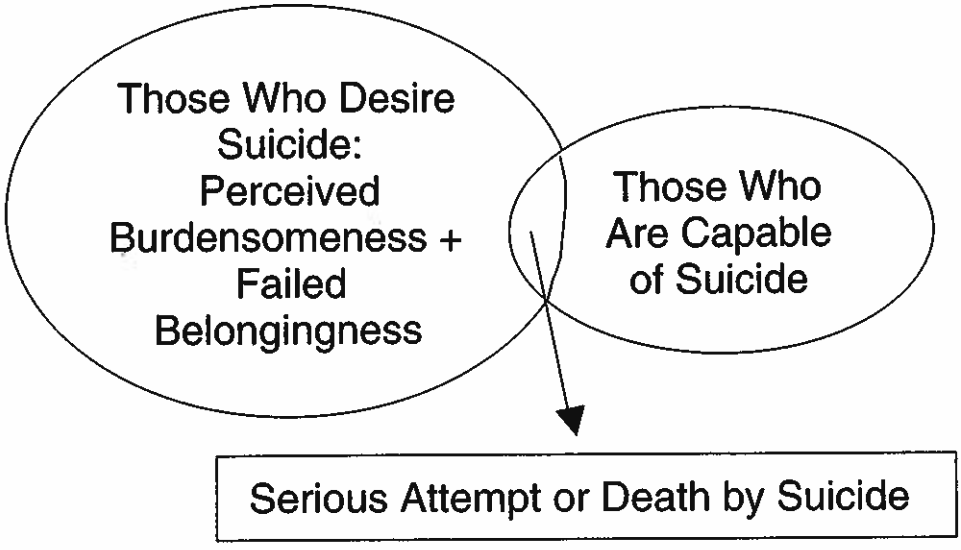

Figure 1. Graphical depiction of the interpersonal theory of suicide. From *Why People Die by Suicide* (p. 138), by T. E. Joiner Jr., 2005, Cambridge, MA: Harvard University Press. Copyright 2005 by Harvard University Press. Reprinted with permission.

capability, perceived burdensomeness, and failed belongingness. The evidence reviewed includes historical events, case examples, and empirical investigations.

Acquired Capability

Killing is hard to do, a fact that is particularly true when it comes to killing a member of one's own species. As Grossman (1995) pointed out in his book *On Killing: The Psychological Cost of Learning to Kill in War and Society*, within-species fights are often nonlethal. Rattlesnakes do not use their venom on each other; they wrestle instead. Piranhas do not viciously bite each other but have a kind of sword fight with their tails. When humans fight, even when with guns, a related phenomenon regularly occurs: For example, soldiers in battle often miss each other at rates that far exceed chance. Grossman quoted an eyewitness at the U.S. Civil War battle of Vicksburg in 1863, who said,

> It seems strange that a company of men can fire volley after volley at a like number of men at not over a distance of fifteen steps and not cause a single casualty. Yet such was the facts in this case. (p. 11)

The natural prohibition against killing one's own kind surely extends to killing one's own self. Abundant empirical data are consistent with this aspect of the theory, but clinical and case data are persuasive as well, particularly so for a book on the clinical implications of the theory. For example, Shneidman

(1996) provided an illuminating case study of a patient he called "Beatrice." Beatrice wrote,

> I know now that slitting my wrists was not as poetic nor as easy as I imagined. Due to blood clotting and fainting, it is actually difficult to die from such wounds. The evening dragged on with me busy reopening the stubborn veins that insisted upon clotting up. I was patient and persistent, and cut away at myself for over an hour. The battle with my body to die was unexpected, and after waging a good fight, I passed out. (p. 4)

Similarly, in his memoir *Quitting the Nairobi Trio*, Knipfel (2000) speculated as to why his suicide attempts had not resulted in death:

> It was clear that it was cowardice that had kept me from going all the way before. I had never succeeded because I didn't have the nerve. . . . No matter how hard I tried, nothing worked. I threw myself down a flight of stairs, drank bleach, cut my wrists, stepped in front of buses, all to no avail. (pp. 13, 33)

Public Radio International's *This American Life* featured a compelling radio diary of someone who had survived multiple suicide attempts. Here's one passage:

> 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. (Runyon & Glass, 2002)

The phenomenon of so-called hesitation wounds in those who die by self-inflicted knife wound (often to a central organ such as the heart) also illustrates the fearsome quality of taking one's own life. This fear evidently affects even those who go on to overcome it. Hesitation wounds are minor, nonlethal "practice" cuts that people make in the area of their body that they intend to cut lethally. As medical examiners will attest, those who die by suicide by puncturing their hearts will often have minor knife cuts on their chests—hesitation wounds—whereas those who are murdered with a knife do not (but often do have defensive wounds on their hands and arms from trying to ward off the attack). This fact is considered in differentiating cause of death in cases in which suicide and homicide are both possibilities. The very name *hesitation wounds* underscores the fact that when people try to fight against life, most falter.

In *The Myth of Sisyphus*, Camus (1955/1991) wrote, "The body's judgment is as good as the mind's, and the body shrinks from annihilation" (p. 8).

When it comes to death by suicide, the body is not going to cooperate—it is not designed to—and so suicide entails a fight with basic biologically based (and other) motives. According to the interpersonal theory, fighting this battle repeatedly and in different domains instills the capability to stare down the self-preservation instinct (should an individual want to).

The anecdotal evidence previously summarized is supported by numerous empirical findings. For instance, a straightforward implication of the theory is that those with past suicide attempts will experience more serious forms of future suicidality as compared with other people and that this association will not be accounted for by other variables. Joiner and colleagues tested this proposition in an article describing what they came to call the "kitchen sink" studies. In four separate samples ranging from U.S. undergraduates to psychiatric patients in Brazil, they showed that there was a clear association between past and future suicidality; moreover, this association remained even when a very long list of powerful suicide-related covariates—everything but the kitchen sink—was controlled (Joiner, Conwell, et al., 2005; see also Joiner et al., 2003).

Another implication of the theory is that those whose jobs entail exposure even to others' pain and injury will thereby develop the capability for suicide and thus have higher suicide rates than others. This is because habituation can occur directly, through one's own experiences, or indirectly or vicariously, through witnessing others' experiences. This implication has been affirmed numerous times, including with regard to physicians, who have high suicide rates despite many protective factors (Lindeman, Laeaerae, Hakko, & Loennqvist, 1996).

The theory predicts that those with past suicide attempts will have habituated to pain more than other people, because their past attempts should serve as potent habituation experiences, and thus will show higher pain tolerance than others. This is an interesting prediction for many reasons, including that no other theory of suicidal behavior has conceived of it. This prediction, too, has been supported, principally through the work of Orbach and colleagues (e.g., Orbach et al., 1996), who have shown that psychiatric patients with histories of suicide attempts have higher pain tolerance than similar patients with no history of suicide attempts.

Holm-Denoma, Witte, et al.'s (2008) study combined the anecdotal and the empirical and also supports the view that people who are fearless about their bodies are especially capable of lethal suicidal behavior (under conditions of suicidal desire). They studied individuals who are anorexic who had died by suicide. It is well known that people with anorexia are prone to early mortality; most assume, understandably, that this is due to the consequences (usually cardiac consequences) of self-starvation. Occasionally it is, but it is far more common for early mortality in anorexia nervosa to result from suicide.

What explains the association between anorexia and suicide? One possibility could be termed the *fragility hypothesis:* People who are anorexic may be unable to survive low lethality suicide attempts—attempts that people who are not anorexic may survive—because they are physically fragile because of the effects of self-starvation. Another possibility, which could be called the *fearless stare-down hypothesis*, has to do with fearlessness about grappling with basic instincts related to self-preservation, such as hunger: People with anorexia may engage in very high lethality attempts in part because their previous experiences combating the body have steeled them.

Holm-Denoma, Witte, et al. (2008) examined the methods of suicide of 9 individuals with anorexia, from a sample of approximately 250 who had been prospectively followed for approximately 15 years. The goal was to determine whether suicide methods conformed more to the fragility or the fearlessness hypotheses. The findings were graphic but illuminating. One of the least lethal methods involved ingestion of 12 oz. of Lysol toilet bowl cleaner (which contains high amounts of hydrochloric acid), along with an unknown amount of a powerful sedative and alcohol (blood alcohol content = 0.16%). The sedative and alcohol likely were not central to her death; the cause of death was that the hydrochloric acid hemorrhaged her stomach, and she bled to death internally.

Van Orden, Witte, Gordon, Bender, and Joiner (2008) presented two studies relevant to the acquired capability for suicide. In the first study, they examined the association between past suicide attempts and acquired capability, which they assessed using a scale designed to tap the acquired capability construct. Results showed that number of past suicide attempts significantly predicted levels of acquired capability in a sample of psychotherapy outpatients, with highest levels of acquired capability reported by individuals with multiple past attempts, just as the interpersonal theory would predict. In the second study, they showed that the statistical interaction between scores on the acquired capability scale and a measure of perceived burdensomeness predicted clinician ratings of suicide risk. That is, those who had both high capability and high desire (in this study as only indexed by perceived burdensomeness) were the ones with highest suicide risk as rated by clinicians. This latter finding further corroborates the involvement of acquired capability in suicidality, and it also supports its role within the larger theory, which predicts that capability is only related to suicidality under conditions of desire. We turn to evidence regarding desire next.

Perceived Burdensomeness

In theories of evolution, terms such as *survival* and *fitness* are key, and terms such as *self-sacrifice* seem opposite in meaning and to not fit in an evolutionary framework. Yet, there is a substantial amount of self-sacrifice in nature. Humans, of course, die not only by suicide in the conventional sense

but through quasi-suicidal phenomena such as suicide terrorism, kamikaze pilots, and falling-on-grenade kinds of heroism. The winged sexuals of fire ants, both males and females, leave the nest and take flight, mostly in the spring (Tschinkel, 2006). They mate in midair. The male's genitalia literally explode into the female's, along with all the 7 million or so sperm the female will need for the rest of her life. This is a kind of suicide mission for the males—they die, and the females go on to found colonies and become queens (incidentally, it is interesting to ponder the perhaps coincidental fact that at the very same time male winged fire ants' self-sacrifice is peaking in the spring, so are human deaths by suicide, which is a predominantly a male phenomenon). Pea aphids, a kind of lice, are parasitized by wasps, who inject an egg into the host aphid; the young wasp matures inside the aphid, feeding on its organs. When the wasp is ready to emerge as an adult, it chews a hole out the back of the aphid's body. Entire aphid populations can be devastated by parasitic wasps. Parasitized aphids frequently engage in self-sacrifice—specifically, well before the parasite kills them, they drop from their host plant to the ground, where they are preyed on by ladybugs and other natural predators. Male lions will fight to the death to protect their pride of lionesses from intruders, which would make sense if the lions were protecting their mates, but even male lions that never mate with the lionesses will do this.

If the same motive for self-sacrifice were at work in aphids, fire ants, lions, and humans (including such diverse deaths in humans as suicide terrorism, heroic self-sacrifice, and conventional suicide), that would represent a "damn strange coincidence"—a phrase coined by Salmon (1984) and popularized by eminent psychologist Paul Meehl (1990)—that is, a co-occurrence that probably points to something important about nature. We suggest that the interpersonal theory identifies this motive, and it is represented in the phrase "my death will be worth more than my life to my genes, my loved ones, my society."

Why do aphids and fire ants self-sacrifice? Because their deaths will be worth more than their lives to their genes. For the fire ants, that one fatal flight costs them their life but gains them something more—passing on genes to potentially millions of descendants. Parasitized aphids are engaging in the insect version of falling on a grenade, only for them the grenade is the parasite. Dropping to the ground and dying kills not only themselves but also the parasite, which spares the rest of the aphid population, where more of the self-sacrificing aphid's genes reside even than inside the aphid itself. Its death (taking one copy of genes down with it) is worth more than its life because the death spares the many copies of genes floating around in the aphid's relatives. Why do male lions give themselves up to protect other male lions' lionesses? Because packs of male lions are mostly brothers, who share roughly half their genes; defending the brothers' pride ensures spread of one's genes through one's brothers.

Why do humans self-sacrifice? The literature on suicide terrorists and kamikaze pilots is quite clear that a main motive is benefit to family and society (e.g., see Reuter, 2004)—that is, "my death—and its effects—will be worth more than my life to my family and society." Falling-on-grenade heroism has been described similarly by those who engage in it and survive. The data suggest that those who engage in conventional death by suicide are also motivated at least partly by their perceptions of burdensomeness—that is, that their suicide will be worth more to others than their lives. It is key to reiterate that this is a misperception, a fatal one, but that the suicidal individual does not see it as mistaken.

A vivid example of perceived burdensomeness was noted by Shneidman (1996). In a woman's suicide note to her ex-husband, she wrote, "[The girls] need two happy people, not a sick, mixed-up mother. There will be a little money to help with the extras—it had better go that way than for more pills and more doctor bills." To her daughters, she wrote, "Try to forgive me for what I've done—your father would be so much better for you. It will be harder for you for awhile—but so much easier in the long run—I'm getting you all mixed up" (p. 94).

A similar example was included in a study of people interviewed after surviving suicide attempts:

> I started to list the people who wouldn't mind if I wasn't around. I clearly wasn't a good wife for my ex-husband. He wouldn't miss me. And I never felt that comfortable in my role as a mom—didn't feel like I was a good mom necessarily. . . . It's like I'll be a burden off their backs. Clearly their lives will be enhanced because I'm not around. At that point, I honestly felt I was doing them a favor. (Heckler, 1994, p. 64)

The phrase "burden off their backs" clearly implies perceived burdensomeness.

The suicides of an elderly Malaysian couple who died by jumping from a high floor of their apartment building also illustrates the concept of perceived burdensomeness (Ananova, 2001). Their suicide note read, "If we had waited for our death due to sickness, we would have caused much inconvenience to all of you." The individual whose radio diary from *This American Life* mentioned earlier highlighted his feelings of burdensomeness as he recounted his early episodes of suicidality:

> 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. (Runyon & Glass, 2002)

Tina Zahn (2006), who was prevented at the last instant by police from jumping from a bridge to her death, as described in the memoir *Why I Jumped: My True Story of Postpartum Depression, Dramatic Rescue, & Return to Hope*,

stated, "I was just a lifeless thing—breathing but worthless. I knew everyone would be better off if I were dead. It would end my misery and relieve their burden" (p. 150).

We find this anecdotal evidence to be of inherent interest, and it does lend some credence to the role of perceived burdensomeness in suicidal behavior. A higher standard of evidence of course is controlled empirical studies that corroborate the role of perceived burdensomeness in serious suicidal behavior. Joiner et al. (2002) studied an archive of suicide notes, half of which were written by people who had actually died by suicide and half of which were written by people who intended to die by suicide, attempted suicide, and survived. Raters were trained to rate the notes on several dimensions, including how much burdensomeness the note conveyed but also how much hopelessness and general emotional pain were conveyed. The study showed that raters detected more expressions of burdensomeness (a) in the notes of people who had died by suicide versus notes from those who intended to die but survived and (b) in the notes of those who died by violent means versus those who died by less violent means. The effect was specific to burdensomeness; it did not hold regarding hopelessness and general emotional pain.

In a study of psychotherapy outpatients, Van Orden, Lynam, Hollar, and Joiner (2006) showed that a measure of perceived burdensomeness was a robust predictor of suicide attempt status and of current suicidal ideation, even controlling for powerful suicide-related covariates such as hopelessness. As already noted, Van Orden et al. (2008) showed that an index of perceived burdensomeness interacted with scores on an acquired capability scale to predict clinician ratings of suicide risk.

Failed Belongingness

The need to belong is a powerful motive indeed. In fact, one could make the case that the need to belong rivals in its power such instincts as self-preservation and reproduction, and there is no doubt that when the need to belong is thwarted, negative mental and physical health outcomes ensue (Baumeister & Leary, 1995). Of all the various risk factors for suicidal behavior, ranging from the molecular to the neurobiological to the psychological to the social to the cultural levels, the clearest overall support has emerged for indices related to social isolation (Joiner, 2005).

Friend's (2003) *New Yorker* article on suicides at San Francisco's Golden Gate Bridge included a clear example involving belonging and suicidality. A young man had jumped to his death from the bridge, and psychiatrist Jerome Motto, whom Friend interviewed, said,

> I went to this guy's apartment afterward with the assistant medical examiner. . . . He'd written a note and left it on his bureau. It said, "I'm going to walk to the bridge. If one person smiles at me on the way, I will not jump." (p. 6)

Colapinto (2000), in his book *As Nature Made Him: The Boy Who Was Raised as a Girl*, described David Reimer, who was born a boy, raised as a girl, and then changed back to a man in his teens. A few years before suicide at age 38, he related some of his past experiences in interacting with others and said, "There's no belonging. . . . you're an outcast. It doesn't change" (p. 102). Similarly, when asked how he had felt watching his classmates pair off romantically, he said, "These people looked like they knew where they belonged. There was no place for me to feel comfortable with anybody or anything" (p. 127).

Empirically, as already mentioned, the data in support of a connection between low belonging and suicidality are numerous and very supportive. The connection has been made in diverse ways: Norwegian mothers with many children (and thus, on average, high levels of belonging) have far lower rates of suicide than women with fewer children—despite the stress of numerous children (Hoyer & Lund, 1993); identical twins (who, on average, have high levels of belonging through twinship) have lower rates of suicide than others—despite having the risk factor of somewhat higher rates of mental disorders (Tomassini, Juel, Holm, Skytthe, & Christensen, 2003); suicide rates go down during times of celebration (when people pull together to celebrate; Joiner, Hollar, & Van Orden, 2006) and during times of hardship or tragedy (when people pull together to commiserate [e.g., President Kennedy's assassination]; Biller, 1977).

In a study of people formerly addicted to heroin and being maintained on methadone, Conner, Britton, Sworts, and Joiner (2007) showed that low feelings of belongingness predicted lifetime history of suicide attempts. This population allows an interesting test of specificity, because intentional suicide attempts are fairly common, as are unintentional overdose episodes. The association between low belonging and lifetime suicide attempts was specific to intentional suicidal behavior; belongingness was unrelated to unintentional overdoses. In the Van Orden et al. (2008) study mentioned earlier, low belonging was associated with a measure of suicidal desire among undergraduates, and this was particularly true for those who also experienced perceived burdensomeness, as the theory would predict.

Psychotherapeutic and Other Clinical Implications of the Theory

The overarching goal of this book is to draw out in clear and usable detail the various clinical implications of the interpersonal theory. Any compelling explanation of a clinical condition should have usable and novel things to say to clinicians about how to assess, treat, and prevent the condition in question. In this book, we aim to offer a comprehensive guidebook for clinical work with suicidal patients, with the theory as our map and compass. In what follows, we offer a foreshadowing of material in subsequent chapters. We do so by selecting one application of the theory—psychotherapy—and

illustrating clinical actions that guides using our theory as map and compass might take on a journey up and over a suicidal crisis.

Optimal Therapeutic Stance

Reflecting on a mountaineering course, a student wrote

> All of us bore the bruises, scrapes, chapped lips, and insect bites that are the badges of having climbed, descended, crossed, and plowed through steep tundra, loose rocks, talus, crevasses, glaciers, snow fields, raging creeks, and rain forest vegetation with sharp thorns and endless deadfall tree obstacles. . . . Every turn brought some new challenge, completely unforeseeable—usually uncomfortable. . . . No one gets through a day without helping another or being helped by another; indifference to your fellow traveler is just not possible. (Outward Bound International, 2008)

This passage emphasizes the central role of relationships in making it up and over the mountain safely. So too for clinicians and patients attempting to traverse the steep, craggy slope of a suicidal crisis: Without a firm therapeutic relationship that provides both support and instruction on skills, preventing negative outcomes—suicidal behavior—is unlikely.

The therapeutic stance we advocate throughout our guidebook is grounded in our theory and in a theory of human motivation that has gained a great deal of empirical support, self-determination theory (SDT; for overviews see Ryan & Deci, 2000, 2002). SDT proposes three fundamental human needs—relatedness (i.e., belongingness), competence (i.e., lack of burdensomeness), and autonomy. SDT further proposes that intrinsic motivation and well-being are fostered by the fulfillment of these needs. Sheldon, Williams, and Joiner (2003) proposed that the application of SDT principles to therapy would increase patient motivation to engage in therapy: Given that the work of therapy is difficult, it is unlikely that a high degree of intrinsic motivation will be readily available unless these needs are met by the therapeutic relationship. Just as mountaineering students support each other as they climb up and over the mountain, clinician guides working with suicidal patients must also provide support.

SDT proposes that the fulfillment of basic human needs will foster not only motivation but also well-being. The theory assumes that humans have an innate tendency for health and growth. Thus, by applying SDT principles to a therapeutic stance, therapists create an alliance that allows patients to find their voices of health. For suicidal patients, this voice of health involves finding the desire to live. We advocate taking a therapeutic stance with suicidal patients that attends to needs for social connections and social competence. Throughout the book, we return to this theme—the clinician as guide who supports and instructs—and provide illustrations of how this can be done across all domains of clinical work with suicidal patients: assessment, treatment, and prevention.

Treatment Targets

Another theme that appears throughout the book is the use of the interpersonal theory to clarify treatment targets with suicidal patients. We believe that perceived burdensomeness, thwarted belongingness, and acquired capability for self-harm should be high-priority clinical targets. Regarding perceived burdensomeness, we believe that this misperception should be a constant target. Again, the crucial calculation regarding burdensomeness is "my death is worth more than my life to others," and when it involves humans contemplating suicide (as opposed to fire ants and pea aphids), it is in error. The whole point of cognitive therapy is to identify and correct such errors. In doing this, the therapist's stance should combine deep empathy for the plight of the person who believes that his or her removal would be a net benefit to others (among other purposes, this empathy will likely enhance belonging within the therapeutic relationship), on the one hand, with agnosticism about the validity of the perception, on the other hand. A therapist might state, "It is an important enough perception—indeed a life-and-death one—that we should be 100% sure that it's true, and if a life-and-death proposition is true, it should be easy enough for us to demonstrate" (the use of *we* and *us* is intentional to attend to belongingness issues).

As one suggestion for collaborative empirical activities that might follow, the therapist may suggest the therapeutic relationship as a starting point to examine the calculation's validity and to note that the patient's death is not worth more than his or her life to the therapist. The therapist must be able to defend this statement with reference to actual facts regarding the patient's contributions to loved ones, family, friends, and society. Predictable responses from the patient will be along the lines that the therapist "doesn't really count, because it's a 'bought' relationship," which the therapist can (a) dispute, stating that the therapeutic relationship is real, involving two humans discussing personal, emotional, and sometimes life-and-death material (this of course further attends to belongingness needs) and (b) use to pose the question to the patient, "If I perceive your contributions, I wonder whether others in your life do too. Let's collect some data to address that question." It should be noted that lists of pleasant activities (more on these in chap. 3, this volume; see also Linehan, 1993b) include elements that may relieve feelings of burdensomeness, for example, volunteering at a pet shelter; giving blood; volunteering time to agencies such as the Red Cross, Habitat for Humanity, Big Brothers Big Sisters, and Goodwill; helping a struggling child or adult learn to read; participating in community cleanups or fundraisers; participating in grassroots groups involved in city or county governance; and participating in efforts to affect issues of personal political concern, such as global warming, tax reform, reducing the size of government, human rights, and so on. Note that each element of this partial list is geared to society at large and thus is applicable to a wide swath

of people, including those who feel disaffected from family and friends. When possible, activities of contribution to family and friends should be prioritized too.

Regarding belongingness, it is an essential fact that one and only one intervention has been shown to be effective in preventing deaths by suicide. It was described by its creators as a belongingness intervention, and it involved mailing letters expressing concern to high-risk individuals who refused further treatment after hospitalization (Motto & Bostrom, 2001). A matched control group received no letters. The "caring letters" received by the first group simply consisted of very short expressions of concern and reminders that the treatment agency was accessible when patients needed it (e.g., "It has been some time since you were here at the hospital, and we hope things are going well for you. If you wish to drop us a note we would be glad to hear from you"). Fewer deaths by suicide occurred in the group who received the letters.

In the caring-letters study, the letters were signed, with original signature, by the person in charge of the patient's care, and any note the patient sent in response to the previous letter was answered in a subsequent letter. In some ways, managing these personal letters represented the bulk of the project's work. How much of this kind of detailing is necessary to make the letters convey enough caring to make a difference in people's suicidal behavior? The answer appears to be "not much," judging from a study from Australia (Carter, Clover, Whyte, Dawson, & D'Este, 2005). The study was designed to replicate the caring-letters study and so was structured similarly. But there was an intriguing difference, and it had to do with the caring letters themselves, which were automated postcards printed out by a computer, with few personalized features. However, they did contain an expression of caring and availability. Those who received the postcards engaged in fewer nonlethal suicidal behaviors than those who did not receive them. The expression of caring and availability, even though automated, evidently got through to the participants.

Taken together, these studies show that belongingness is a potent force. To reiterate, the only study, ever, to show an effect on death by suicide was a belongingness intervention (Motto & Bostrom, 2001). Motto and Bostrom's (2001) study, and the "caring automated postcards" study (Carter et al., 2005), show that quite a little intervention can go a very long way, not to mention that these studies' interventions cost very little relative to virtually all other interventions. We believe that these findings should have far more influence on clinical practice than they currently do; clinicians ought to emphasize belongingness in their work with suicidal patients.

We have three suggestions as to how this may be accomplished. First, clinicians working with suicidal patients should pay constant attention to the therapeutic relationship as a potential source of belongingness. This could include,

for example, making statements such as "We're in this together" and "We'll work through this together"; regularly revisiting the therapeutic relationship as a source of help, care, and support and brainstorming together about how the development of this resource can be generalized to other relationships in patients' lives; and examining problems and disagreement in the therapeutic relationship, how these are overcome, and how these generalize to other relationships in patients' lives.

Second, and related to the first point, clinicians should consider formal clinical frameworks that have been developed to highlight the therapeutic relationship in work with suicidal patients. We highlight a few later in chapter 2 of this volume (e.g., Jobes's, 2006, The Collaborative Assessment and Management of Suicidality). Third, and compatible with the first and second suggestions, clinicians should constantly assign belongingness-related homework to suicidal patients. Among others, Linehan (1993b) has developed a list of over 100 pleasant activities (as referred to earlier), many of which involve belongingness (and many of which negotiate pragmatic barriers of availability and cost). With just a little checking, it is remarkable to see the number of artistic, musical, theatrical, dance, museum, academic, athletic, civic, and other events—many of them free of charge—that occur on a daily basis in most communities.

The preceding recommendations address the aspects of the model having to do with perceived burdensomeness and failed belongingness, respectively. In contrast to the model's third aspect, acquired capability, which is relatively fixed and static, failed belongingness and perceived burdensomeness are fluid and dynamic, and are thus more malleable and responsive to short-term interventions. For this reason, they deserve priority. Still, acquired capability merits consideration too. Patients should be counseled to avoid or curtail activities that may further the habituation trajectory that underlies acquired capability; repeated discussions of the psychological function of these activities, and ways to achieve the same function less provocatively may be useful. The static nature of acquired capability, together with the fluid nature of failed belongingness and burdensomeness, represent a clear rationale for the need for frequent and regular suicide risk assessment (e.g., risk can escalate suddenly), which some patients question. Finally, it may be worth pointing out that although acquired capability clearly involves danger, it also involves characteristics such as fearlessness, steeliness, and resolve. William James wrote that to persuade a suicidal person to live, one could "appeal—and appeal in the name of the very evils that make his heart sick—to wait and see his part in the battle out" (as cited in Dublin & Bunzel, 1933, p. 235) The tactic of turning the very fearlessness that may facilitate self-injury against itself may have promise for some patients, in that it redirects the resolve of the suicidal person on to fighting against evil on behalf of others, which in turn may alleviate low belongingness and perceived burdensomeness.

CLINICAL TERRAIN COVERED IN THIS GUIDEBOOK

Each chapter in this guidebook addresses a component of clinical work with suicidal patients. The first two chapters address aspects of assessment. In chapter 1 we focus on diagnoses associated with suicide. It is a fact that some *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; American Psychiatric Association, 2000) diagnoses are more associated with suicidal behavior than others. Therefore, we provide a theory-based quick reference linking diagnosis to suicide risk and use the theory to explain, at least in part, why certain disorders are particularly associated with suicidal behavior. In chapter 2 we offer theory-based recommendations on what information should be gathered in the process of suicide risk assessments as well as how to optimally obtain and analyze this information. We also provide an overview of available risk assessment frameworks through the lens of the interpersonal theory.

The next three chapters address aspects of treatment. In chapter 3 we describe crisis intervention strategies and techniques through the lens of the theory. A main goal of crisis intervention is to take the edge off the pain of the current crisis, so that it is within a tolerable range. We describe interventions that target the pain of thwarted belongingness and perceived burdensomeness (e.g., duty-to-other roles), as well as those that may inhibit the expression of acquired capability (e.g., removal of lethal means and commitment-to-treatment contracts). In chapter 4 we focus on treatments that work for suicidal behavior, surveying various treatment approaches through the lens of the theory and describing in detail one approach that directly targets all components of the interpersonal theory. In chapter 5 we focus on the therapeutic relationship, including a more detailed exploration of the optimal therapeutic stance described earlier in this chapter. We also address between-sessions accessibility by the therapist.

The final two chapters take a step back and use a broader perspective to examine clinical implications of the interpersonal theory. In chapter 6 we address suicide prevention and public health campaigns. In the concluding chapter we provide an integrative statement on a comprehensive, theory-based protocol for clinical work with suicidal patients.

Recall the statement on the importance of relationships, previously discussed, put forth by a student after completing a mountaineering course: "No one gets through a day without helping another or being helped by another; indifference to your fellow traveler is just not possible" (Outward Bound International, 2008). We realize that to climb up and over the mountain, guides as well as clients must experience connection and competence. It is our hope that this book will facilitate those experiences for those who work with suicidal patients.