Adlerian Perspective on the Interpersonal Theory of Suicide
in Relation to Adolescents and Young Adults

A Research Paper

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Abstract

Suicide is a leading cause of death for adolescents and young adults. This paper reviews empirical literature pertaining to suicide ideation, suicide attempts, and suicide. Current research identifies risk factors which act as triggers for suicidal behavior. Assessing the potential moderating role of protective factors such as resilience and coping skills will be discussed. Gatekeeper training and screening assessments, two of the most promising programs in the pursuit of suicide prevention, will be summarized. This review of literature describes Dialectical Behavior Therapy and Cognitive Behavior Therapy, protocols proven effective in the treatment of adolescent suicidal behaviors. An examination of the Interpersonal Theory of Suicide and Adlerian Theory highlights their impact on suicide assessment, prevention, and treatment.
Acknowledgements

With great love, I wish to express appreciation to my sons, Frankie and Rob. I’m honored to be their mother and pleased to have sons who value education, embrace autonomy, and live their lives with courage and compassion. They are my finest work.

With great sadness, I was inspired by Dusty, who was like a son and brother to us for many years. He died by suicide using a firearm on November 13, 2011 at the age of 21.

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Adlerian Perspective on the Interpersonal Theory of Suicide in Relation to Adolescents and Young Adults

Suicide is a worldwide public health concern and a leading cause of preventable deaths. The Centers for Disease Control and Prevention (CDC, 2012) estimates that young adults between the ages of 15 and 24 years old attempted suicide approximately 100 to 200 times for every completed suicide. Understanding the origins of suicidal ideation and identifying high risk populations is critical in the pursuit of suicide prevention. Awareness of risk factors that decrease suicidal behavior and protective factors that increase resilience and coping skills are essential components of suicide prevention.

Research highlights the urgency of developing and implementing effective assessment, prevention and treatment strategies. Theoretical frameworks form a basis for empirical study from which effective strategies evolve. The Interpersonal Theory of Suicide (Joiner, 2005) contains the most up-to-date research in the field of suicide assessment and management of risk.

The Interpersonal Theory of Suicide posits that two painful interpersonal states comprised of low belonging and misperceptions of being a burden are risk factors for suicidal desire. When these two psychological states occur simultaneously in an individual capable of lethal self-injury, the potential for suicide is most elevated. The unique strength of this theory lies in distinguishing between those who desire death by suicide, but do not attempt suicide and those who make a serious attempt to enact lethal self-harm.

Alfred Adler’s 1937 essay on suicide underscored the significance of interpersonal characteristics such as social isolation and feelings of inferiority. Adler understood the origins of suicide to be complex and accounted for both distal and proximal factors. The process of Adlerian therapy includes increasing social interest and challenging an individual’s private logic
and mistaken beliefs. Current research on suicidal behavior confirms many of the assertions Adler formulated nearly a century ago.

**Adolescent and Young Adult Suicide**

According to the CDC (2012), suicide is the third leading cause of death among youth aged 15 to 24 years. Accidents and homicides are the only two causes that take more lives than suicide. Among youth between the ages of 10 and 14 years, suicide is also the third leading cause of death, preceded only by accidents and cancer.

A youth risk behavior study of students in grades 9-12 undertaken by the CDC found that in a 12-month period, 15.8% of students had seriously considered attempting suicide, 12.8% reported having a specific plan, 7.8% reported making one or more suicide attempts, and 2.4% reported making an attempt that required medical attention.

These statistics underscore the necessity of identifying risk factors for vulnerable young adults as well as providing protective factors and timely interventions. Awareness of the links in the suicide process is critical in the study of suicide. These links include suicidal ideation, attempted suicide, and completed suicide. Because of its link to suicide, suicidal ideation has proven to be an early warning sign for suicidal behavior (Mark et al., 2013).

**Suicidal Ideation**

The CDC defines suicidal ideation as thinking about, considering, or planning for suicide (2012). Robinson et al. (2013) defines suicidal ideation as having thoughts of engaging in behavior intended to end one’s life. A survey in research by Logan, Crosby and Hamburger (2011) supported the findings by the CDC that nearly a fifth of the adolescent population had considered suicide in the previous year. Consequently, identifying adolescents at risk is an important goal of suicide prevention programs.
Research by Husky et al. (2012) found that most young people with suicidal ideation and half of those with a suicide plan or who had made a suicide attempt did not receive mental health treatment. Husky et al. also reported male adolescents were significantly less likely to receive mental health services, even though the risk of suicide for boys is four times greater than for girls. At the same time, female students are nearly twice as likely to consider or plan suicide as their male counterparts. As Logan et al. (2011) emphasized, suicidal ideation is a mental health issue that is a burden of particular significance to the young adult female population.

**Suicidal ideation in high school populations.** Logan et al. (2011) found that adolescents who felt connected to their school were significantly less likely to seriously consider suicide. The results of this study suggested that schools can help prevent suicidal ideation at an early age by encouraging students to engage in extracurricular activities and also by helping students achieve academic success. In a similar study, researching the effect of resilience as a protective factor against suicide, Everall, Altrows, and Paulson (2006) determined that involvement in extracurricular activities fosters a sense of connectedness and a support system that buffers suicidal behavior.

Logan et al. (2011) found that having relationships with delinquent youths increases the risk of suicidal ideation. Although research confirms that having positive relationships with peers acts as a protective factor in suicidal ideation (Everall et al., 2006), Logan et al. suggest schools take extra precautions when encouraging peer connectedness by also teaching violence-prevention and substance-abuse strategies, especially in high-risk communities.

Results in a study by Husky et al. (2012) pointed out that adolescent suicidal behaviors are often undetected and emphasized the need for implementing suicide risk assessment into the routine mental health screening of high school students. Researchers also suggested that schools
incorporate programs to educate students in the areas of resolving conflict, enhancing social-problem skills, and increasing self-esteem (Logan et al., 2011).

**Suicidal ideation in college populations.** According to Arria et al. (2011), in 2010, one in ten college students contemplated suicide and 1% to 2% of the college population attempted suicide. In a study by Bauer, Chesin and Jeglic (2013) almost two-thirds of the college students who reported a past suicide attempt had attempted suicide more than once. A longitudinal study assessing college students with suicidal ideation found that 59% of the participants who experienced having suicidal ideation in college had reported having at least one earlier episode during adolescence (Arria et al., 2011).

One implication from the study by Arria et al. (2011) is the importance of assessing young people for risk at the earliest age possible to avoid incorrectly attributing problems in college to immediate environmental or social situations. Previous behavior needs to be taken into consideration due to the elevated number of students who had contemplated suicide prior to attending college.

Participants in this study reported seeking treatment more often if they had received mental health services before attending college, especially if the treatment experience had been positive (Arria et al., 2011). This research also found that nearly half of college students reporting suicidal ideation did not receive mental health services and 44% of those who obtained treatment felt they needed more treatment than they received, presumably indicating a lack of mental health services for college students (Arria et al., 2011).

**Suicidal ideation and family connectedness.** Research by Logan et al. (2011) found that adolescents were significantly less likely to experience suicidal ideation if they believed that they received both supervision and caring from their parents, as opposed to only supervision. Results
of this study substantiate the importance of parental affection and positive reinforcement in preventing suicidal ideation, and even more so when coupled with parental supervision. Parental caring and supervision are particularly impactful for female adolescents. Girls who reported lacking parental connectedness were five times more likely to have suicidal ideation, compared to adolescents who reported having both parental factors present. In contrast, boys who reported a lack of parental connectedness were only twice as likely to have suicidal ideation as young males who perceived having both parental supervision and caring parents (Logan et al., 2011).

Suggestions for reducing suicidal ideation by increasing parent-child connectedness include improving access to family counseling and encouraging involvement in programs that enhance positive and caring relationships (Logan et al., 2011). Randell, Wang, Herting and Eggert (2006) recommend focusing on helping parents identify the warning signs of suicidal ideation and provide support systems for parents and adolescents to discuss suicidal behavior.

Risk Factors

Risk factors for suicide consist of characteristics or conditions that contribute to the risk that a person may take his or her life (American Foundation for Suicide Prevention [AFSP], 2014). Lamis, Malone, and Ellis (2010) point out that oftentimes mental health facilities and suicide prevention centers are unable to detect college students most at risk for suicide and that only a small percentage of those individuals experiencing suicidal behavior have contact with mental health services. Therefore, recent emphasis has been on assessing suicide proneness by focusing on risk factors (Lamis et al., 2010). AFSP emphasizes that potential for suicide is greater when multiple risks are present. Risk factors can be based on individual, relational, or environmental characteristics.
Individual characteristics of suicide risk. Individual risk factors that increase the likelihood of suicide published by the CDC (2012) include: previous suicide attempt(s), a history of mental disorders, alcohol and substance abuse, feelings of hopelessness, physical illness, isolation, and impulsive or aggressive tendencies.

The CDC (2012) reports that about 20% of the people who die by suicide have attempted suicide in the past. A prior suicide attempt is one of the most reliable predictors of future suicidal behavior, particularly in the adolescent population (Van Orden, Witte, Braithwaite, Selby, & Joiner, 2010).

According to AFSP (2014), over 90% of the people who die by suicide have a mental disorder at the time of their death. In many cases these disorders have not been acknowledged, diagnosed, or professionally treated (AFSP, 2014). After performing “psychological autopsies”, which entails interviews with family, friends, and associates, investigators found that one-third of those who died by suicide did not tell anyone of their intentions.

In a study focusing on suicide risk factors, Mark et al. (2013) found that school children who smoked or consumed alcohol, particularly by the age of 13 or earlier, reported a higher level of suicidal behavior. Participants in the study by Mark et al. also reported increased suicidal behavior when they were involved in physical fighting and/or bullying, whether they were the one bullying or the one being bullied.

Lamis et al. (2010) studied alcohol use among college students and confirmed that drinking is a significant predictor of suicidal behavior. The research by Lamis et al. supported the hypothesis that depression may lead to alcohol use, which may make students prone to suicide ideation. However, results of their study also indicated that alcohol may be the trigger for depression, which may result in suicidal behavior. Finding that both alcohol use and depression
are precursors to suicide, Lamis et al. recommend that colleges focus on both increased screening for depression and the development of more specific alcohol prevention programs.

In researching depression and delinquency among college students, Bauer et al. (2013) established that depression is a significant predictor for delinquent behavior, which, in turn, strongly predicts suicidal behavior in both adolescents and young adults. As adolescents emerge into adulthood, delinquent behavior becomes less tolerated by peers. This contributes to an individual’s sense of isolation and social withdrawal, which increases the likelihood of suicidal behavior. Suggestions by the authors of this study include assessing for suicide risk by including questions about delinquency in the screening process and targeting delinquent behavior in suicide prevention programs (Bauer et al., 2013).

Lamis et al. (2010) also researched body image dissatisfaction as another individual suicide risk characteristic. Lamis et al. did not find that body image dissatisfaction was a direct predictor of suicidal behavior, but did corroborate a connection between poor body image and depression as well as increased alcohol use. Researchers found that study participants who felt they deviated from the norm with regard to their body image may have felt ostracized and isolated from social peers. This sense of rejection and disconnection may lead to a depressed state for young adults. Furthermore, research showed that individuals who were less likely to protect and care for their bodies were more apt to engage in high-risk behaviors, perhaps causing bodily harm, and potentially leading to suicidal behavior (Lamis et al., 2010).

**Relational characteristics of suicide risk.** Characteristics of a relational nature that elevate the risk of suicide include a family history of attempted or completed suicide, family history of child mistreatment, and cultural and religious beliefs (CDC, 2012). Recent research
has also established a correlation between poor parent-child communication and suicide (Mark et al., 2013) and youth perception of family depression and drug use (Randell et al., 2006).

Participants in the study by Mark et al. (2013) who reported difficulties in communication with their parents also reported increased levels of suicidal ideation. The research by Mark et al., which was undertaken in European countries, found that in some countries, suicidal behavior was more likely when the communication problem stemmed from the relationship with the adolescent’s mother as opposed to one’s father, but this was not supported in every study.

In researching family factors that increase suicide risk, Randell et al. (2006), found elevated risk among teens who perceived a higher level of parent-child conflict, family alcohol and drug use, and family depression. In addition, adolescent perception of his/her family’s inability to set fair rules, communicate openly, do things together, and find value in the youth’s capabilities increased the likelihood of suicidal behavior. In addition, research by Randell et al. found increased suicide risk among young adults confronted with stressors such as; perceived family conflict, parental job loss, family member illness, and death in the family.

Furthermore, Randell et al. (2006) emphasized that parents are often unaware their child might be at risk for suicide, therefore, programs are needed to focus on improving family communication and on helping parents identify warning signs. Enhanced parent-child communication would include talking about depression and suicidal thoughts as well as providing stress management and coping techniques (Randell et al., 2006).

According to the AFSP (2014), exposure to attempted and completed suicide by a family member may heighten suicide risk for others in the family. Studies have shown that the risk of suicide is genetically-linked. Research has established that depression is also inherited, but the
risk of suicide is a precursor that exists independently of depression (AFSP).

**Environmental characteristics of suicide risk.** In the literature provided by the AFSP (2014), one of the conditions in an individual’s life that may increase the possibility of suicide is exposure to a suicide or several suicides in one’s community. This exposure is considered a contagion or epidemic. Media coverage has been shown to play a role in increasing suicidal behavior, especially among young adults (AFSP). Machlin, Pirkis and Spittal (2013), in their research about the media reporting on suicide, found that journalists may consider what is in the public’s best interest and forego including details in their coverage to discourage copycat behavior.

Access to a lethal method of suicide, especially during a period of higher risk, is another environmental factor of suicidal behavior (AFSP, 2014). In 2010, according to the CDC (2012), almost half of young adults between the ages of 15 and 24 who died by suicide did so with a firearm. Young men are more apt to use firearms as a method for suicide, whereas young women tend to use poisonous substances, particularly medication overdoses. In all likelihood, due to the lethality of firearms, males completed suicides four times more than females (AFPS, 2014). As Husky et al. (2012) points out, one of the most effective means of suicide prevention would be restricting access to firearms. Additionally, in situations where individuals do not make a suicide plan and the window for intervening is brief, limiting access to firearms may be the most effective strategy for preventing suicide among an at-risk population (Bagge, Glenn, & Lee, 2013).

Additional environmental risk factors in the CDC (2012) and AFPS (2014) literature include stressful events such as a family, social, or financial loss and prolonged stress as a result of unemployment, relationships, or harassment.
Protective Factors

Factors in a young adult’s life that may protect them from suicidal thoughts and behaviors include access to mental health facilities for assessment and treatment; feeling connected through family, friends, and community; and availability of programs focusing on problem solving, conflict resolution, and nonviolent intervention (CDC, 2012). Another buffer may be religious and cultural beliefs that dissuade young people from suicide and instill a sense of self-preservation (CDC). A study by Mark et al. (2013) noted that being female may be a crucial protective factor in the context of communication, relationships, and expressing feelings more easily; which lends itself to being more socially integrated.

Resilience. The CDC (2012) has emphasized the importance of identifying and implementing protective buffers, but until recently research has focused on risk rather than protective factors. Research by Everall et al. (2006) established resilience as a protective factor against suicide. Everall et al. defined resilience “as an adaptive process whereby the individual willingly makes use of internal and external resources to overcome adversity or threats to development” (p. 462). In addition, the authors consider resilience to be a process of adaptability that can be learned; it is not a unique quality that one possesses.

Everall et al. (2006) opined that resilience is needed to overcome adversity. The authors consider adversity to be similar to the risk factors demonstrated to be precursors to suicidal behavior. Adversity stems from significant events or circumstances in one’s life and might include: parental separation and divorce, abuse and neglect, serious illness or disability, and chronic poverty. Research by Everall et al. pointed out that adversity is frequently due to severe trauma, but it may also be as simple as an accumulation of life’s hassles and stressors. Consequently, research underscores the necessity of accounting for each individual’s
DEATH BY SUICIDE

perspective. Factors that enhance resilience include individual, family, and community associations.

**Individual factors that enhance resilience.** Several characteristics of resilience include the ability to focus on problems rather than ignoring them, creatively finding solutions to problems, and asking others for help (Everall et al., 2006). Additional traits of resilience encompass positive self-esteem, future aspirations, the persistence to succeed, the belief that one has control over one’s life, and a sense that adversity can be overcome with personal effort. Research has shown that humor, flexibility, empathy, and an easygoing nature increase social competence. Subsequently, young adults with strong social skills and the ability to communicate interpersonally exhibit more resilience (Everall et al., 2006).

**Family factors that enhance resilience.** Mark et al. (2013) validated the importance of establishing good communication with at least one parent to decrease the likelihood of suicidal behavior. Similarly, as reported in the study by Everall et al. (2006), possessing a secure connection to at least one nurturing parent increased resilience. Resilient individuals are able to seek support from caregivers outside the family when caring and support is not available from a parent. Parents of adolescents who provided encouragement and guidance increased their teen’s sense of optimism, motivation, and belief in their ability to be successful (Everall et al., 2006).

**External and community factors that enhance resilience.** Possible adult caregivers adolescents may reach out to in a time of adversity, when a parent is not available, include teachers, coaches, school counselors, ministers, and neighbors (Everall et al., 2006). As Bauer et al. (2013) and Logan et al. (2011) demonstrated, positive relationships with peers decreased suicidal behavior, whereas suicide proneness increased when peer groups included delinquents
engaging in antisocial or illegal activities. Everall et al. pointed out that involvement in extracurricular activities also enhanced resilience.

Everall et al. (2006) described the following four areas of resilience that impact suicidal behavior: social processes, emotional processes, cognitive processes, and purposeful and goal-directed action. The domains were determined by input culled from female participants who reported being suicidal at one point in their life between the ages of 15 and 24 years.

**Social processes.** A peer network of close friendships that provided camaraderie, a sense of belonging, emotional support, companionship, and acceptance was instrumental in the process of overcoming suicidal inclinations (Everall et al., 2006). Participants reported peer relationships being most beneficial when friends were understanding, caring, encouraging, patient, and respectful listeners. As many studies have shown, Everall et al. also point out the importance of having a relationship with at least one supportive parent when confronted with suicidal ideation and behavior. This study found that young adults not only benefited from a parent(s) who responded to their problems and concerns with acceptance and consideration, but who also provided assistance financially and helped in procuring treatment. In the event of a non-involved parent, an adult outside the immediate family, such as a teacher or counselor, could be a valuable alternate source of support. The influence of a substitute parent has a significant impact when they demonstrate an unwavering belief in the young adult’s ability to achieve his or her goals (Everall et al., 2006). This research underscores the role of social interaction and the significance of having the support of at least one caring individual.

**Emotional processes.** Dealing with the painful feelings of sadness, anger, fear, and depression generally elicited the most trauma when individuals faced their suicidal behavior (Everall et al., 2006). Confronting these difficult feelings took courage and determination. The
participants in this study acknowledged the importance of having others listen to them in a nonjudgmental manner without providing hasty reassurances and solutions, allowing them time to sort through their feelings. Expressing their feelings to others who had similar experiences provided normalization with regard to their own difficulties. Some of the participants engaged in writing as an emotional outlet; composing poetry to increase self-awareness and journal writing to help identify and explore feelings (Everall et al., 2006).

**Cognitive processes.** Participants in the study gained greater perspective when they focused on the positive aspects of their life, especially when they compared their life to others less fortunate (Everall et al., 2006). Learning to be more objective about their thoughts resulted in redirecting those thoughts more positively. Researchers utilized this shift of perspective by encouraging the participants to explore the small things in their life that brought them hope, pride, and optimism and to concentrate on today and the future rather than agonizing over the past. Individuals also reported experiencing a sense of control when they recognized they had the ability to make choices in response to situations in their life (Everall et al., 2006).

**Purposeful and goal-directed action.** The participants in the study by Everall et al. (2006) described heightened feelings of self-efficacy and control when they took action to make positive changes in their life. They also reported that being involved in activities such as studying, working, and spending time with friends kept suicide ideation at bay. Keeping busy helped ease the emotional pain and acted as a distraction from negative thinking. Some participants reported the necessity of changing their environment. As other studies have corroborated, Everall et al. reported the significance of developing relationships that have a “positive influence” and ending friendships with peers involved in drugs, alcohol and destructive behaviors. Another useful tool involved learning to ideate a future based on goals attached to a
new self-identity with a sense of purpose in life. Everall et al. noted an increased sense of self-esteem and optimism as these new behaviors were implemented.

**Lesbian, Gay, and Bisexual Youth**

Lesbian, gay, and bisexual (LGB) youth ideate and attempt suicide at rates two to seven times that of their heterosexual peers (Diamond et al., 2013). Recent estimates indicate that between 15% and 40% of LGB youth attempt suicide each year, but there is insufficient data to determine how many LGB adolescents actually die by suicide (Diamond et al., 2013). Risk factors that are particularly pernicious to LGB youth include victimization, discrimination, and rejection. Encountering these circumstances often leads to depression, low self-esteem, hopelessness, and social isolation, which, in turn, increases LGB youth’s vulnerability to suicidal behavior.

Research by Diamond and colleagues (2013) points to parental rejection as the most detrimental experience faced by LGB youth. Reporting a perception of disengagement, nonacceptance, and disdain from their parent(s) leads adolescents to believe that something is wrong with them. The effect of parental rejection can be devastating, with emerging LGB adults having no one to turn to when feeling victimized. This void threatens the attachment relationship between parent and child and the protection that a parental relationship provides (Diamond et al., 2013).

On the other hand, LGB sons and daughters feel accepted by parents who regard their child’s sexual orientation as a unique and valued component of his/her personhood. Diamond et al. (2013) added that parents who validated their child’s LGB status are in a better position to support, guide, and advocate for their child as their child maneuvers through the challenges that life presents. Accepting parents are better able to provide protection when necessary and
available to help when assistance is requested, ameliorating and strengthening the attachment bond between parent and child (Diamond et al., 2013).

LGB youth who reported having families who were not accepting of their minority sexual orientation were twice as likely to experience suicidal thoughts as those who reported having families who were highly accepting of their LGB orientation (Diamond et al., 2013). LGB adolescents and young adults who reported having strong parental support as well as good communication and emotional connection to their parents also reported having fewer symptoms of depression, less suicidal ideation, and fewer suicide attempts.

Focusing on suicide in the LGB population, Diamond and colleagues (2013) studied the effect of a family-based intervention designed specifically for adolescents exhibiting suicidal behavior. The researchers implemented Attachment Based Family Therapy (ABFT). Research findings have indicated that prevention and treatment would be significantly enhanced by including programs that reinforce the attachment between parent and child. Diamond et al. define secure attachment as “the adolescent’s sense that her or his distress will be registered and that an adult will come to provide comfort and protection in times of need and is dependent on the presence of at least one stable, reliable, and responsive caregiver” (p. 92). In contrast, insecure attachment may develop due to an unavailable or unresponsive caretaker and, this, in turn has been associated with suicidal behavior.

ABFT is a two-part program developed specifically to treat adolescent depression and suicidal behavior. The first half of the treatment model focuses on helping the parent and child identify and discuss family conflicts. Further discussion emphasizes the harm this dissension has inflicted on the family bond, the trust with one another, and the ability of the child to ask his/her parent for support and protection when needed (Diamond et al., 2013). The second half of the
treatment model focuses on encouraging adolescent independence and competency. Improving school connections, increasing social involvement, and securing employment accomplish autonomy on behalf of the adolescent. By decreasing isolation, providing positive experiences, and increasing self-esteem, these experiences enhance optimism for the future and decrease suicidal behavior (Diamond et al., 2013).

Diamond et al. (2013) considered their recent study to be the first to implement a treatment specifically for LGB youth at risk for suicide. Research findings indicated the necessity of providing parents adequate time to work through their feelings of disappointment, fear, anger, and embarrassment surrounding their child’s sexual orientation. Once the parent had explored these emotions, they reported being in a better place to empathize with their child and listen to her or his concerns. By utilizing the processes of ABFT, adolescents reported feeling listened to, taken seriously, loved, and protected by their parent(s). Some parent participants reported increased awareness of their own indirect and, at times, unconscious invalidating responses to their child’s sexual orientation. Researchers found ABFT to be a model for reducing parental criticisms and increasing parental care, which strengthened the parent child relationship, and, ultimately decreased suicidal behavior among LGB adolescents and young adults.

Negative Life Events

Bagge and colleagues (2013) hypothesized that, in keeping with the interpersonal theory of suicide, interpersonal negative life events increased feelings of low belongingness and perceived burdensomeness, therefore, triggering suicidal behavior. The impact of negative, stressful events increased an individual’s vulnerability and decreased her/his ability to cope.

Risk factors for suicide are considered to be either distal or proximal. Distal factors occur in the weeks, months, or years prior to a suicide attempt. These factors aid in identifying who is
at increased risk for suicide, but not when an individual may attempt suicide. Proximal factors occur in a closer timeframe during the minutes, hours, day(s) prior to attempting suicide. These factors heighten the ability to pinpoint when an individual is at an elevated risk of attempting suicide (Bagge et al., 2013).

Individuals who experience negative and potentially traumatic life events significantly increase their risk for suicidal behavior (Rowe, Walker, Britton, & Hirsch, 2013). Current research established a link between suicide attempts and evidence of a significant, interpersonal negative life event in the weeks and months prior to the suicide attempt (Bagge et al., 2013). As was shown in the research by Smith, Cukrowicz, Poindexter, Hobson, & Cohen (2010), life events of a particularly painful and provocative nature elicited a stronger tendency toward suicidal behavior than general negative life events. A more recent study by Bagge et al. indicated that romantic and partner relationship life events that have a negative impact on an individual increase the likelihood of attempting suicide to a greater degree than other interpersonal relationships. Additional findings from their research suggested that individuals attempting suicide due to a romantic negative life event do not plan their suicide, but attempt suicide with little forethought. With that data in mind, researchers pointed out the necessity of putting in place a strategy for effectively handling potential negative life events for those most at-risk for suicide.

Additionally, the previously noted research by Bagge and collaborators (2013) found that a negative life event did not trigger immediate suicidal action in individuals currently planning suicide. The effect of proximal negative life events, such as romantic relationship problems, appeared to not deter a suicide planner from following through with their original plan for suicide. In summary, individuals with a suicide plan in place, when confronted by a negative life
event, do not alter their suicide plans. However, individuals without a current suicide plan are more apt to respond to a negative life event by engaging in suicidal behavior.

Recent research by Rowe et al. (2013) confirmed that not all study participants who identified negative life events reported suicidal behavior. Their study explored the possibility that meeting one’s basic needs acts as a buffer between negative life events and suicidal behavior. The basic psychological needs they studied included autonomy, relatedness, and competence. Participants reported a sense of emerging autonomy and empowerment when they made self-determined decisions, which aided in reducing stress and decreasing suicidal behavior. Researchers also found that feelings of isolation were lowered by connecting with others, which reduced the risk of suicide. In addition, this study found that individuals empowered by feelings of self-efficacy and competency tended to resolve stressful and negative issues more effectively, thereby, lowering their suicide risk. Individuals who demonstrated an ability to adapt and cope when confronted with negative situations decreased their likelihood of suicide.

Suicide Prevention Strategies

The goals of suicide prevention strategies aim to heighten awareness and understanding of suicide, reduce factors that increase the risk of suicide, and enhance protective factors such as resilience and other coping techniques. A critical component of suicide prevention for adolescents and young adults focuses on the link between an individual recognizing that he/she has a problem and the youth at-risk obtaining treatment. A key objective for current prevention programs involves encouraging suicidal youths to seek help (Klimes, Klingbeil, & Meller, 2013). Research indicated that adolescents frequently confided in their peers and received vital support during a crisis, however, sharing this information with peers rarely led to professional
intervention. Studies have shown that almost 75% of adolescent peers do not share an individual’s suicidal intentions with anyone else (Klimes, et al., 2013).

A number of programs designed to prevent suicide, particularly over the past 30 years, have succeeded in increasing knowledge about the gravity of suicide as a public health concern. Recent empirical evidence has shown that the two strategies with the most significant impact on suicide prevention consist of gatekeeper training and suicide screening programs (Klimes, et al., 2013; Robinson et al., 2013).

**Gatekeeper training.** Gatekeeper programs, with the goal of securing resources for at-risk youth, have proven to be effective. Staff members including: teachers, counselors, mental health professionals, and administrative personnel may become gatekeepers in an academic setting. Gatekeeper training consists of building a trusting relationship with students, increasing knowledge about suicide risk factors, and providing the necessary skills to identify vulnerable adolescents. Robinson et al. (2013) consider gatekeeper intervention to be a selective intervention of identifying individuals displaying risk factors as opposed to seeking intervention for only those who manifest distinct signs of suicidal behavior.

Klimes et al. (2013) consider gatekeeper programs to be of either a surveillance or a communication nature. The surveillance model consists of increasing a gatekeeper’s knowledge and awareness of risk factors allowing her/him to respond effectively by providing appropriate referrals. The latter model emphasizes communication between gatekeepers and students with the goal of encouraging the students themselves to seek help. In underscoring the importance of this type of program, Klimes et al., noted “the most concerning findings regarding the impact of suicide-prevention efforts were for adolescents who reported symptoms of depression or previous suicidality. These at-risk adolescents are often the least likely to engage in help-seeking
behavior” (p. 91). Educating gatekeepers has proven to decrease suicidal behavior by increasing knowledge of risk factors, enhancing awareness of mental health and suicide, reducing the stigma associated with help-seeking and providing access to referral services.

**Suicide screening programs.** Screening programs identify youth who may be at risk for suicide, but have not come forward seeking help. These programs also focus on individuals who have not been identified as vulnerable by a mental health professional. The screening programs administered by Robinson et al. (2013) included the Suicidal Ideation Questionnaire (SIQ), the Reynolds Adolescent Depression Inventory (RADS), the Suicide Risk Screen (SRS), the Columbia Suicide Screen (CSS), the Beck Depression Inventory (BDI), and the Strengths and Difficulties Questionnaire (SDQ). These programs, administered as the first step in a two-part process, focused on detecting youth most at-risk for suicide. During the second stage of the process, at-risk individuals met in a face-to-face, in-depth interview with professional clinicians. Following the interview phase, mental health providers determined which of those at-risk youth required ongoing support through school- or community-based services.

Researchers noted a lingering perception, even among professionals, that discussing suicide may elevate suicidal behavior. Current research by both Robinson et al. (2013) and Eynan et al. (2013) demonstrated that suicide assessments do not cause undue stress, nor do they increase suicidal urges. In fact, Eynan et al. explained that a decline in suicidal behavior following an assessment “may be due to the therapeutic and cathartic effect of the assessment interviews, including both the content of the research interview and the relationship formed between the interviewer and interviewee” (p. 129).

Robinson et al. (2013) pointed out the necessity of providing effective treatment to the at-risk individuals identified by screening programs. Research findings confirmed the benefit of
early treatment in attaining more desirable results. This study by Robinson et al. emphasized that “it is widely acknowledged that mental health services are overstretched, and that identifying people to be in need of support, yet not being able to provide that support, is clearly problematic” (p. 177).

**Psychotherapeutic Techniques for Treatment of Suicidal Behavior**

As previously noted, AFSP (2014) pointed out that 90% of the people who died by suicide manifested a mental illness at the time of their death. Medication for the treatment of depression has proven to reduce suicide rates. In addition to medication, psychotherapy has been shown to effectively treat depression. Psychotherapeutic techniques proven most successful for treating individuals with suicidal behaviors who may also be manifesting symptoms of depression include Dialectical Behavior Therapy and Cognitive Behavior Therapy.

**Dialectical Behavior Therapy (DBT).** DBT evolved from Linehan’s biosocial theory that suicidal and self-harm behaviors stem from an individual’s inability to regulate her/his emotions. According to Neece, Berk, & Combs-Ronto (2013), “emotion regulation is generally defined as the ability of an individual to control, modify, change, and manage emotional reaction and expression to achieve one’s goals and effectively manage social, interpersonal relationships” (p. 258). DBT emphasizes teaching skills to cope with emotion dysregulation and eliminating behaviors that cause self-injury.

Incorporating cognitive and behavioral techniques, as well as strategies originated from Eastern philosophy and religion, DBT focuses on teaching and developing emotion regulation skills. A deficit in emotion regulation skills stems from interactions between a child and his/her caregiver beginning in infancy. Individuals manifesting suicidal behaviors generally exhibit less developed emotion regulation skills, oftentimes similar to coping skills of much younger
children (Neece et al., 2013). Referencing DBT, Joiner (2005) pointed out that “biological deficits, exposure to trauma and the failure to acquire adaptive ways of tolerating and handling negative emotion all contribute to suicidal behavior” (p. 41).

Researchers consider self-injury to be either an attempt to regulate emotions due to the breakdown of more typical tools for emotion regulation or the usual mechanisms for regulating emotions never developed sufficiently (Joiner, 2005). DBT provides an array of skills designed to change self-destructive patterns of regulating emotions (i.e., cutting) to more constructive means of regulating emotions (i.e., seeking support). As an approach for decreasing suicidal and self-harm behaviors, DBT consists of four specific domains: individual therapy, multifamily group skills training, telephone-based coaching between sessions, and weekly consultation team meeting with therapists (Neece et al., 2013).

Individual therapy consists of the therapist conducting a detailed analysis of each self-injurious behavior inflicted by the client. Following this analysis, the therapist and client formulate appropriate coping skills with the intention of preventing future self-injurious behaviors. They also determine what triggers and reinforces the client’s dysfunctional behavior.

The multifamily skills’ training operates in a didactic format, teaching adolescents and parents a new skill each week which they are expected to work on prior to the next therapy session. Parents have access to telephone coaching, enabling them to talk with a mental health professional and receive immediate counsel, when needed. DBT emphasizes the following three intervention modalities: adolescent, parent, and family.

**Adolescent-focused interventions.** Skills taught to adolescents designed to improve their ability to regulate emotions include mindfulness skills, interpersonal effectiveness skills, distress tolerance skills, and emotion regulation skills. Mindfulness embraces attending to emotions
without judging them as good or bad and right or wrong. Another component of mindfulness consists of refraining from impulsively acting upon emotions.

Interpersonal effectiveness involves learning skills to improve the quality of interactions by communicating needs and coping with interpersonal problems that generate strong negative emotions. Learning to tolerate stress incorporates methods used for distraction and calming oneself. Adolescents learn to decrease emotion dysregulation by attending to self-care (e.g., proper nutrition and adequate sleep), increasing the likelihood of evoking positive affect (e.g., spending time with cherished friends and family), and decreasing negative affect (e.g., through therapy, lessen anxiety by becoming accustomed to something that previously elicited fear).

**Parent-focused interventions.** Parents of suicidal teens occupy a significant role in DBT interventions due to the belief that emotion dysregulation as a factor in suicidal behavior has its origins in childhood. Neece et al. (2013) pointed out that many parents had difficulties regulating their own emotions and also may have had parents who inadequately responded to them. DBT teaches parents how to identify their own emotions, as well as the emotions of their child.

Instead of attributing an adolescent’s negative behavior to defiance or obstinacy, DBT encourages parents to believe that their child is doing the best he/she can, that behaving badly is not a choice, and that, in all likelihood, her/his behavior is the result of emotion dysregulation. Due to the adolescent’s delay in emotional development, parents may need to incorporate behaviors typically used with younger children, such as physical affection, distraction, and soothing verbal assurances. DBT emphasizes the necessity of utilizing those types of behavioral strategies as opposed to cognitive strategies, such as reasoning with a teen or pointing out the distortions in his/her thinking (Neece et al., 2013).
Family-based interventions. Prior to teaching emotion regulation skills in the context of the family, a positive parent/adolescent relationship needs to be established. Family conflict increases suicidal behavior in adolescents, therefore, DBT focuses on ameliorating communication and fostering positive interactions between parent and teen. Improved communication offers parents more information about their child, enhancing parents’ ability to identify factors that increase her/his risk of suicidal behavior.

Skills focused on fortifying the relationship between adolescent and parent include identifying and labeling emotions of oneself and others, looking at situations from each other’s perspective, listening to each other’s viewpoint, and establishing a middle ground solution when necessary. In parent/adolescent conversations, DBT teaches teens and parents to refrain from using extreme words, such as “always” or “never”.

Validation encompasses the ability to communicate that the way another individual is thinking, feeling, or acting makes sense in certain situations. In explaining the difference between validation and agreement, Neece et al. (2013) pointed out “that validation communicates that one understands the other person’s perspective, whereas agreement indicates that one approves of the other’s thoughts, feelings, or behaviors” (p. 261). As an intervention aimed at reducing self-harm and suicidal behavior, DBT has proven to be an effective strategy by focusing on regulating emotions and enhancing coping skills.

Cognitive Behavior Therapy (CBT). CBT helps individuals understand the thoughts and feelings that influence behaviors. Individuals learn how to recognize and change self-destructive thought patterns that negatively affect behavior. CBT aims to teach an individual that although one may not control what happens in his/her environment, one can control how she/he interprets and responds to situations. As a treatment strategy for suicidal behavior, CBT assists in
recognizing, challenging, and changing unhealthy thoughts, as well as observing those thoughts without believing or acting on them.

In the initial phase of CBT, therapists help individuals identify their mistaken and problematic beliefs. Because this negative thinking pattern may result in suicidal and self-injurious behaviors, CBT encourages individuals to recognize inaccurate and negative thinking and to view challenging situations more clearly.

The second phase of CBT focuses on the problem behaviors that result from these faulty beliefs. CBT therapists foster the development and practice of new coping skills, helping individuals be better equipped to either deal with or avoid self-harming and suicidal behaviors. Individuals make gradual progress by taking incremental steps toward more effectively responding to challenging situations.

Research by Alavi, Sharifi, Ghanizadeh, and Dehbozorgi (2013) found that “CBT was effective in decreasing hopelessness and depression” and “that CBT is an effective, appropriate, and acceptable treatment modality for the adolescents with recent suicidal attempts and current suicidal ideas” (p. 471). Alavi et al. pointed out that hopelessness predicts suicidal ideation, suicidal attempts, and suicide. The hopelessness theory of suicide proposed by Beck in 1986 characterized hopelessness as an inclination to attribute a negative scenario to future events (Ribeiro, Bodell, Hames, Hagan, & Joiner, 2013).

Based on a cognitive-behavioral approach, both CBT and DBT utilize cognitive restructuring techniques by attempting to identify negative thought patterns and replace them with more adaptive cognitions useful in reducing suicidal behaviors. The Hope Box embraces both treatment strategies by redirecting an individual’s attention from thinking about reasons to die, and instead, challenges them to unearth reasons to live. As Neece et al. (2013) explained
“The Hope Box consists of a box that contains objects that remind the patient of positive life experiences, current reasons for living, personal values, and available sources of social support and interpersonal connections” (p. 214). For suicidal individuals who feel hopeless, lonely or in a time of crisis, reflecting on the objects in The Hope Box may increase feelings of belongingness and optimism.

**Interpersonal Theory of Suicide**

The interpersonal theory of suicide (Joiner, 2005) proposes that the likelihood of suicidal behavior increases when an individual has both the will to die by suicide and the ability to do so. Individuals develop the desire for death when they simultaneously hold two specific psychological states that involve misperceptions of being a burden and a sense of low belongingness or social alienation. When both interpersonal states of mind are simultaneously present and for a long enough period of time, the interpersonal theory of suicide posits that there is a desire for death (Joiner et al., 2009). To enable an individual to engage in suicidal behavior, the desire for death must be accompanied by the acquired capability to harm oneself. This ability to self-injure is developed by habituation to past suicide attempts as well as exposure to repeated painful experiences.

**Perceived Burdensomeness**

Individuals dealing with perceived burdensomeness sense that they are a burden to others and that the world would be better off without them. They perceive themselves to be ineffective and/or incompetent and feel this failure negatively affects those around them. Those contemplating suicide due to this perception feel that being a burden is a permanent state and that death is the solution (Joiner, 2005). This misperception of self can be fatally dangerous when people believe they need to choose between the ongoing feelings of burdensomeness or death.
Van Orden et al., (2010) pointed out that family conflict, unemployment, homelessness, and physical illnesses are risk factors closely associated with suicide. They proposed that these risk factors increase the sense of burdensomeness, which increases the likelihood of suicidal ideation. Joiner (2005) emphasized that the perception of being a burden is misplaced. On the other hand, Lester and Gunn (2012) pointed out that while in some cases it may be an irrational thought, in other situations one could truly be a burden. This actual burden could be of an emotional, financial, or physical (being cared for by another) nature.

In a study of perceived burdensomeness among older adults, Cukrowicz, Cheavens, Van Orden, Ragain, & Cook (2011) found that those limited in their life by physical illness, depression, and functional impairment were more apt to ideate about suicide due to burdensomeness. Cukrowicz et al. hypothesized that perceived burdensomeness would have a greater impact on males than females with regard to suicide ideation. Contrary to their expectations, they found no gender bias.

**Thwarted Belonging**

Thwarted belonging is characterized by a low sense of belongingness and a perceived or actual sense of social alienation from family or social groups (Ribeiro & Joiner, 2009). This lack of belonging also includes feelings of loneliness, social withdrawal, domestic and family violence, having few social supports, losing a spouse due to death or divorce, and being incarcerated in a single jail cell (Van Orden, Cukrowicz, Witte & Joiner, 2012). Thwarted belongingness is the sense of disconnection from others and the absence of mutually satisfying relationships. Ribeiro et al. (2013) pointed out that the state of low belongingness fluctuates over time depending on intrapersonal (e.g., emotional) and interpersonal (environment) conditions. Suicidal behaviors increase when one perceives her or his situation to be unchanging and static,
and therefore, seemingly hopeless. Van Orden et al. noted that suicide ideation increases when one feels disconnected from others and decreases when one feels he or she is an integral part of a family, circle of friends, or other significant groups. In 2011, Van Orden et al. described thwarted belonging as “a psychologically painful mental state that results when the fundamental need for connectedness, the need to belong, is unmet” (p. 90).

Joiner (2005) theorized that there are two components necessary to meet the need of connectedness. One is interaction with others, which needs to be frequent and of a positive nature. The other is a feeling of being cared about. He further stated that, ideally, these relationships should be comprised of a consistent group of people who offer stability.

**Acquired Capability**

The essential third element in Joiner’s (2005) interpersonal theory of suicide is the ability to overcome the instinct for self-preservation and to act on the desire for suicide. He posited that there is a capacity for suicidal behavior if one has a desire for suicide, which is manifested in the simultaneous feelings of perceived burdensomeness and thwarted belonging. The acquired ability to enact lethal self-harm must also be present. This ability is developed through repeated exposure to dangerous and/or painful experiences, as well as a lowered fear of death. Ribeiro and Joiner (2009) opined that having the capacity to self-injure is composed of both elevated tolerance to pain and a sense of fearlessness. Experiences that inure one to pain include physical abuse, self-starvation, and nonsuicidal self-injury (Joiner et al., 2009). It logically follows that, due to habituation of increasingly more painful experiences, past suicide attempts are indicative of future suicidal behavior. Van Orden et al. (2010) pointed to a number of studies positively correlating multiple suicide attempts with a higher capacity for self-harm. Prior suicide attempts
are a strong indicator of suicidal behavior in both adolescents and adults (Van Orden et al., 2010).

Repeatedly exposing oneself to painful practices, such as self-injury by cutting, becomes less frightening and may offer emotional relief, enabling one to engage in increasingly more harmful behaviors. Van Orden et al. (2010) illustrated how familiarity to potentially dangerous activities increased the likelihood of suicidal behavior in the military. A study of military personnel indicated that repeated exposure to a specific lethal means tended to determine the method used to die by suicide. This research found that members of the Army more frequently died by suicide using guns, those in the Navy were more likely to die by hanging and knots, and Air Force personnel died from suicide by falling and heights. According to a study done comparing persons attempting suicide, nonsuicidal psychiatric patients, and nonsuicidal patients, those attempting suicide had a significantly higher exposure to violence (Joiner, 2005).

All three components must occur simultaneously to support Joiner’s interpersonal theory of suicide. One may have the desire for suicide, but not the capability. On the other hand, one may engage in dangerous and painful behaviors, but have no desire to cause lethal self-harm (Joiner, 2005). This theory suggests that risk assessment and prevention strategies may be enhanced by an awareness of an individual’s sense of burdensomeness, lack of belongingness, and one’s capability for self-harm. Following are recent empirical studies based on Joiner’s interpersonal theory of suicide.

**Research based on the Interpersonal Theory of Suicide**

In a 2008 sample of diverse undergraduates, Van Orden and colleagues (2012) corroborated that students who reported the highest levels of suicidal ideation also reported elevated levels of both perceived burdensomeness and low belonging. The following year,
Ribeiro and Joiner (2009) confirmed the interaction between perceived burdensomeness and thwarted belonging and the desire for suicide, specifically in relation to individuals who reported a sense of low family support and feelings of insignificance.

As a predictor of suicidal ideation, Joiner et al. (2009) found a significant connection between thwarted belonging and perceived burdensomeness. The first study in their empirical research utilized a diverse group of participants, allowed for major depressive disorder and relied on measurement scales designed by other research groups. The second study in their research added the construct of acquired capability and tested the hypothesis of the three-way interaction of the interpersonal-psychological theory. The number of previous suicide attempts determined the levels of acquired capability. Results showed that the combination of perceived burdensomeness, low belongingness and elevated levels of acquired capability increased the likelihood of attempting suicide.

Research by Smith et al. (2010) focused on the acquired capability for suicide and compared patients who attempted suicide with those who ideated about suicide. Patients who attempted suicide saw themselves as more fearless and insensitive to pain than those who ideated about suicide. Suicide attempters also reported a more extensive history of distressful and aggravating events than suicide ideators. This research lends support to the theory that the acquired capability is a distinguishing factor between individuals who desire suicide from those who both wish to die by suicide and are also capable of attempting suicide. Smith et al. recommended psychoeducation for suicidal patients to identify and avoid behaviors and situations that fostered acquired capability.

Another important factor to consider based on a 2013 research study by Klonsky, May, and Glenn is the effect of nonsuicidal self-injury (NSSI) on suicidal behavior. NSSI refers to
causing intentional harm to oneself such as cutting or burning. An estimated 14 to 17% of adolescent and young adults have reported inflicting intentional self-harm. In the context of the interpersonal theory of suicide, Klonsky et al. make the connection that “NSSI may be relatively unique among suicide risk factors in that it serves as a marker for both increased desire and capability” (p. 232). To illustrate, a risk factor such as depression may indicate desire, but not capability, whereas, access to firearms may indicate capability, but not desire. NSSI is associated with heightened emotions and anxiety, which may lead to the desire for suicide. NSSI increases one’s capability for suicide by repeated self-infliction of pain and violence. This study points to NSSI as the second strongest predictor of attempted suicide; suicidal ideation is the only risk factor that is more potent. Considering that adolescent males more frequently engage in high-risk behaviors, such as fighting and delinquency, they acquire the capability for lethal self-harm by means other than NSSI. Consequently, Klonsky et al. consider NSSI to have a unique effect of increasing capability of suicide among female adolescents. Current research by Neece et al. (2013) confirms that self-harm behaviors are a predictor for future suicide attempts and that effective suicide prevention strategies are essential for adolescents and young adults who engage in NSSI.

In a study of the American Indian population, O’Keefe et al. (2013) found a positive correlation between perceived burdensomeness, thwarted belonging and suicide ideation. However, when each of the psychological constructs was studied separately, perceived burdensomeness was a significant indicator of suicide ideation, but the hypothesis that thwarted belonging would predict suicide ideation was not supported. Researchers suggested that future studies utilize questionnaires that ask more culturally appropriate questions to accurately access specific information regarding the American Indian population.
Current research by Davis, Witte, and Weathers (2013) focused on the association between posttraumatic stress disorder (PTSD) and suicidal behavior. Empirical results significantly correlated PTSD with suicidal ideation, although their findings did not establish a strong association between PTSD and suicide attempts or deaths by suicide. Of the symptoms for PTSD, researchers found detachment/estrangement to have the strongest association to suicidal ideation. Davis et al. defined detachment/estrangement as “feeling distant or cut off from other people” (p. 6), which is similar in concept to the construct of thwarted belongingness posited in the interpersonal theory of suicide. These findings indicate that a link between exposure to trauma and suicidal ideation may be social disconnection or lack of social support. This research established compelling arguments for including queries about detachment, estrangement, and social connections in assessing trauma survivors for suicidal behavior, particularly suicidal ideation.

Adlerian Perspective on Suicide in Relation to the Interpersonal Theory of Suicide

Brief Biography of Alfred Adler

Alfred Adler was born on February 7, 1870 in Vienna, Austria to a Jewish grain merchant and his wife; he was their third child and second son. His youth was significantly affected by the death of a younger brother; rivalry between him and his older brother, Sigmund; and by personal illness in the form of rickets, pneumonia, and poor eyesight. According to Dinkmeyer and Sperry (2000), coping with a childhood overshadowed by illness spurred Adler to attend medical school and become a doctor. He began his career as an ophthalmologist, shifted to general practice and eventually turned to psychiatry. Adler’s clients included circus performers who influenced his theories on an individual’s ability to compensate and overcompensate for unusual strengths and weaknesses (Carlson & Maniaci, 2012).
In 1902, Adler, Freud, and three others founded the Wednesday Night Meetings, which evolved into the Viennese Psychoanalytic Society. As explained by Dinkmeyer and Sperry (2000), Adler resigned from the society in 1911 in reaction to “Freud’s insistence on uniformity and strict allegiance to his theory” (p. 4). The year following the break from Freud and his psychoanalytic approach, Adler founded the Society for Individual Psychology based on the premise that each individual is a holistic being.

During World War I, Adler served as a medical field officer and saw first-hand the damage done by war. Social interest, one of the primary concepts of Individual Psychology, resulted from his war experience. Following the war, Adler was instrumental in designing child-guidance clinics in the Vienna Public Schools to educate teachers, counselors, social workers, and physicians in the areas of educational reform and therapeutic education (Dinkmeyer & Sperry, 2000). Due to political obstacles, these schools were abolished in 1934, but a precedent had been established of using Adlerian techniques for group therapy and community education (Brett, 1997).

Adler began lecturing in the United States in 1926, secured a teaching position in medical psychology in 1932 at Long Island College of Medicine, and permanently moved with his family to the United States in 1934. On May 28, 1937, at the age of 67, Alfred Adler died of a heart attack in Aberdeen, Scotland while on a lecture tour (Ansbacher & Ansbacher, 1956).

**Brief Overview of Fundamental Adlerian Concepts**

Adler developed the theory of Individual Psychology emphasizing the importance of viewing the individual holistically. His view is succinctly expressed in Carlson and Maniacci (2012): “to us Individual Psychologists, the whole tells much more than the analysis of the parts” (p. 48). Adler’s influence permeates the field of social psychology through his impact on parent
education, early intervention by teachers, psychotherapy, group therapy, coaching, and self-help. Following are a number of Adler’s Individual Psychology concepts.

**Lifestyle.** From its genesis, Adlerian psychology emphasized that human beings are indivisible and function holistically. Adler stressed that people needed to be perceived in the context of their social and physical environment and that a single part is never completely understood independent of the whole. Adler believed that each person develops a unique style of living in early childhood, which determines how one responds and behaves within her/his environment. Carlson and Maniacci (2012) quoted Adler’s description of lifestyle as “this unity in each individual – in his thinking, feeling, acting: in his so-called conscious and unconscious – in every expression of his personality” (p. 16). Lifestyle is the overall psychological movement toward one’s goal. Negative experiences from early childhood, such as abuse and trauma, greatly impact lifestyle, which may lead to a decrease in resilience, a risk factor for suicidal behavior.

**Teleology.** From the perspective of Adlerian psychology, all behavior is goal-directed and purposeful. Teleology is the concept of moving toward unique conscious and unconscious goals created by the individual. Adler believed that people were not driven by things that happened in the past, but, rather, pulled by future goals, purposes, and ideals. Because one may not be conscious of a goal, Adlerians assist in recognizing what is motivating a particular behavior and making changes if the goal appears to be self-defeating. As Brett (1997) points out, all behavior is considered purposeful and when one understands the motivation behind behavior, one can change the behavior when necessary.

**Social interest.** Social interest or “gemeinschaftsgefühl” is an Adlerian construct based on social rather than biological behavior. In Carlson and Maniacci (2012), gemeinschaftsgefühl is described as “true community feeling (e.g., sense of belonging, empathy, caring, compassion,
acceptance of others) which results in social interest (thoughts and behaviors that contribute to the common good, the good of the whole at both micro- and macro- systemic levels); true social interest is motivated by community feeling” (p. 43). Individuals embracing social interest have an attitude of contributing and cooperating with others to reach mutual goals.

As Brett (1997) explained, Adlerians believe that “social interest begins with the ability to empathize with a fellow human being, and leads to the striving for an ideal community based on co-operation and personal equality” (p. 163). Adler believed an individual’s mental health could be determined by his/her measure of social interest. Conversely, Adler considered all psychological problems and maladaptive behaviors to be the result of insufficient social interest.

**Private logic.** Each individual views reality and interprets situations relative to one’s own perspective, unconsciously justifying motivations for moving toward the desired outcome. Private logic includes goals, attitudes, expectations, and decisions. How one perceives and deciphers his/her personal view of the world comprises private logic. To put it quite simply, what happens to an individual is not as important as how one feels about it. Carlson and Maniacci (2012) point out “the person’s private logic hides the purpose for the self-defeating behaviors” (p. 142).

**Feelings of inferiority.** Feelings of inferiority are universal; however, problems emerge when an individual becomes overwhelmed with a sense of inadequacy (Ansbacher & Ansbacher, 1956). Adler believed social interest organically develops when an individual feels competent and capable in his/her life. Conversely, when confronted with overwhelming feelings of inferiority, an individual is more apt to focus inwardly. Individuals may respond to feelings of inferiority in either of two ways: compensation (making up for one’s deficiencies by some means) or striving for superiority (covering up one’s feelings of inferiority by feigning
superiority). These feelings may result in low self-esteem and a preoccupation with one’s self, thereby quelling social interest.

Tasks of life. Adler proposed that individuals face challenges in life, which he divided into the following three areas: work (establishing a socially useful occupation or profession), friendship (creating relationships with others), and love (realizing one’s role in love, marriage, and family). Current theories indicate an increase in suicidal behavior when individuals experience a negative change in the three tasks of life. In relation to the interpersonal theory of suicide, perceived burdensomeness may result from retirement, chronic illness, and failing health. Low belongingness may be exacerbated by the death of a loved one, social isolation, and loneliness (Carlson & Maniacci, 2012).

Psychological types. Adler distinguished between four psychological types; each defined by the amount of social interest one has and the level of energy one manifests. He believed very strongly in the uniqueness of each individual and considered these types to be a heuristic device, a useful fiction helpful for learning. Three out of the four types are not prepared to solve life’s problems because all problems are social and they lack social interest. Individuals demonstrate their lack of social interest by their inability to cooperate, collaborate, and contribute in solving social problems.

The ruling type. The ruling type is characterized by a preponderance of aggression but lacking in social interest. While striving for personal power, an individual tends to steamroll anyone or anything that gets in her/his way. Ruling types with higher levels of energy may become tyrants, sadists, and delinquents. An individual with less energy and lower levels of social interest may be more inclined to hurt him/herself. Ruling types include alcoholics, drug addicts, and those engaged in suicidal behavior.
The leaning type. A typical behavior of the leaning, or getting, type would be reliance on others to carry them through when life becomes difficult. They may feel overwhelmed, dependent, and overly sensitive. Leaning types lack both social interest and energy in dealing with life’s problems and, depending on individual lifestyle, may display symptoms of phobias, neurosis, and anxiety.

The avoiding type. By sidestepping problems, the avoiding type never has to experience defeat. This type has the lowest level of energy and essentially survives by avoiding life. If life becomes stressful enough, one may retreat into a world of her/his own, resulting in psychosis.

Socially useful type. Adler considered a socially useful type of person to be healthy, benefitting others by cooperation and contribution. This type uses both social interest and energy to help solve the problems of society, from the miniscule to the worldly.

Alfred Adler’s 1937 Article on Suicide

In 1910, Adler led a symposium on suicide in Vienna responding to an elevated number of suicides in the community. Following the symposium, the presenters published a paper in which Adler outlined his unique view of suicide from a social perspective with interpersonal implications. He fine-tuned his ideas over the years, and in 1937 published an article detailing his concepts of suicide. Prior to describing his ideas, Adler prefaced his remarks by acknowledging that suicide frequently results from mental illness, particularly depression. Contributing factors influencing suicide proposed by Adler include situational, interpersonal, and predisposing components.

Situational factors that Adler considered an impetus for suicide included money losses and indebtedness, disappointment in love, and ongoing unemployment (Adler, 1937). He pointed out an increase in the number of Viennese associations involved in the prevention of suicide,
adding that individuals only seek help if they have hope for the future; inferring that hopelessness is ultimately a precursor to suicide. He also noted the possibility of suicide epidemics and the increase of suicide in people over the age of 50.

From an interpersonal standpoint, Adler proposed that suicide evolves as a solution to a problem when an individual is lacking social interest including “all forms of working together, of living together, and of fellowship…” (p. 59). In keeping with the fundamental concept of Individual Psychology as goal-directed, Adler wrote that “every step of an individual is directed toward the successful solution of a presently imminent task” and that “what the individual considers success is always a matter of his subjective opinion” (p. 59). In that description, he deftly points out how private logic and mistaken solutions to goals can lead to suicide.

Adler endeavored to determine who is most apt to attempt suicide by recognizing predisposing factors. He believed the pampered child to be at most risk as well as alcoholics and drug addicts. He also wrote that those who have a “tendency to collapse under psychological pain when confronted with difficult life situations” (p. 60) are more prone to suicide. In addition, Adler noted that genetics is also considered a predisposition to suicide.

**Adlerian Concepts in Relation to the Interpersonal Theory of Suicide**

As stated earlier, the interpersonal theory of suicide posits that suicidal behavior manifests when the desire for suicide, in the form of low belonging and perceived burdensomeness, is accompanied by the capability for self-harm. In his 1937 essay on suicide, Adler identified interpersonal factors that increased the desire for suicide. Neuringer (1974) considered Adler to be a pioneer of dynamic psychiatry and that he “was the first to truly appreciate the importance of cognitive style as a determinant of ideation and behavior” and “not the product only of drives, motives or needs” (p. 59). He further explained that Adler realized
that what individuals experienced was not as important as what they perceived happened; that a
“certain cognitive style (or way of encoding experience) determined certain outcomes in a much
more powerful way than the experiences themselves” (p. 63). The interpersonal theory of suicide
concerns a cognitive style of perceiving belongingness and burdensomeness.

Ansbacher and Ansbacher (1956) defined social interest as “the feeling of belongingness”
(p. 138). Adler believed suicide resulted from insufficient social interest; the interpersonal theory
of suicide posits that feelings of not belonging increase suicidal behavior. Dinkmeyer and Sperry
(2000) pointed out the Adlerian belief that “our basic striving is to belong and to be accepted and
valued” (p. 177).

Perceived burdensomeness represents a potentially lethal misperception based on an
individual’s private logic. People use private logic rather than common sense when they search
for solutions to problems and conclude that suicide is the best option. In his 1937 article, Adler
pointed out that suicide was a mistaken solution to life’s problems. An example of private logic
articulated by Neuringer (1974) stated that “only a certain kind of cognitive organization would
lead an adolescent to construe that ‘not being able to have the family car for a Saturday night
date’ is a legitimate overwhelming reason for killing oneself” (p. 63).

From an Adlerian point of view, the acquired capability for fatal self-injury may derive
from the concept of striving for superiority. Ansbacher and Ansbacher (1956) pointed out that
suicidal behavior garners attention and with that may come an increased sense of superiority. An
individual may also feel superior because “I have done what not everyone could do” (p. 151).
One’s private logic creates “intelligent” arguments for suicide, therefore, heightening those
feelings of superiority.
Adlerian Concepts as Suicide Intervention Strategies

As the 1974 article by Neuringer so deftly encapsulated, “the critical cornerstone of Adler’s theory of suicide rests on the inability of the individual to cope with the urgent problems of life” (p. 64). An Adlerian therapist would be supportive, respectful, and encouraging in her/his attempt to determine what is motivating an individual’s behavior when confronted by life’s problems. The therapist would confront her/his private logic to assist in ferreting out both the vaguely conscious and unconscious goals.

To enhance belongingness, an Adlerian therapist would encourage social interest by identifying possible avenues for interacting with others. Encouraging involvement would enhance feelings of belongingness. The therapist would also foster self-acceptance and self-esteem by emphasizing her/his strengths and potential for growth. Adlerians believe an individual is ultimately responsible for his/her mental health, however, a sincere relationship between a patient and client provides a basic form of social interest. Because risk factors for suicidal behavior include a child’s sense of not belonging and feelings of inferiority, Carlson and Maniacci (2012) expressed the importance of educating parents and preventing child neglect and abuse as a means of preventing suicide.

Future Implications

Suicide is a serious public health problem that has persistent and detrimental effects on individuals, families, and communities. Conducting research and collecting consistent data provides a means of gauging the scope of the problem, helps identify high-risk populations, and monitors the effectiveness of prevention strategies. In commenting on the dearth of research on suicide, Eynan et al. (2013) pointed out that “as a serious public health concern, suicide research is imperative, yet there are fewer empirical studies on suicide than on numerous less common
causes of death” (p. 123). Researchers hesitate to conduct empirical studies with individuals who are at high risk for suicide. Eynan and colleagues found that including high-risk individuals in research studies could be done safely when meeting specific conditions. The safeguards recommended by Eynan et al. specify employing researchers trained to identify elevated risk among participants. In situations where risk appears to be heightened, researchers must have safety measures in place which include the names and locations of professionals competent in assessing and managing risk. Additionally, resources must be made available as needed for individuals participating in the study.

Current research has improved society’s understanding of the factors that increase the likelihood of suicidal behavior and the components that act as protective factors in the face of suicidal behavior. The implication of these findings underscores the necessity of awareness training for both peers and adults regarding factors that put adolescents and young adults most at-risk for suicide. A number of studies emphasized the significance of a supportive and secure parent-child relationship as a protective factor. More recent research identified resilience as a protective buffer and focused on a number of processes which enhance the acquisition of resilience.

Strategies found to be most successful in the prevention of suicidal behavior include gatekeeper and suicide screening programs. The psychotherapeutic techniques of DBT and CBT are beneficial in identifying negative thought patterns and have been shown to be effective for the treatment of suicidal behavior.

Both Adler and Joiner’s theories of suicide consist of interpersonal views attributing suicidal behavior to feelings of disconnectedness. The compatibility of these theories is underscored by their mutual emphasis on increasing feelings of belongingness in the effort to
reduce the likelihood of suicide. Furthermore, Adler’s concept of private logic and mistaken beliefs could be considered a precursor to Joiner’s supposition of perceived burdensomeness. The implication of these findings emphasizes the significance of assessing adolescents and young adults for feelings of belongingness and the mistaken belief that suicide is the one and only solution for easing their pain.


