

COPING WITH THE ECONOMIC AND LABOR CRISIS: MODELS AND TOOLS FOR THE EVALUATION OF SUICIDE RISK

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This review derives from the application of models and tools to address the suicidal risk of people affected by the Italian economic and labor crisis, especially since 2010. This crisis has resulted in a sharp increase in the number of suicides by employers who lost their companies — mostly small and family-run — and employees who lost their job. A national psychological support service was implemented with the purpose of listening to and counseling those who were in serious economic difficulties, thus preventing their disease. Over 1000 people turned to this support service; the authors of the study could therefore observe the strengths of various theoretical and practical approaches and their implications in situations where the risk of suicide was present. On the basis of this experience as well, the authors propose a description of the models and tools, mainly addressing psychologists and psychotherapists faced with suicidal risk situations.

Key words: Economic crisis; Labor crisis; Psychological support service; Models and tools; Suicide.

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The World Health Organization (2001) defines suicide as “an act with a fatal outcome, deliberately initiated and performed by a person in the full knowledge or expectation of its fatal outcome” (p. 37). It is estimated that each year approximately one million people die from suicide.

The aim of this work is to analyze definitions, processes, and risk and preventative factors from different theoretical perspectives with reference to several empirical studies, in order to present the main models that explain and aim to prevent the phenomenon, also describing some

of the most relevant tools employed by specialists. The main models and derived tools illustrated were selected on the basis of their relevance and their ability to advance the knowledge of the suicide phenomenon through specific contributions integrating previous models.

The professional experience supporting this study was also acquired through a three-year direct intervention in suicide risk situations related to the economic and labor crisis that has swept Italy since 2010, especially the North-Eastern regions, where a sharp increase in work-related suicides has taken place. As is known, in addition to the effects of the economic crisis and to personal and social factors, the work environment can contribute to create situations of discomfort (Di Sipio, Falco, Kravina, & De Carlo, 2012; Falco, Girardi, Dal Corso, Di Sipio, & De Carlo, 2013; Falco, Girardi, Parmiani, et al., 2013; Falco et al., 2012).

Some of the authors of this study (Alessandro De Carlo, Laura Dal Corso, Annamaria Di Sipio) have worked at planning and managing a national help and support service for employers and employees together with an association, *Speranzaallavoro*, established following the suicide of two employers. The Association was founded by the employers' families together with the trade unions operating in their companies and some consumer associations: such a synergy has proven the transversality of suicide risk and the need of society to intervene cohesively to face it. The help and support service assisted over 1000 people, offering psychological counseling and referring them to the most appropriate local support facilities. The service encompassed three main lines of action. The first was psychological support and counseling. This activity was particularly relevant to break the potential suicidal intention, provide options and feedback, gather data for further interventions. The second was providing contacts of useful territorial resources to the people who called. The services to which callers were referred were diverse: from public mental health services to charities providing food and shelter, from trade union accountants who could assess the situation of a company in difficulty to psychologists who accepted to intervene for free. The last resource, in particular, was crucial given that it was offered in cooperation with the *Ordine degli Psicologi del Veneto*,¹ which proposed to the professionals in the region to supply the first two sessions for free, in order to evaluate the concrete suicide risk and, in case, continue with private psychotherapy or refer the person to the public services. The service interacted with the territorial facilities, often informing them that someone who contacted *Speranzaallavoro* would call them or walk in so that they could pay particular attention. The third line of action was to gather data which proved to be especially significant in the development and improvement of the service. Within such a service, the need for effective strategies to reduce suicide risk in different contexts and for different people in different conditions has become apparent. This is especially so — as it often happens during real interventions — before the risk condition becomes evident or when no structured and long-term psychological and/or psychotherapeutic support work can be provided. The article, therefore, focuses on both research and practical application, in order to present both a global overview of the state-of-the-art of the international scientific literature, useful for advancing academic studies on suicide, and a fundamental series of empirical tools to be used by psychologists during interventions, especially when suicide risk is high.

THE CUBIC MODEL OF SUICIDE

The starting point is the notion that complete suicides (i.e., those resulting in death) tend to have many features in common. Specifically, Shneidman (1985, p. 121) defined “the ten commonalities of suicide:

1. the common purpose of suicide is to seek a solution;
2. the common goal of suicide is cessation of consciousness;
3. the common stimulus of suicide is intolerable psychological pain;
4. the common stressor in suicide is frustrated psychological needs;
5. the common emotion in suicide is helplessness and hopelessness;
6. the common cognitive state in suicide is ambivalence;
7. the common perceptual state in suicide is constriction;
8. the common action in suicide is egression;
9. the common interpersonal act in suicide is communication of intention;
10. the common consistency in suicide is with lifelong coping patterns.”

In the later *Perspectives on suicidology. Further reflections on Suicide and Psychache*, Shneidman (1998) claimed that “the author of suicide is pain. This pain has various common-place names: despair, loneliness, fear, anxiety, guilt, shame, depression, angst, and other more-or-less technical labels, such as schizophrenia, affective disorders, depression, alcoholism, widowhood, mental illness” (p. 246). Shneidman analyzed several cases from which it can be inferred that suicide is driven by pain and that suicide thoughts and acts are efforts to escape and stop the pain that inhabits one’s mind. Such pain is defined as a special form of pain, a psychological pain, the pain of negative emotions that he called *psychache*. It is unbearable, intolerable, and unacceptable and “has crossed a certain line somewhere in the mind” (p. 248). Moreover, this pain is originated, is preserved, and is supported by frustrated or thwarted psychological needs.

These arguments constitute the background of the theoretical model called cubic model of suicide. It maintains that suicidal behavior can be understood by referring to the image of a cube, formed by the confluence of three psychological forces situated on three axes of its surface. The first axis of the model is an unbearable psychological pain (*psychache*) that can be assessed on a 1-to-5 scale. The second axis is a strong psychological pressure (stressor), also assessed from 1 to 5. Finally, the third axis measures the construct of perturbation (defined as a state in which one is emotionally shaken, disturbed, or troubled), assessed on the same scale as the preceding two. Through this model, Shneidman stated that each suicidal person completes the act if he/she is at the highest levels of pain, pressure, and perturbation. Such a condition is graphically represented by the angle of the cube where the maximum scores of the three axes intersect (5-5-5). Shneidman also pointed out that not all people in that condition will necessarily commit suicide, but he insisted that each suicidal person, at the moment of the act, finds him/herself in such a condition.

Starting from the premise of the cubic model of suicide, suicide happens at the maximum peak of the three dimensions considered. The interventions, therefore, can concentrate on only one of the axes — the one the psychologist considers to be the most appropriate to the situation, the characteristics of the person at risk, or the psychological/psychotherapeutic approach chosen. This markedly reduces the risk of suicide acts in the short term. In such a perspective, therefore, targeted interventions such as the Stress Inoculation Training of cognitive-behavioral origin (Meichenbaum, 1985) may be effective when suicide risk is considered to be particularly high.

THE DIATHESIS-STRESS-HOPELESSNESS MODEL OF SUICIDAL BEHAVIOR

In 1982 Schotte and Clum proposed a suicidal behavior model called diathesis-stress, where *diathesis* expresses a constitutional predisposition or a tendency to develop a certain con-

dition, and is extended to any personal characteristic that may increase its likelihood, among which there is a possible cognitive deficit in problem solving. With *stress* the authors referred to the events in each individual's everyday life that may become very significant obstacles when the person is not able to devise alternative solutions needed to develop adaptive coping. The key argument of such a model is based on the assumption that cognitive rigidity, by determining a certain inability to identify problems and their solutions, mediates the relation between stressful events and suicidal behavior (Clum, Patsiokas, & Luscomb, 1979; Schotte & Clum, 1982).

According to this model, individual deficiencies in the ability to think flexibly render people facing a high number of stressful events cognitively unprepared to develop effective alternative solutions. As a result of their problem-solving inability, under critical circumstances, they may lose hope (Neuringer, 1974). Such loss puts the individual at high risk of suicidal behavior, so the factor hopelessness was added to the model (diathesis-stress-hopelessness). The assumptions of the model were analyzed in later research, which discovered that the level of negative stressful events is positively correlated to both the level of loss of hope and that of suicidal intention — the higher the number of stressful events, the higher the level of both factors. It has also been noted that, the greater the number of problems faced by an individual, the lower the ability to cope (Schotte & Clum, 1987).

According to the diathesis-stress-hopelessness model, an effective intervention against suicide risk may be that of acting on flexibility of thought and problem solving. Such an approach seems more appropriate when there is extra time to act than in the interventions based on the previous model, which mainly focuses on urgent situations. In order to create the conditions for the improvement of problem-solving abilities, the professional may, for example, create a therapeutic-educational condition of individual or group learning — constructivist in nature — founded on the fact that knowledge and abilities derive from an interactive series of meanings (Duffy & Jonassen, 1992).

SUICIDE AS ESCAPE FROM SELF

It had already been noted that “escape” was an important cause of suicide (Bromberg & Schilder, 1936). Such a theory was later drawn upon by Smith and Bloom (1985) and advanced by Baumeister and Scher's (1988) studies, according to which the main causes of the choice of committing suicide derives from the desire to flee a hostile emotional state and critical self-awareness. In line with such a perspective, Baumeister (1990) elaborated a theory on the possible causes of suicide attempt, dividing them into six steps: 1) not reaching the standards the person would like to achieve (discrepancy between one's expectations and actual results); 2) internal attribution of failure (the failure being experienced is exclusively blamed on oneself); 3) deep-rooted self-awareness and awareness of one's inadequacies (according to one's own and others' standards); 4) strong negative feeling (derived from feelings of depression and anxiety); 5) cognitive deconstruction (through which the individual strives to face negative emotions shutting oneself into a state of insensitivity); 6) negative effects of cognitive deconstruction (disinhibition, passivity, lack of emotions, and irrational thought). In brief, according to Baumeister, suicide is a way to escape one's feelings of inadequacy. The reasons why some people are more successful than others in carrying through the suicidal act are determined, among others, by how lethal the methods and tools employed are, by the low level of desire to live and, often, by chance. The fac-

tor that is considered most relevant is the strength of the self-destructive impulse: the stronger it is, the more likely the lethal result.

On the basis of this model, therefore, an appropriate intervention mode may be cognitive-constructivist psychotherapy, where the patient, supervised by the specialist, understands his/her personal way of getting to know the world and finding personal alternative interactions with it that may be less rigid and more feasible, through an emotionally significant relationship with the therapist. It is a shared space where the patient, guided by the therapist, finds more flexible and articulated modes to give meaning to his/her experience, thus acquiring a higher degree of emotional-cognitive stability and ability to handle negative events (Winter, 2008).

THE SUICIDAL MODE

The suicidal mode model is based on the concept of *mode*, expressing the set of adaptive or maladaptive schemas at work in a person at a given moment. The main modes are reflexive, geared toward survival and safety, and habitual (or prevalent), characterizing personality traits, a constant in a person's life (Rudd, 2000).

According to Beck (1996), in suicidality the cognitive, affective, motivational, and behavioral systems are particularly relevant. The cognitive system is described as including all aspects of the information process, comprising data selection, attentive process (the attribution and creation of meaning), memory, and information recall. This system includes the notion of cognitive triade which comprises beliefs about oneself, experience, and the future. The main convictions permeating the cognitive triade fall within two primary domains, originally identified by Beck: loss of hope (e.g., "I cannot do anything to solve my problems") and inability to love oneself (e.g., "I don't deserve to live; I am useless"). A third category is also proposed: low tolerance to stress (e.g., "I can no longer see myself in this state"). The main ideas expressed by a suicidal patient fall within at least one of these categories.

The affective system produces emotional and affective experiences. Beck pointed out its importance by paying attention to the role that the system has in reinforcing the adaptive behavior through both positive and negative life experiences. The negative experiences are characterized by emotional dysphoria — a combination of negative emotions.

Finally, motivational and behavioral systems allow neurovegetative activation or deactivation of the individual's response. However, Beck observed that motivational and behavioral systems mostly become active automatically. When the suicidal mode is active, the physiological system is excited, but the physiological excitement necessary for the suicidal act can only be maintained for short periods, with recurrences that can depend on the chronicity of the problem (one attempt vs. more attempts) and the complexity of the diagnosis on Axis I and II of DSM IV. Therefore, suicidal crises are acute and limited in time, even for those who suffer from evident chronic conditions and recurrent suicidal behaviors.

In the perspective of the suicidal mode, a fundamental component to reduce suicide risk can be the development of the person's motivation. Work focusing on motivation can in fact be effectively carried out in a shorter time than in larger or more structured interventions. Motivation is defined as the presence of goals, clear directions for one's behavior, and persistence in goal pursuit. A possibility of intervention on motivation, defined as above, is based on the theory

of the dynamics of action (Atkinson & Birch, 1970). This theory postulates that change takes place when the direction of a new inexpressed behavior becomes dominant over the direction presently motivating the action. Theoretically, the strength of action tendencies increases or decreases as a consequence of internal and external stimuli (sources of impulse) and inhibiting factors involved in performing an action. In this theory, three causes are responsible for behavior and change: instigation (increases the tendency when an activity is intrinsically satisfying); inhibition (decreases the tendency when no obstacles are present in carrying out an activity); and consummation (decreases the tendency when an activity is carried out) (Reeve, 2009). An intervention on motivation of a purely cognitive-behavioral type can, therefore, be a way to reduce suicide risk in the short term.

THE CRY OF PAIN MODEL

Developed from different psychological research on suicidality, the cry of pain (CoP) model considers the suicidal behavior and ideation as the final results deriving from the perception of being entrapped in a highly stressful situation with no way out nor rescue (Williams, 2001; Williams & Pollock, 2001). The CoP was derived from the theses of the diathesis-stress theory (Alloy et al., 1999), Baumeister's escape theory (Baumeister, 1990), and the "arrested flight" phenomenon (Gilbert & Allan, 1998), characterizing some fear and "block" behaviors in the world of birds (MacLean as cited in Rasmussen et al., 2010).

According to Williams (2001) and Williams and Pollock (2001), the suicidal behavior should be considered a "cry of pain" rather than a "cry for help." The authors maintained that, in spite of some self-harming behaviors, people may not be driven by the suicidal act, but rather by the desire to escape an unbearable situation. In this sense, the main element of the suicidal behavior is its derivation from a psychic distress. Later the hypothesis was developed that suicidal acts may have a communicative reason.

According to Williams (2001), suicidal behavior is reactive; it is the reaction to a stressful situation and comprises three components which, when working together, increase suicide risk: 1) presence of defeat; 2) perception of not having a way out; 3) idea of not being able to save oneself. Williams and Pollock (2001) argued that the perceptions are, at least partly, determined by psychological variables.

The concepts of defeat and being entrapped, however, originated in the evolutionistic model of depression, in which the first term is taken in the sense of losing a battle or social status. Feeling entrapped represents the desire to escape associated to the awareness that all ways out are blocked (Gilbert & Allan, 1998). Thus, when the attempts to solve problems are perceived as ineffective, people feel they do not have a way out of the situation, and this, in turn, can lead to a feeling of despair and to the idea that the future will grant few opportunities to regain or obtain positive results in the solution of problems.

As for operational tools, refer to the Defeat Scale and the Entrapment Scale (Gilbert & Allan, 1998). The former is a self-report questionnaire with 16 items with which the responders are to indicate their agreement on a 5-point scale (from 0 = *Never* to 4 = *Always*). Responders are asked to express their thoughts and feelings on defeat, with reference to the seven days prior to the administration (e.g., "I feel that I have not made it in life"). This scale has very high internal

consistency, with alpha coefficients of .94 for females and .93 for males in both groups, furthermore reliability of .94 for students and .93 for the depressed group. The Entrapment Scale is likewise a 16-item self-report questionnaire divided into two subscales: internal entrapment — the motivation to escape one's own feelings and thoughts (e.g., "I feel powerless to change myself") — and external entrapment, measuring the perception of being blocked by external contingencies and the motivation to escape (e.g., "I feel trapped by my obligations"). The response options are 0 = *not at all like me*, 1 = *a little bit like me*, 2 = *moderately like me*, 3 = *quite a bit like me*, and 4 = *extremely like me*. Gilbert and Allan (1998) reported high levels of internal consistency for both student and depressed groups, with Cronbach's alphas of .93 and .86 in Internal Entrapment, and .88 and .89 in External Entrapment, respectively.

The intervention based on the CoP model, therefore, can be devised as the sum of the interventions based on the cubic model of suicide and on the diathesis-stress-hopelessness model: on the one hand, the components of acute stress and pain can be treated, especially in the acute phases, with the SIT therapy (Meichenbaum, 1995); on the other, the feeling of entrapment can be dealt with through the constructivist (Kelly, 1955) or cognitive-constructivist therapies, which aim to reconstruct the meaning of experience by allowing the individual to see ways out of situations perceived as desperate and entrapping (Neimeyer, 2009).

THE INTERPERSONAL THEORY OF SUICIDE

The objective pursued by Joiner (2005) through the interpersonal theory of suicide was to understand the aetiology of the phenomenon and some related factors that appeared hardly explainable. The term suicidal behavior refers to both lethal and non-lethal acts.

The basic assumption of interpersonal theory is that the most dangerous situation in terms of suicide risk is caused by the simultaneous presence of two interpersonal constructs: *thwarted belongingness* and *perceived burdensomeness*. Together with such simultaneous presence, a major role is played by the ability to enact a suicidal behavior that is considered separately from the desire to enact such a behavior.

According to interpersonal theory, thwarted belongingness is a first level variable with two subordinated factors: loneliness and absence of reciprocal care relationships. The loneliness factor is positively associated with self-reported loneliness, living on one's own, and self-reported low or absent social support, also with seasonal variations (for example, the decrease in social interactions that can exacerbate feelings of loneliness has been considered a possible explanation for the increase of suicide cases in the summer). At the same time, the loneliness factor is negatively associated with collaboration, care relationships, and interventions geared to increase social contacts, through the presence of spouse, children, and friends, with different types of cooperation with others.

Six observable risk-predicting factors are noted: social isolation, low openness to experience, being in jail, domestic violence, being victims of abuse, and family conflict. As we saw in relation to thwarted belongingness, also perceived burdensomeness comprises two dimensions: believing that one's Self is so imperfect that it represents a burden for others (liability), and cognitions emotionally charged with self-hatred. The first dimension gives rise to six suicide risk factors constituting as many categories of distress caused by: unemployment (which may increase

suicide risk when stress is expressed as the perception of not meeting one's responsibilities); imprisonment (high levels of suicide risk have been found among convicts); homelessness; serious physical illness; perception of oneself as expendable; perception of oneself as unwanted, or perception of being a burden to others. The second dimension underlying perceived burdensomeness is the self-hatred construct, with three indicators of suicidal risk: low self-esteem, self-blame and shame, and agitation.

Interpersonal theory does not consider thwarted belongingness as a stable trait, but a dynamic cognitive-affective state that can be influenced by both interpersonal and intrapersonal factors. Moreover, it is observed that a condition where thwarted belongingness can directly influence suicidal ideation is where perceived burdensomeness is present at the same time.

To complete the picture of the interpersonal theory of suicide, a third dimension, named *acquired capability*, must be mentioned: the desire to die through suicide is not sufficient on its own to enact the suicidal behavior, because committing suicide is not easy to do. In order to die through suicide, people need to acquire the capability to commit suicide and to do so much of the fear associated with suicidal behavior must be overcome. Joiner (2005) maintained that such capability is acquired and is made up of lowered fear of death and increased physical pain tolerance; this can happen through habit and activation of opposite processes such as a response to repeat exposure to physical suffering and/or experiences inducing fear. For example: an individual's initial response to a stimulus like bungee jumping will be mostly fear. However, with subsequent exposure, the effect of the primary process (fear) will get reduced, and the effect of the opposite process (for example, euphoria) will be amplified, thus obtaining an observable emotional response of a reduction of fear. If the process continues, presumably, the magnitude of the opposite process will greatly exceed the valence of the initial emotional experience, turning from negative to less negative, to positive, and even highly positive.

Two tools assessing suicidal risk are associated with this theory. The first is the Acquired Capability for Suicide Scale (ACSS; Van Orden, Witte, Gordon, Bender, & Joiner, 2008), made up of 20 items (e.g., "The fact that I am going to die does not affect me" and "I can tolerate a lot more pain than most people") aimed to assess whether the person has the courage to perform lethal and self-harming acts. Individuals responded to each item on a 0 (*not at all like me*) to 4 (*very much like me*) scale. The total score resulted from summing all items ($\alpha = .68$). Such a tool is, therefore, derived from the previously described factor in Joiner's (2005) theory. The second tool, whose items derive from the interpersonal theory hypotheses too, is the Interpersonal Needs Questionnaire (INQ; Van Orden et al., 2008). The INQ was revisited in 2012 by Van Orden, Cukrowicz, Witte, and Joiner. The new version consists of 15 items, 9 of which assess thwarted belongingness (e.g., "These days, I rarely interact with people who care about me") and 6 perceived burdensomeness (e.g., "These days the people in my life would be better off if I were gone"). Responders are to indicate, on a 7-point Likert scale (from 1 = *Not at all true for me* to 7 = *Very true for me*), the degree of correspondence with their feeling in the recent period. The coefficients alpha for burdensomeness and belongingness subscales are respectively .61 and .54 for the clinical sample, .56 and .49 for the young adult sample.

On the basis of the interpersonal theory of suicide, therefore, the intervention can be conducted mainly on two axes: isolation and self-esteem. The former can be pursued by the professional psychologist's thoroughly analyzing the patient's social and relational network, possibly also involving in therapeutical sessions people significant to the patient, in order to understand

the existence and composition of such a network and the patient's perception of it. Both objective and perceived isolation will have the same consequences. Together with this approach mainly geared to the understanding of the patient's social network, the professional can work on self-esteem with interventions aimed to boost it, ranging from actions on the social origin of self-esteem — based on theories such as the terror management theory (Arndt et al., 2009; Becker, 1973) — to therapeutic interventions, such as humanistic psychotherapy, having among its key points the support to self-esteem (Wickman & Campbell 2003).

THE COGNITIVE MODEL OF SUICIDAL BEHAVIOR

Wenzel and Beck's (2008) main aim is that of unifying the main theoretical and empirical approaches to better understand suicidal behavior. According to them, only in this way will the in-depth knowledge of the mechanisms underlying suicide render interventions of prevention and assessment targeted and effective.

The cognitive model of suicidal behavior stems from the already mentioned Beck's general cognitive theory of psychopathology and integrates the different psychological constructs, the importance of which has been proven for the distinction between suicidal and non-suicidal individuals. The three main constructs involved in the cognitive model of suicidal behavior are dispositional vulnerability factors, cognitive processes associated with psychiatric disturbance processes, and cognitive processes associated with suicidal acts.

More specifically, the model maintains that dispositional vulnerability factors are long-term trait variables constituting a non-specific risk for the development of psychiatric disturbance and suicidal behaviors, though they increase their likelihood. Five categories of dispositional vulnerability factors have been identified, taken from empirical literature: 1) impulsivity and related constructs; 2) problem-solving deficit disorder; 3) overgeneral memory style (difficulty retrieving specific personal memories from the past); 4) a maladaptive cognitive style; 5) some personality traits.

The cognitive processes associated with psychiatric disturbances are made up of maladaptive, that is, dysfunctional, cognitive contents (what people think), and distortions in the process of information processing (how people think), associated with several psychiatric symptoms and conditions (Ingram & Kendall, 1986). Such cognitive processes associated with psychiatric disturbance are different from the dispositional vulnerability because they vary depending on the seriousness of the symptom and their content is very specific and relative to the pathology experienced (Beck, Brown, Steer, Eidelson, & Riskind, 1987; Westra & Kuiper, 1997). Finally, the cognitive processes associated with suicidal acts are the maladaptive cognitive contents and the information processes hypothesized to be activated when a person is going through a suicidal crisis. Within such a model, the term "suicidal crisis" refers to the moment in which the person experiences the suicidal ideation — thoughts, images, feelings, or other conscious cognitions to end one's life (Wenzel, Brown, & Beck, 2008), and/or enacts behaviors that point to that intention.

In many of these processes loss of hope is the central and motivating factor. It is defined as a negative future expectation (Minkoff, Bergman, Beck, & Beck, 1973). To quantitatively evaluate the subjects' negative expectations, Beck and colleagues developed the Beck Hopelessness Scale (BHS; Beck, Weissman, Lester, & Trexler, 1974), a self-evaluation tool made up of 20 items (e.g., "My future seems dark to me") of which nine were keyed false and 11 were keyed true. For every

statement, each response was assigned a score of 0 or 1 and the total hopelessness score was the sum of the scores on the individual items. The internal consistency of the scale was alpha .93.

Another essential term for the understanding of such model is “tolerance threshold,” defined as the precise moment when a person can no longer contain the distress caused by overwhelming emotions and cognitions emerging during the suicidal crisis. Such a threshold coincides with the moment when the cognitive processes impulse the subject to carry out the suicidal act.

Great importance within this model is attributed to stressful factors that may be at the basis of psychiatric disturbance and may push beyond the tolerance threshold into the enactment of the suicidal behavior. The number and the seriousness of the dispositional vulnerability factors are related to the extent of daily stress that may lead to trigger a suicidal crisis (Mann, Water-naux, Haas, & Malone, 1999; Oquendo et al., 2004). Individuals with few dispositional vulnerability factors and experiencing minor psychiatric disturbance need a high number of stressful factors to activate cognitive processes relevant to suicide. Conversely, subjects with a high number of dispositional vulnerability factors experiencing serious psychiatric disturbance, need few stressful factors to activate cognitive processes relevant to suicide.

Beck, Kovacs, and Weissman (1979) developed a scale specifically aimed to evaluate suicidal ideation: the Scale for Suicide Ideation (SSI). It is an interview, semi-structured by the operator, made up of 19 items ($\alpha = .89$), grouped into three factors — active suicidal desire (e.g., “Desire to make active suicide attempt”), preparation (e.g., “Method: specificity/planning of contemplated attempt”), and passive suicidal desire (e.g., “Sense of capability to carry out attempt”) — assessed on a 3-point scale (from 0 to 2). The total score is computed by adding the individual item scores. Thus, the possible range of scores is 0-38. In developing such a scale, the authors decided to focus on the intensity and pervasivity of ideation and its characteristics in order to reasonably predict suicide risk and, if necessary, implement preventive actions.

THE INTEGRATED MOTIVATIONAL-VOLITIONAL MODEL OF SUICIDAL BEHAVIOR

The integrated motivational-volitional model of suicidal behavior (IMV; O’Connor, 2011) tends to summarize, refine, and widen our knowledge and understanding of why people die in such a way, with a particular focus on the psychology of the “suicidal mind.” This three-phase model places the emphasis on a map of the relationships among context factors and triggering events, the modes of the development of ideation and the final outcome of the suicidal behavior. O’Connor’s aim consisted in integrating the main components of the predominant literature in a new integrated model on suicidal behavior, which could also be used to predict the types of factors distinguishing those who merely think about suicide and those who try to enact it.

IMV specifies the presence of moderators representing the transition from failure/humiliation to entrapment or threat to oneself (pre-motivational moderators), from feeling entrapped to suicidal ideation (motivational moderators), and from such an ideation to suicidal behavior (volitional moderators). The moderators of the threat to oneself are, therefore, the variables that weaken or strengthen the relationship between threat and self-evaluation, which, as we have seen, are represented by both failure and humiliation and the perception of being entrapped; among the moderators of this relationship that are activated are problem solving, autobiographical memory (Pollock & Williams, 2004), and rumination. A motivational moderator — another aspect considered by the

author — is defined as the factor that can modify the likelihood that the perception of entrapment may induce the person to have suicidal ideations. The lack of positive thoughts relating to the future, the lack of commitment to new goals, and little social support are among the main risk elements. To these are to be added the perception of loneliness and the perception to be a burden to others, seen above in the interpersonal theory of suicide (Joiner, 2005; Van Orden et al., 2010). O'Connor considered the third factor of Joiner's theory, namely the capability to commit suicide, among the moderators (together with impulsivity and others) leading to the suicidal behavior.

Transitions are, therefore, determined by the moderators defined as "phase-specific," that is, by factors that favor/hinder the movement between the various phases. Moreover, the basic factors, such as privation and vulnerability, as well as life events, for example a relationship crisis, fall within the phase prior to the formation of an ideation, and provide a wider context integrating biologic and social factors.

The model analyzed claims, therefore, that the suicidal behavior derives from a complex interaction of factors, the main predictor of which is the intention to enact suicidal behaviors. Such intention, in turn, is, however, determined by feelings of entrapment, in which the suicidal behavior is seen as the salient solution to life circumstances. Feeling entrapped is indeed triggered by evaluations of failure/humiliation, often associated with acute or chronic stress factors.

Because of its complexity, an intervention on the basis of such a model can be difficult for the professional who, first of all, must be able to individuate the phase in which the patient is, in order to intervene on the most critical factor or moderator. However, the complexity of the model and the fact that it considers a wide range of variables and an extensive timespan allow greater flexibility of intervention, granting the professional extremely broad opportunities of interpretation and action. The concrete actions that the professional can implement on the basis of this model are those that have already been listed, from the intervention on self-esteem to that on isolation, from cognitive-constructivist therapy to humanist psychotherapy. The focus, therefore, must be diagnostic and aimed to set the patient within an individual path of development and change, intercepting the phases of greater risk and greater fragility.

DISCUSSION

The analysis of the models on suicidal behavior has led us to consider and discuss the main relationships existing among the theories on suicide. In particular, as already stated, to examine the different models, we have used a temporal criterion.

Among the developments of Shneidman's (1985) theory, according to which the author of suicide is pain, Beck's (1996) suicidal mode is particularly relevant. Shneidman describes the various components of the suicidal mode, with a particular focus on the affective schemas (namely, emotional pain and tolerance to pain). The behavioral schemas, according to this theory, represent an extreme means to alleviate emotional pain and are a function of the low tolerance to pain. Beck's model, instead, considers, apart from the affective behavioral schema, also the cognitive and motivational systems. The suicidal behavior is, therefore, activated by the fact that these systems act contemporarily.

Another theory associated to Shneidman's (1985) is the interpersonal theory of suicide by Joiner (2005). According to such a theory, the suicidal act is determined by the simultaneous presence of both the perception of being a burden to others and the perception of being alone.

The capability to enact the suicidal behavior, without which it remains at the level of ideation, is also to be considered. According to the interpersonal theory of suicide, the social connection is tied to the extreme gesture through some variables, which highlight the fact that a fundamental psychological need is not met; this aspect is also present in Shneidman's theory, which considers the concept of psychache (psychological pain) in relation to a threshold beyond which it is perceived as intolerable. Such a perception takes place when some of the person's basic needs are contrasted.

The interpersonal theory of suicide suggests that the central need for the development of the desire for suicide is the need for belonging. Such a need has been described by Baumeister and Leary (1995). According to them, when this need is not met the desire to die develops. Baumeister (1990) relates back to Baechler's (1980) model according to which suicide is defined as "all behavior that seeks and finds the solution to an existential problem by making an attempt on the life of the subject" (p. 74). In order to overcome such limitations, he proposed a more elaborate version of Baechler's theory, that is a six-step model as described in the section "Suicide as Escape from Self." In particular, as already stated, when the person does not achieve the set goals, he/she can attribute such a failure to his/her inadequacy. Later, such a perception turns into an excessive awareness of one's limitations, which is also accompanied by the development of an intense and adverse feeling. In order to confront such negative emotions, the person makes a cognitive deconstruction to separate the forms of thought and conscience. Finally, such a deconstruction leads to four consequences related to the theme of suicidality (passivity, disinhibition, lack of emotions, and irrational thought). Apart from defining these steps, Baumeister analyzes specific deterrents tied to the reasons against making an attempt on one's life. They are: life pleasantness, which can lead to anticipate future happiness; love of self (Taylor & Brown, 1988); internal fears and inhibitions against taking or risking one's life; finally, feelings of responsibility to family and fear that others will disapprove of suicidal behavior (Linehan, Goodstein, Nielsen, & Chiles, 1983).

Linehan and colleagues (1983), in turn, detected another four groups (in adjunct to the two reasons mentioned above), defined as "reasons for living": survival and coping beliefs, child-related concerns, fear of suicide, and moral objections. Consequently, the Reason for Living Inventory was formulated, assessing the potential protective factors observed in people who express suicidal ideation. It is a self-administered questionnaire made up of 48 items and divided into six subscales. The following six distinct clusters of reasons for living emerged: 1) survival and coping beliefs (sample items, "I believe I can find other solutions to my problems," "I do not want to die"); 2) responsibility to family (sample item, "My family depends upon me and needs me"); 3) child-related concerns (sample item, "I want to watch my children as they grow"); 4) fear of suicide (sample item, "I am afraid of death"); 5) fear of social disapproval (sample item, "Other people would think I am weak and selfish"); 6) moral objections (sample item, "I believe only God has the right to end a life"). These factors are composites of true or false responses. Internal consistency (alpha coefficients) ranged from .72 to .89 for the six subscales.

One of the basic arguments in Williams and Pollock's (2001) theory is that people are motivated to the suicidal act by the need to escape from a situation perceived as unbearable.

Therefore, the authors go beyond Baumeister's (1990) hypotheses, previously treated, according to which suicide is determined by the desire to escape from self, and they refer to the concept of arrested flight relative to animal behavior. For this reason Williams (2001) considered the suicidal behavior a reactive phenomenon, originating from a stressful event, which represents, for humans, the same as the entrapment state for animals.

Returning to the concept according to which the suicidal act originates from the need to flee from a situation perceived as unbearable, a connection can be noted with Shneidman's (1985) theory, previously stated, according to which suicide is driven by pain, and suicidal fantasies and acts are efforts to escape and block such pain which pervades the mind. Also in Williams' (2001) theory such psychic anguish is present, deriving from the perception of having no way out nor possibility of rescue.

Given the difficulty of drawing a sharp distinction between the concepts of defeat and entrapment, Johnson, Gooding, and Tarrier (2008) devised a cognitive model of suicidal behavior relating, specifically, to schizophrenia. Such a model is made up of three main components: 1) negative-information processing biases, 2) the presence of suicide schema (or cognitive model), 3) appraisal system. To conclude, O'Connor's (2011) integrated IMV model originated in particular from three theories, which he unified and then organized in three phases: pre-motivational, motivational, and volitional. The first theory, cited in O'Connor's model, is that of diathesis-stress (Schotte & Clum, 1987), highlighting the centrality of the role of the vulnerability factors (cognitive and biological), which become particularly harmful when they are activated by stressful events. Generally, though, together with environmental influences and negative life events, these diatheses characterize the IMV pre-motivational phase, still within the framework taking into account a bio-social context, where the suicidal ideation and/or behavior can develop. The second theory, present in O'Connor's model, is represented by the arrested flight model (Gilbert & Allan, 1998; Williams, 2001; Williams & Pollock, 2001), according to which feeling defeated, entrapped, and with no chances of rescue are the setting conditions for the suicidal behavior, which can manifest itself after real traumatic experiences (e.g., sexual abuse) or as a consequence of the way in which a person perceives one's life condition (e.g., personal failure). Moreover, a further contribution derives from the theory of planned behavior (TPB; Ajzen, 1991), which provides a unifying theoretical frame for IMV, because it postulates that the expectation of any behavior can be divided into two groups of factors (motivational and volitional). In short, the motivational phase describes the factors associated with the development of the suicidal ideation and one's intention to transform it into behaviors, while the volitional phase factors consider the act, that is, those aspects that increase the likelihood that attempts will follow the suicidal thought. Finally, O'Connor drew from the interpersonal theory of suicide (Joiner, 2005; Van Orden et al., 2010), which provides a twofold influence both in the motivational phase through the perceptions of loneliness and of being a burden, and in the volitional phase through the individual's capability of enacting the suicidal behavior.

In short, the path outlined in this work starts with the critical analysis of the first models reported in the literature, such as the cubic model of suicide, the diathesis-stress-hopelessness, the suicide as escape from self, and the cry of pain. The report continues with the models linked to cognitive studies, looking, in particular, at the contributions provided by Beck and colleagues (1987). Finally, the two most recent models are presented, Joiner's (2005) interpersonal theory of suicide and O'Connor's (2011) integrated motivational-volitional model of suicidal behavior,

both operating an integration and systematization process of the main elements emerged from the previous theories.

Similarly, for each theory examined we analyzed the main assessment tools — fundamental to develop and implement appropriate and necessary actions for the prevention of suicidal acts. In particular, in the context of the cry of pain model, the influence of the Defeat Scale and the Entrapment Scale (Gilbert & Allan, 1998) can be discerned. The Acquired Capability for Suicide Scale and the Interpersonal Need Questionnaire (Van Orden et al., 2008) were developed on the basis of the theories of the interpersonal theory of suicide. Beck's team (1987) elaborated several assessment scales for suicidal intentions and ideations, for example, the Scale for Suicide Ideation, determining the empirical approach of cognitive therapy. Among these, the Hopelessness Scale evaluates the tendency to have negative expectations for the future. Finally, the motivations driving individuals to not transform suicidal ideation into suicidal act are considered in the Reason for Living Inventory (Linehan et al., 1983), a useful tool to assess individual protection factors.

An in-depth evaluation of the different aspects of the models can be found in the previously mentioned references. Moreover, on the basis of the analyses carried out to date, we consider O'Connor's (2011) integrated motivational-volitional model useful, even when used on an experimental basis. In general, however, an increasing use and sharing of the models and assessment/action tools is desirable to constantly support professionals of the sector in both preventing suicidal risk and carrying out support actions.

LINES OF ACTION AND CONCLUSION

Several studies and reviews (Monaghan & Harris, 2015) have demonstrated the effectiveness of psychotherapy for people at risk of suicide, taking into consideration different theoretical and applicative approaches, each obtaining positive results in risk prevention treatments. The approaches most frequently analyzed empirically are the cognitive-behavioral therapy (CBT), the dialectic behavioral therapy (DBT), the problem-solving therapy (PST), the mentalisation-based therapy (MBT), and the interpersonal psychodynamic therapy (PIT) (Brown & Jager-Hyman, 2014). At the same time, the authors do not exclude the validity of other models, which, with their peculiarities and basic theories, can respond to the calls for help of patients who have enacted self-harming behaviors or who manifest the intention to put an end to their lives.

In this sense, also Kelly's (1961) constructivist perspective focuses on the search for meanings and sense of reality. These meanings can be manifold and diverse and can lead to the suicidal act. According to the personal construct theory, suicide is defined by Kelly as "an experience of chaos or fatalism (. . .) everything seems so unpredictable that the only definite thing one can do is to abandon the scene altogether [experience of chaos] (. . .) the course of events seems so obvious that there is no point waiting around for the outcome [fatalism]" (p. 260).

Psychotherapy, in such a perspective, is a process suited to intervene in the person's systems of meaning. In an interview held in Sydney during the XX International Congress on Personal Construct Psychology, Neimeyer claimed that "through psychotherapy one can articulate, symbolize and re-negotiate the meanings that people use to understand their choices and options, to somehow express — maybe through language or other communicative channels — what Kelly

named nuclear constructs” (Bordin & Dagani, 2014, p. 54). Constructivist psychotherapists, therefore, focus not on why but on the direction toward which the person is moving among the different alternatives. In such a perspective, the dimensions of meaning in patients at risk of suicide have been discovered also thanks to the help of the repertory grid technique (Hughes & Neimeyer, 1993). Such a technique represents a flexible method to elicit in each person how he/she perceives him/herself and the world, and to monitor the changes in content and structure of his/her system of meaning during therapy (Fransella, Bell, & Bannister, 2004).

The analysis of recent qualitative and quantitative reviews (Benelli, De Carlo, Biffi, & McLeod, 2015; Winter, Bradshaw, Bunn, & Wellsted, 2013, 2014) highlighted that the difference in the effectiveness of psychotherapy in relation to the different models used is modest, given that the degree of change is to be mostly attributed to the therapeutic relation with and the proactivity of the patient. The patient looks for specific characteristics in the therapist that are considered important for the effectiveness of the path of change: empathy and understanding. At the same time, the psychotherapeutic path is rendered smooth by the perception of support that users feel and the commitment and responsibility that they place in the relationship.

Moreover, several studies have highlighted the obstacles to the course of psychological intervention, among which, a certain resistance for fear of criticism, disapproval, and rejection. Still in terms of adversities, from the psychological and psychotherapeutic point of view, Gurrister and Kane (1978) noted that working with patients who attempted to commit suicide may evoke in professionals feelings such as anxiety, rage, frustration, concern, and a desire to protect the patient. Moreover, the perception of lack of support and education with regards to the treatment of people with suicidal behaviors has often been mentioned. Education and experience are two variables that have been examined empirically in relation to the abilities that operators of the sector should possess to respond to the different requests for help (Neimeyer, 2004).

Similarly, the attitudes and opinions that psychologists/psychotherapists have toward death and the act of suicide and the presence or lack of personal experiences of suicide constitute areas that require further research. Neimeyer and Pfeiffer (1994), in particular, maintained that response modalities characterized by avoiding strong feelings, as well as taking up a defensive position or passivity, can compromise the effectiveness of the management of patients at risk of suicide.

Further, several authors have examined what can be done to improve professionals’ responses in these specific cases; Neimeyer (2000; Neimeyer, Fortner, & Melby, 2001), for example, tried to develop a training program congruent with intervention/psychotherapy in the area of suicide, as well as a course in professional and crisis management. Moreover, the authors presented a questionnaire to assess psychologists’ competence in managing suicide risk: the Suicide Interventions Response Inventory (SIRI; Neimeyer & MacInnes, 1981). Such a tool is composed of 25 affirmations ($\alpha = .84$) corresponding to the requests of a hypothetical patient — expressing severe concern over a difficult situation — followed by two possible responses by the professional, one of which is appropriate to prevent suicidal risk while the other is neutral or detrimental for the purpose of the intervention; for example, “Client: No one can understand the kind of pain I’ve been through. Sometimes I just feel like I have to hurt myself, so I cut my wrists. Helper A: It seems like you’ve been suffering so much that cutting your wrists is the only way you can make the pain go away. Helper B: But you’re so young, you have so much to live for. How can you think of killing yourself?” (Neimeyer & Bonnelle, 1997, p. 76).

To conclude, most of the models presented in this study were effective in the support service, to understand suicidal risk factors and respond effectively to distress calls. During the three-year activity of the support service and later, there were no suicidal behaviors, not even in people seriously exposed to such a risk — employers involved in bankruptcy proceedings or employees who lost their job, with a modest or non-existent chance of re-employment, therefore, people experiencing serious identity crisis, or loss of meaning and value in their existence.

The experience on the field and the analysis of the literature on suicidal intention and behavior prove that a specific training on this topic could be extremely relevant, not only among psychologists but also among all the professionals who may deal with people in need and people with difficulty. In this way, effective monitoring networks may be put in place, which can act fast and make use of the different professional specificities in order to give hope, reduce loneliness, increase awareness, and, thus, prevent suicide.

NOTE

1. The “Ordine degli Psicologi” (psychologists’ board) is a professional, public board, present in each Italian region. In this article, the authors refer to the “Ordine” of the Veneto region.

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