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# Clinical Applications of the Interpersonal-Psychological Theory of Attempted and Completed Suicide



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This article reviews the interpersonal-psychological theory of attempted and completed suicide and describes its applications in suicide risk assessment, crisis intervention, and skills-based psychotherapies. Three components are necessary, but not sufficient, for an individual to die by suicide: (1) the acquired capability to enact lethal self-injury, (2) a sense that one is a burden on others, and (3) the sense that one does not belong to a valued social group. We suggest that therapeutic interventions should focus on ascertaining the presence of these components and work to amend the cognitive distortions, negative interpersonal response styles, and ineffective coping behaviors that serve to maintain suicidal urges. © 2005 Wiley Periodicals, Inc. *J Clin Psychol: In Session* 62: 211–222, 2006.

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In the United States of America approximately 30,000 people die by suicide each year and an additional 750,000 attempts at suicide are drawn to the attention of medical and mental health professionals. Further, estimates indicate that at least one third of the population have thoughts about suicide at some point in life (e.g., Paykel et al., 1974). Taken

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as a whole, these statistics are troubling for those working to prevent suicidal ideation and behavior.

Joiner (2005) recently proposed an interpersonal-psychological theory of suicide that can be applied to risk assessment and treatment. The theory hypothesizes that three components must exist for an individual to die by suicide: (1) the acquired capability to enact lethal self-injury, (2) the sense that one is a burden on loved ones or society (burdensomeness), and (3) the sense that one does not belong to or feel connected with a valued group or relationship (thwarted belongingness). The theory asserts that all three components are necessary for completed suicide. Thus, for example, even if one desires death by suicide (e.g., feels disconnected or a burden on others), the risk of serious attempt or completion should be moderate unless acquired capability to enact lethal self-injury is in place. These components suggest points of emphasis for both assessment and therapy in that, if they are addressed, an individual's trajectory toward greater frequency and intensity of suicidal behavior can be curtailed.

Typical points of intervention with suicidal clients occur during risk assessment, during crisis intervention, and in skills-based, relatively long-term psychotherapy. The principal goal of risk assessment is to determine whether a client who reports suicidal symptoms is in imminent danger of causing self-harm. Once risk level is assigned, the clinician can decide on a course of action and/or initiate crisis intervention, most commonly aimed at alleviating acute psychological distress. Although such interventions will not resolve all the underlying sources of a suicidal crisis, they can bolster a client's ability to cope until skills-based techniques may be taught. Even minimal decreases in emotional distress, typically brought about through crisis intervention, may have important therapeutic effects. For example, a small decrease in emotional discomfort may facilitate positive moods, which have been shown to improve treatment outcome in suicidal individuals (Joiner et al., 2001). Thus, relieving emotional distress or providing clients with "quick fix" tools to manage a crisis may facilitate participation in psychotherapy in which underlying problems and skills deficits may be addressed. In this article we elaborate on the three components of completed suicide, present an illustrative case example, and summarize empirical research on the three components.

### Acquired Capability

Central to our perspective is the idea that people "practice up" to suicide, or develop competence and fearlessness regarding suicide by repeatedly engaging in painful and provocative activities, such as deliberate self-injury (Joiner, 2005). We believe that acquired capability is attained when habituation to the negative aspects of self-injury (e.g., fear, pain, and shame) occurs and, in accordance with opponent process theory (Solomon, 1980), the opposite effect is strengthened (in this case, emotion regulation or calming effects of repeated self-injury are typical). Further, as with substance addiction, in order to continue to generate the rewarding properties of the act, self-injury must become more extreme over time. Thus, as suicidal behavior becomes more normative for an individual, it serves to facilitate future (and more serious) suicidal behavior.

Research on multiple suicide attempters and populations with histories of self-harm indicates that these experiences are indeed associated with increasing intensity, frequency and lethality of suicidal behavior. For example, Rudd, Joiner, and Rajab (1996) compared multiple suicide attempters to one-time suicide attempters and suicide ideators on various symptom and personality indices. Their findings indicated that even when compared to one-time attempters, multiple attempters experienced more intense suicidal symptoms on both self- and clinician-rated scales, as well as more hostility. Comparable

findings have also been reported for adolescent samples (e.g., Gispert, Davis, Marsh, & Wheeler, 1987; Lewinsohn, Rohde, & Seeley, 1996).

Further, a significant past history of deliberate self-harm distinguished those who die by suicide from living control subjects (Cavanagh, Owens, & Johnstone, 1999). When controlling for many variables typically related to suicidality, the relationship between past suicide attempts and current suicide risk remains strong (Joiner et al., in press). Thus, past suicide attempts appear to be a significant factor in determining how likely it is that an individual will engage in future suicidal behaviors.

Although a history of suicide attempts is clearly the most direct pathway to practice and habituation, it is not the only pathway. There is preliminary evidence that a less direct pathway is exposure to pain and provocation, which would entail accidental injury, reckless or impulsive behavior, and submission to multiple surgeries. For example, Whitlock and Broadhurst (1969) compared 50 suicide attempters with 50 nonsuicidal psychiatric patients and 50 nonpsychiatric control patients who were attending a heart clinic. They found that suicidal patients had experienced various violent episodes, to a significantly higher degree than either control group. For another example using National Comorbidity Survey data, Joiner and colleagues (2005) assessed individuals with a family history of childhood verbal abuse, physical abuse, sexual abuse, or molestation. They found that participants who had been physically or sexually abused were more likely than those who had been verbally abused or molested to have a lifetime suicide attempt, even when controlling for numerous covariates. Serious drug abuse may provide another means for habituation to pain and provocation. For example, heroin users are more likely than community sample peers to attempt and die of suicide (Darke & Ross, 2002). It is interesting to note that overdoses seem to play a relatively small role in suicide among this group (Darke & Ross, 2002), consistently with the view that it is not mere access to drugs, but the pain and provocation associated with the lifestyle of a serious drug abuser that are implicated in escalating suicidality.

### *Risk Assessment*

Ascertaining previous attempt status, current and past presence of self-injurious behavior, and experience with pain and provocation will help determine risk status and relevant target areas for therapeutic intervention. We posit that the more one habituates to injury and pain, and the more familiar with the mechanics of planning and executing self-injury one becomes, the greater the likelihood that a suicide plan will be carried out (Joiner, in press). Given the research summarized above indicating that multiple suicide attempts and previous self-injury episodes are associated with increased risk of completed suicide, as are courage and competence about self-harm, assessing attempt status and resolved plans and preparations will be of primary interest to clinicians. In illustration of this point, a study of several hundred current suicide ideators found that worst-point resolved plans and preparations, assessed for patients' worst suicidal crisis, was the strongest predictor of suicide attempts and the only significant predictor of later death by suicide (Joiner et al., 2003).

Questions regarding resolved plans and preparation should be directed at determining a client's degree of experience, or practice, with suicide attempts or self-injurious behavior. In addition, questions that assess the specificity of current suicidal ideation and degree of detailed planning as well as competence and courage about suicide will help the clinician determine the potential risk to the client. We also recommend inquiry about other forms of violence or provocation, such as history of drug use by self-injection, history of physical or sexual abuse, and general trait levels of impulsivity.

### *Crisis Intervention*

Acquired capability is viewed here as relatively static in nature and therefore relatively less malleable over the short term. It is unlikely that brief crisis intervention will materially influence this component in any lasting way. However, if a client reports resolved plans and preparations for suicide, there are several preventative measures available to clinicians. For example, clinicians may ask clients to discuss their suicide plans with a significant other who can provide support or remove any weapons or medications involved in the suicide plan. The clinician and client may also choose to delineate steps the client can take if suicidal urges grow more intense. Such steps may range from cognitive practicing coping exercises, to contacting the clinician or an emergency mental health professional, to calling 911 or going to the emergency room. Involuntary hospitalizations must be considered in some cases.

### *Long-Term Psychotherapy*

Although clients' acquired capabilities cannot be easily or directly altered, deficits in emotion regulation, problem-solving abilities, and impulsive response styles are amenable to psychotherapy. Fitzpatrick, Witte, and Schmidt (in press), for example, studied the effects of a brief problem-solving intervention on suicidal ideation and problem-solving ability. A treatment group was shown a video focused on problem-solving and coping styles, while a control group watched a video on health-related issues (e.g., diet, exercise, and sleep habits). Although both groups showed symptom improvement over time, the treatment group showed a more pronounced initial drop in ideation and more rapid improvement on measures of depression relative to the control group. However, problem-solving skills did not appear to be significantly impacted by the video. These results suggest that a brief, nonspecific problem-solving intervention may be potent enough to result in immediate decreases in psychopathology.

Empirically supported treatments that focus on increasing distress tolerance and emotion regulation should serve to inhibit the expression of self-harm and discourage involvement in other provocative experiences (e.g., fighting or drug abuse) that can strengthen acquired capability to enact lethal self-injury. For example, Linehan's (1993) Dialectical Behavior Therapy (DBT) elicits and evaluates negative thoughts and maladaptive behavior patterns. This therapy emphasizes techniques, such as chain analysis, which serve to identify the *who*, *when*, *where*, *how*, and *why* culminating in a suicide attempt or deliberate self-harm. This technique can be used to elicit and amend negative thought patterns leading to self-harm incidents. Further, DBT skills training emphasizes instruction in distress tolerance skills that clients can use to facilitate more adaptive coping responses when feeling the urge to engage in self-harm (e.g., distracting from negative emotions, self-soothing of emotions, improving the moment, and evaluating the pros and cons of self-harm or suicide; Linehan, 1993). In short, these skills constitute a way that clients can *survive* a negative situation and learn to take control of emotions and behaviors without self-injury.

### Burdensomeness and Thwarted Belongingness

Burdensomeness and thwarted belongingness share features that, for the sake of precluding redundancy, can be discussed in tandem. Both are interpersonal in nature and typically arise from distorted cognitions about one's significance to and integration with a valued social support network. The principal research for each component is addressed

separately; the assessment and intervention strategies are similar and thus are discussed together.

The second component of the interpersonal-psychological theory is that feelings of ineffectiveness, or burdensomeness, contribute to one's desire for suicide (Joiner, 2005). For example, a client may feel that loved ones would be better off in some way if he or she were no longer living. Such feelings may commonly arise from medical problems or job loss that results in financial strains (e.g., Filiberti et al., 2001). In addition, an individual may begin to believe that a persistent negative mood or the subjective quantity of problems may be too intense for a loved one to handle.

Research indicates that perceived burdensomeness is associated with increased suicide risk. In two studies, Joiner and colleagues (2002) compared suicide notes written by suicide attempters and suicide completers to determine differential predictors of completed suicide. Their findings indicated that the notes written by suicide completers contained higher levels of perceived burdensomeness than notes written by suicide attempters. Perceived burdensomeness was a significant predictor of the lethality of the chosen suicide method as well (e.g., self-inflicted gunshot wound was considered more lethal than overdose).

In samples of both adults and adolescents, perceived burdensomeness and hopelessness were significantly correlated with suicide attempt status and current suicidal symptoms (Van Orden et al., in press). The relationship between perceived burdensomeness and suicide attempt remained significant after controlling for hopelessness. These results suggest that perceived burdensomeness is a strong predictor of serious suicidal desire, with predictive power similar to that of one of the most consistent predictors of suicidality, hopelessness.

The need to belong to valued relationships and interpersonal groups has been described as a basic human desire (Baumeister & Leary, 1995), and feelings of connectedness may buffer people from suicidal behavior (e.g., "I could not do that to my parents"). Our model proposes that a third component, a need for belongingness, is so powerful that its absence (disconnectedness) increases the likelihood of suicide (Joiner, 2005).

One of the clearest findings in the literature on suicide indicates that individuals who complete suicide often experience social isolation and social withdrawal before their death (Trout, 1980). Findings linking loneliness and suicidality are also common. Significant others frequently point to loneliness in the patient as an important factor in the suicide attempt. Suicide rates in the United States indicated that more single individuals died by suicide than married individuals (McIntosh, 2002), suggesting that the failure or loss of significant relationships may be a contributing factor to the desire for death.

In addition, some research suggests that having a family may act as a *safeguard* against suicide. Women who have six or more children had one-fifth the risk of death by suicide of women who have fewer children (Hoyer & Lund, 1993). The preceding findings are consistent with the proposed notion that a sense of connectedness with, or importance to, others is a basic human need that can influence one's desire for life or death.

Joiner, Hollar, and Van Orden (in press) recently investigated the hypothesis that "pulling together" may also operate in relation to positive events and serve as a suicide buffer. They hypothesized that three different camaraderie-inducing sport events would relate to rates of suicide. First, the authors examined suicide rates in the counties of two prominent football schools: Ohio State University (home of the Buckeyes) and the University of Florida (home of the Gators). They found that suicide rates were higher in the years when the football teams were performing poorly (as assessed by national rankings). Second, they found that fewer suicides occurred on the day of the "Miracle on Ice" (February 22, 1980), the day of the United States hockey team's defeat of the Soviets,

than on any other February 22 in the 1970s and the 1980s. Finally, they investigated suicide rates on Super Bowl Sundays in recent years, as the event has gained prominence as a widespread *social* event, compared to non-Super Bowl Sundays in those years. Fewer suicides occurred on recent Super Bowl Sundays than on non-Super Bowl Sundays. These three examples are consistent with the hypothesis that camaraderie-inducing events may foster increased belongingness and lower suicide rates.

### *Risk Assessment*

Assessing the number and nature of interpersonal relationships and frequency of social contacts an individual experiences, particularly as they relate to burdensomeness and thwarted belongingness, is important in determining risk for suicide. Specifically, if acquired capability is established *in the presence of* burdensomeness or thwarted belongingness, suicide risk will be higher. Multiple attempters who have suffered an interpersonal loss often experience a suicidal crisis longer in duration than nonmultiple attempters. The increased duration may be caused by the multiple attempters' lack of the resources necessary to cope with life stress (Joiner & Rudd, 2000).

To determine the presence of burdensomeness, clinicians can evaluate the client's ability to care for himself or herself (in light of any recent illnesses, hospitalizations, financial setbacks, dependency on others, and general effectiveness in daily living). These components of functioning may be good indicators of the extent to which clients rely on others for help, clients' distress levels associated with needing help, and others' reactions to the client's needs. To assess for the presence of thwarted belongingness, it would be important to inquire about the state of a client's social support network, recent interpersonal losses, and perceived level and significance of social involvement. If possible, clinicians may also wish to consult a client's family and friends about recent decreases in interpersonal involvement.

### *Crisis Intervention*

The focus of any crisis intervention is to help clients tolerate emotional discomfort and to provide relatively straightforward techniques for relief before beginning therapy or between sessions. Such techniques typically recommend interpersonal coping strategies and invite clients to challenge negative thinking that perpetuates suicidality. Whether a client has acquired the ability to enact self-harm or not, targeting distorted beliefs about burdensomeness and failed belongingness may be a quick way to short-circuit suicidal impulses by alleviating emotional pain and directing clients away from their reasons for dying (Joiner, 2005). Challenging distorted beliefs allows clients to review past experiences that made them feel both useful and connected. Patients who espouse the belief that they are a burden to others or that they are not well connected may be challenged by clear examples suggesting otherwise. Further, imagining the impact of one's suicide on loved ones or identifying ways in which the client is needed by others may lessen the intensity of suicidal urges.

One technique that may help clients challenge distorted thoughts is the creation of a crisis card. A crisis card generally delineates multiple, often individualized steps that a client may take if he or she begins to feel upset or suicidal. A straightforward crisis plan may be generated and recorded during a session, and then given to the client to take home. Burdensomeness and belongingness may be addressed within the card itself. For example, the client may identify and list activities that foster connectedness, effectiveness, and feelings of self-efficacy, as well as any activities that have produced symptom

relief in the past (e.g., exercising, going to a movie, or engaging in a favorite hobby). In addition, the client could generate some of his or her most common distorted thoughts about self or others (particularly regarding burdensomeness and belongingness) as well as specific alternatives to those thoughts (e.g., the thought “I am a burden on my family” could be changed to “I regularly offer to help my sister with her studies”).

### *Long-Term Psychotherapy*

Thoughts related to burdensomeness and failed belongingness should be prioritized in psychotherapy. Because burdensomeness and failed belongingness are likely to arise as a function of misinterpreting the meanings of interactions with others, long-term psychotherapy may best be focused on restructuring negative thought patterns. Indeed, Rudd, Joiner, and Rajab (2004) documented that cognitive therapy is the leading treatment for suicidal behavior.

One integrative form of cognitive therapy, the Cognitive-Behavioral Analysis System of Psychotherapy (CBASP; McCullough, 2003), appears well suited for amending distorted thinking because it challenges clients to be goal oriented and planful in their approach to problem solving. Clients are taught to evaluate systematically whether or not their thoughts and behaviors *impede* or promote the attainment of desired outcomes (e.g., increased belongingness). When maladaptive patterns are identified, the client and therapist work together to generate more accurate situational interpretations, such that the client can be more objective when considering perceived burdensomeness and belongingness. Teaching clients to be increasingly evaluative and planful may also decrease impulsive tendencies, and therefore, the likelihood of greater exposure to painful or provocative stimuli (e.g., accidents, injuries, drug experimentation). This reduction may, in turn, lessen or prevent habituation and opponent process effects.

### Case Illustration

The following case provides an example of applying the interpersonal-psychological theory to the risk assessment and treatment of a suicidal adolescent client in a correctional setting.

#### *Presenting Problem/Client Description*

Chris is a 16-year-old boy who is incarcerated at a juvenile correctional facility on charges of battery. Chris was arrested for the first time at age 10 for hitting a school official and was incarcerated at age 13 on larceny charges. He lived with his mother and her boyfriend before incarceration and reported an unstable and abusive home environment, as well as a general lack of parental supervision. He has not been in contact with his biological father.

Upon admission to therapy, it was determined that Chris showed evidence of several features of Borderline Personality Disorder. For example, he continually expressed concerns over being abandoned by his therapist and others and regularly sought feedback verifying his therapist's regard for and commitment to treating him, though such admissions did not appear to set his mind at ease. Chris's opinion of his therapist also varied greatly from day to day. For example, after sessions in which Chris reported feeling known and understood by his therapist, he would ask other staff members to tell his therapist that he hated her and did not want to talk with her anymore. However, when

questioned, Chris could not articulate why he said such things. Further, Chris reported a significant history of depressed mood and irritability and had difficulty identifying emotions or causes of emotional fluctuation. Chris also reported engaging in several varieties of impulsive behavior, including criminal activity, drug use, and fighting. Finally, he reported some self-injurious behavior, including scratching his arms with a pin, punching walls until his hands were bloody and swollen, and provoking bigger boys into fighting with him. The behaviors described led to frequent conflicts with staff and peers, and Chris was often sent to confinement for unruly behavior, escape attempts, and self-injury.

### *Case Formulation*

Though Chris was first called to the attention of the correctional facility's treatment program for frequent fighting on campus, his self-injurious behavior quickly became apparent. Because Chris acknowledged suicidal ideation and carried out self-injury on several occasions, and because he had a variety of past experiences that are hypothesized to engage habituation processes (e.g., history of abuse, drug use, criminal activity), he was assessed to be at moderate risk for suicide. Other factors contributing to this decision were Chris's persistent feelings of both being a burden on his family because of his incarceration and not belonging within his family or his peer group. Chris reported that he does not talk to any of his peers about his concerns and has to maintain an image of toughness around them. He did disclose that he is extremely fearful of death and that his fear prevents him from making a suicide attempt. This disclosure is important in the context of the interpersonal-psychological theory, which posits that fear of death is a key suicide barrier (and that erosion of this barrier signals danger).

It was decided that therapy would consist of teaching Chris to utilize the CBASP in order to help him develop better impulse control, strengthen his coping skills, and allow him to interact more effectively in interpersonal situations. The goals of this strategy are manifold. First, by strengthening Chris's ability to engage in planful behavior, it was hypothesized that engagement in impulsive activities that may serve to engage and strengthen habituation processes would decrease over time and that Chris's movement down the trajectory to lethal self-injury would be halted.

Second, Chris described self-injury as a way to cope with negative emotionality. Although he found it helpful in some ways, it is clearly an inappropriate coping strategy that can contribute to "practicing" for suicide. To help Chris forgo self-injury as a coping strategy, it was necessary to help him develop new strategies, such as utilizing a coping card to help him remember to challenge negative thoughts about himself and his relationships. Also, Chris was encouraged to recognize the temporary nature of mood states and to acknowledge times when he was able to "wait out" a negative mood without resorting to self-injury.

Third, it was hoped that CBASP would provide a means for Chris to identify and challenge distorted cognitions related to feelings of burdensomeness and low belongingness. Teaching Chris to recognize and build on positive interpersonal experiences as well as strategies for effectively handling problems would serve as a protective factor against future suicidal behavior.

### *Course of Treatment*

Although Chris initially was able to develop rapport with his therapist and make gains in therapy, in terms of behavior management (e.g., reduced confinement placements caused

by fighting) he was less successful at implementing appropriate and effective coping strategies for dealing with negative affect. Several negative life events also occurred during the course of therapy that stretched Chris's minimal coping resources to the limit (e.g., Chris's mother stopped communicating with him, and he was informed that he would not be allowed to live with his mother after release because of abuse allegations, making his aftercare situation uncertain). In addition, Chris's therapist was preparing to leave the institution and Chris expressed little belief in his ability to cope without his therapist's guidance. Over time, Chris became increasingly verbally hostile and inconsistent with his therapist and less receptive to therapeutic intervention as a way to cope with stress. Incidents of self-injury increased and Chris spent more and more time in confinement and on "15-minute suicide watch." He made statements such as "If I was dead then I wouldn't have to worry about anything." He began to articulate plans for suicide, such as jumping in front of a moving car, hanging himself with his bed sheets, or jumping on the barbed wire fence, but did not disclose having a specific time frame for carrying out these plans. In addition, he continued to report being afraid of death and acknowledged having one friend at the facility to whom he felt connected. During this time Chris's risk for suicide was assessed as severe for the following reasons: (1) He reported plans for suicide for which he had access to means, (2) he reported feeling he was a burden on and disconnected from his family, and (3) he reported numerous painful and provocative experiences, including self-injury, that put him at risk for habituation to the pain and fear associated with suicide.

To help him manage crisis situations, Chris was asked to make a coping card with a list of activities to engage in if he began having thoughts of hurting himself. Items included reading or writing (activities he found enjoyable), talking to a friend in the cottage (to increase feelings of belongingness), and telling staff if his thoughts elevated to specific plans about suicide. In therapy, the following intervention, aimed at assessing and increasing feelings of effectiveness (rather than burdensomeness) and belongingness took place:

THERAPIST (T): Chris, how do you think your family would feel if you died by suicide?

CHRIS (P): I guess my mom wouldn't care. If she cared about me, she would have called me or answered my letters.

T: What about your grandparents, how do you think they would feel?

P: They might be sad a little bit, but they'd get over it pretty quick. They have enough to worry about.

T: How do you think I would feel if you died?

P: You would probably just get a new client. I don't see how you could care about an offender.

T: I noticed that you always carry a picture of your little sister in your journal with you.

How do you think she would feel if her big brother died?

P (BEGINS CRYING): Why'd you ask me that, ma'am? You know that's my one weakness.

T: Your sister is very important to you.

P: She needs a big brother to look out for her. I used to baby-sit for her and take care of her before I was locked up. Now I don't do anything good for her.

T: She must really miss you.

P: I haven't seen her in a year and a half.

T: What do you think she would want you to do right now?

P: Straighten up so that I can go home.

T: So when you think about your sister, that makes you want not to give up, so you can be there for her?

P: Yes, I love her with all my heart.

T: Maybe you can put “thinking about my sister” on your coping card, so that you can remember how much you mean to your sister and how she would feel if you hurt yourself.

P: Okay. Don’t tell anyone that I cried, ma’am.

Though Chris was able to use thoughts of his sister to bolster him during times of crisis, his report of suicidal ideation and plans remained the same. In addition, he reported increasing levels of depression on the Beck Depression Inventory. Thus, sessions often consisted of reviewing Chris’s coping card and attempting to elicit statements that reflected belongingness and effectiveness. Additions to his coping card included affirmations to himself that he could tolerate distress and affect change in his life.

### *Outcome and Prognosis*

Chris made beginning progress on important parameters but had many areas to continue to improve at the time of this writing: impulsivity, hopelessness, thwarted belongingness, several painful and provocative experiences including some suicidal behavior (e.g., scratching his arm with a needle), and feelings of ineffectiveness. At the time of termination, therapy was focused on finding ways to foster Chris’s feelings of effectiveness (versus burdensomeness) and belongingness (versus loneliness). The amount of life stress he experienced while incarcerated likely contributed to difficulties in building on gains and seriously working at developing better emotion regulation and coping skills. If immediate crises could be minimized, improvements in several areas appear to be possible. It is likely that future efforts with this client will continue to focus on crisis management and distress tolerance, as well as prevention of further self-injury. The value of the interpersonal-psychological theory in this instance is to point the way to specific themes and behaviors on which to focus.

### Clinical Issues and Summary

In treating clients who self-injure and demonstrate minimal ability to regulate behavioral and emotional responses, it is difficult to pick an initial point of intervention. Thorough risk assessment is always crucial and may serve to put important antecedents to self-injury (e.g., feelings of burdensomeness and low belongingness) in focus. Because they threaten the safety of the client, such antecedents warrant immediate attention, though initially it may be necessary to use brief interventions, such as a few points on a coping card, to keep clients safe until they become stable enough to benefit from skills-based treatment. In constructing these and other interventions, the emphases of the interpersonal-psychological theory deserve priority.

Although assessing and treating suicidal behavior are daunting tasks for clinicians, the interpersonal-psychological model of risk assessment, crisis intervention, and skills-based therapies can provide solid directions of inquiry, reduce error in designating risk, and ensure more effective treatment for suicidal clients. The interpersonal-psychological theory provides one framework for identifying pernicious risk factors and tailoring assessments and interventions to address these factors better.

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