



Empirical, Clinical, and Conceptual Evidence Converges to Indicate Good Support for the Interpersonal Theory of Suicide

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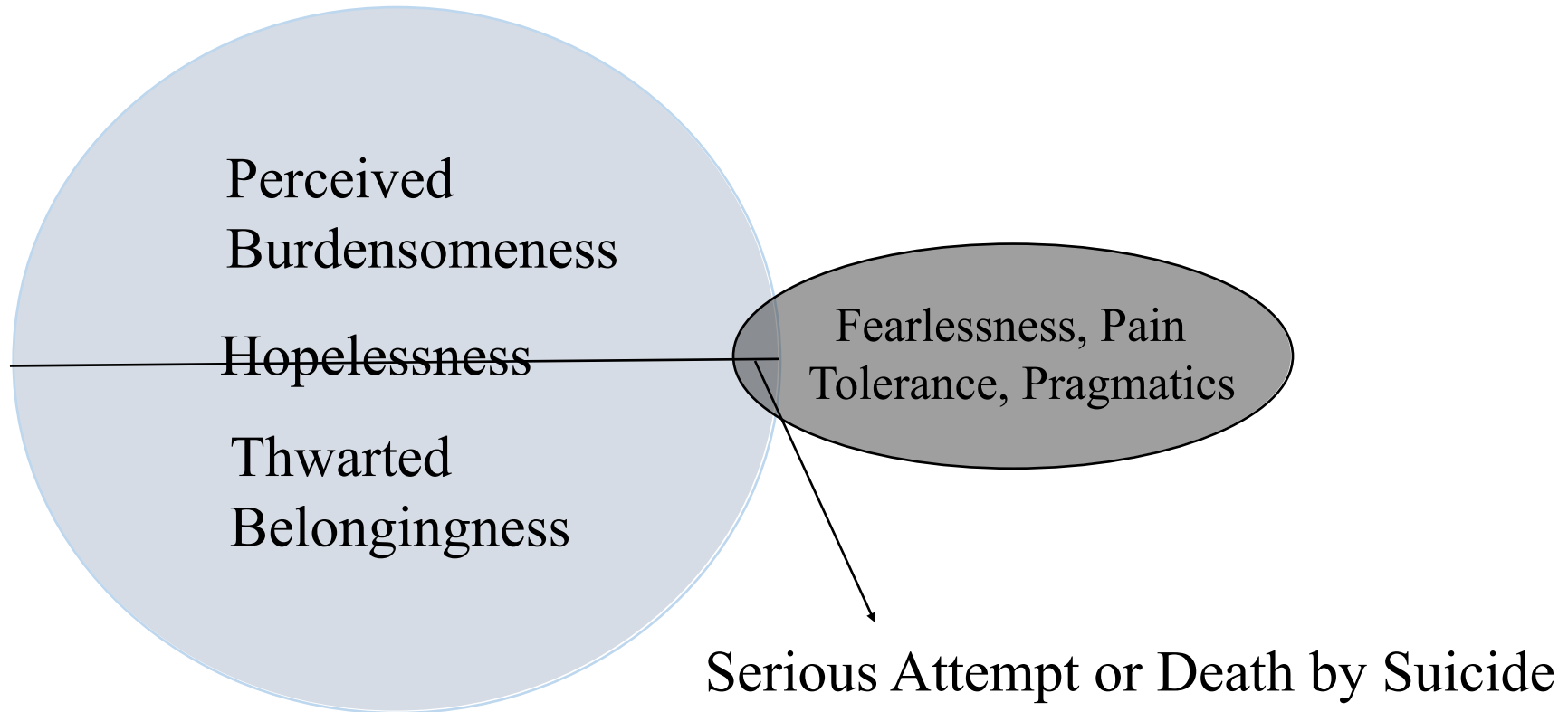
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The Interpersonal Theory of Suicide

Desire for Suicide

Capability



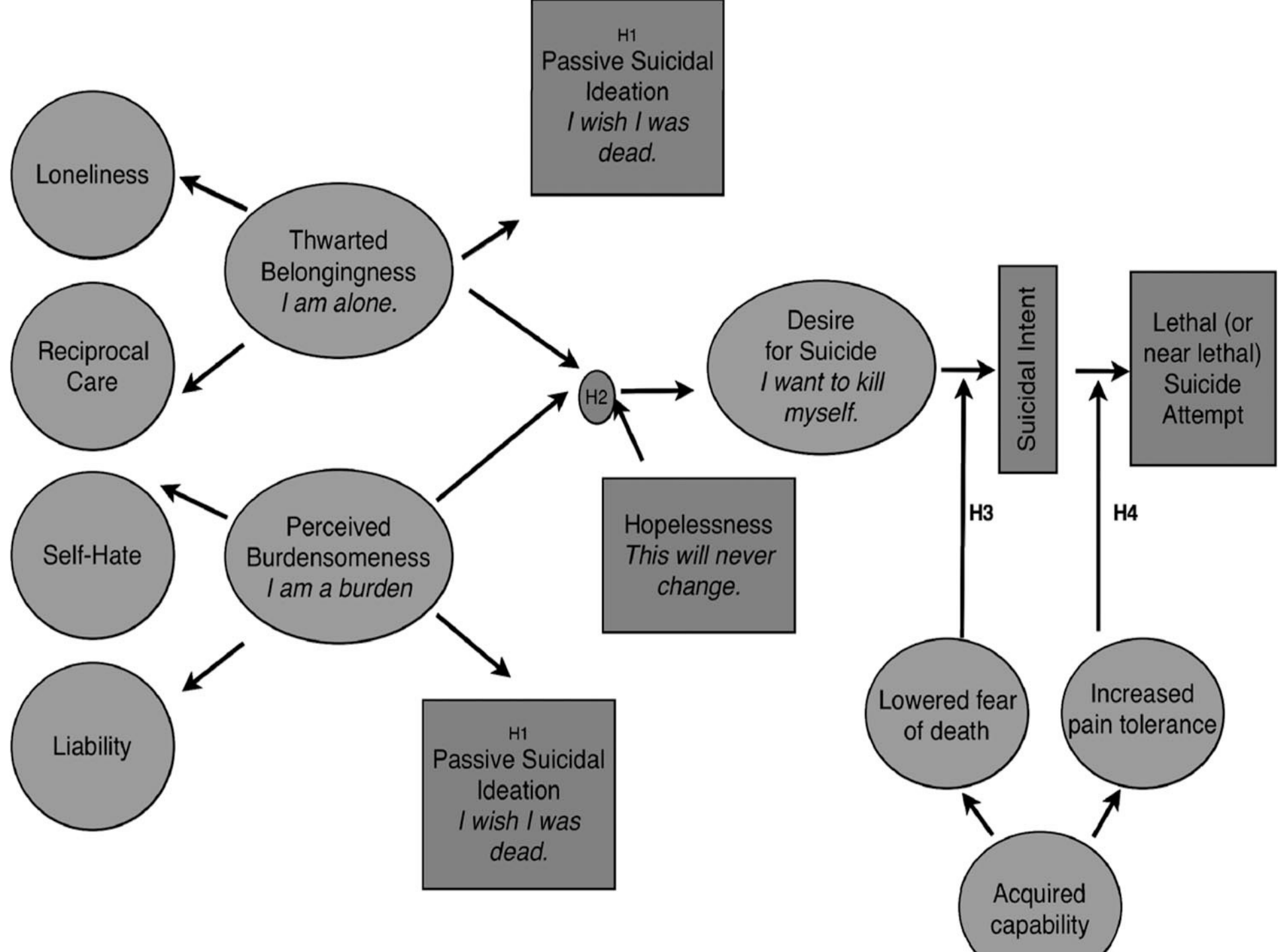
Perceived
Burdensomeness

Hopelessness

Thwarted
Belongingness

Fearlessness, Pain
Tolerance, Pragmatics

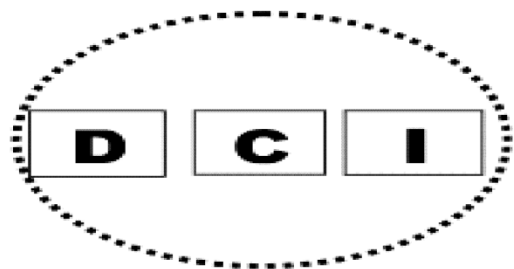
Serious Attempt or Death by Suicide



One Theory-Related Assessment Approach

- U.S. National Suicide Prevention Lifeline (1-800-273-TALK) Guidelines
- transitioned to 988

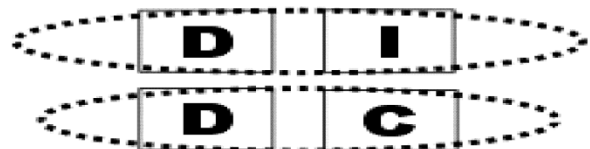
SUICIDAL DESIRE	SUICIDAL CAPABILITY	SUICIDAL INTENT	BUFFERS/CONNECTEDNESS
Suicidal Ideation • Hurting self and/or others	History of suicide attempts	Attempt in progress	Immediate supports
	Exposure to someone else's death by suicide		Social supports
	History of/current violence to others		
Psychological pain	Available means of hurting self/other	Plan to hurt self/other • Method known	Planning for the future
Hopelessness	Currently intoxicated		Engagement with helper • Telephone worker
	Substance abuse		
Helplessness	Acute symptoms of mental illness, for example: • Recent dramatic mood change • Out of touch with reality	Preparatory behaviors	Ambivalence for living
Perceived burden on others	Extreme agitation/rage, for example: • Increased anxiety • Decreased sleep • Recent acts and/or threats of aggression	Expressed intent to die	Core values/beliefs
Feeling trapped			Sense of purpose
Feeling alone			



Key D=Desire I=Intent C=Capability

Risk Remains High Despite
Absence/Presence of Buffers

High Risk
All Three Core Factors Are Present



Key D=Desire I=Intent C=Capability

Absence/Presence of Buffers
May Raise or Lower Risk

Moderate To High Risk
Desire Paired With Intent or Capability



Key D=Desire I=Intent C=Capability

Absence/Presence of Buffers
May Raise or Lower Risk

Moderate To Low Risk
Any Core Factor Presenting Alone

- Applied utility
- Resonance with bedrock
- Incrementality
- Generativity (e.g., 3-Step; IMV model)
- Empirical tests that are fair and contextualized
- Explanatory reach

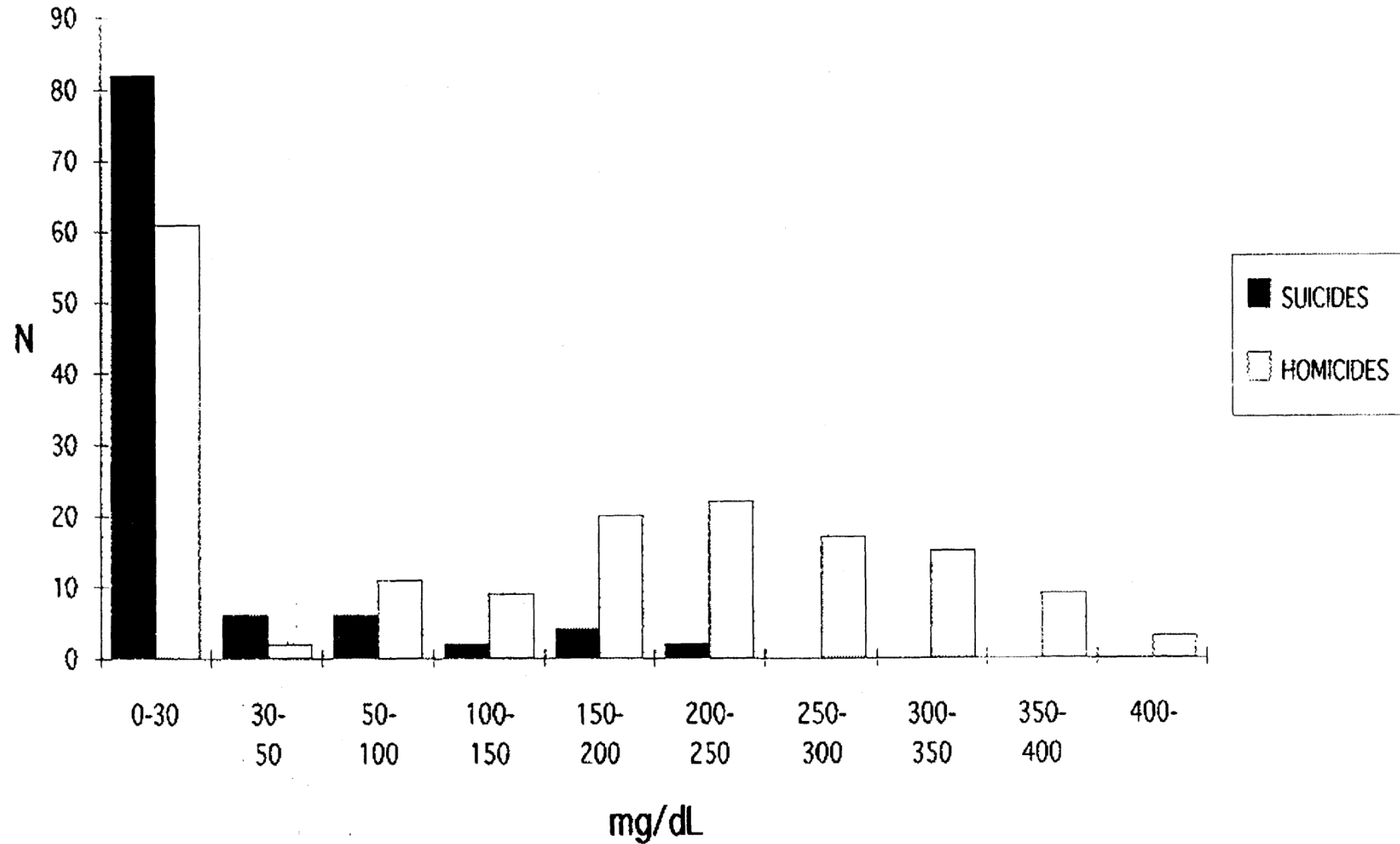
Bedrock and Explanatory Reach: Self-sacrifice in mold, ants, bees, naked mole rats, and humans (young and old)

- inclusive fitness (i.e., “things” will be better without me)
- “things” = genes in close, biological relatives

Last-Instant Regret

- “... the scene was decent and peaceful but she was off the bed and on the floor, and the bedside telephone had been dislodged from its cradle. It’s impossible to ‘read’ this bit of forensics with certainty, but I shall always have to wonder if she had briefly regained consciousness, or perhaps even belatedly regretted her choice, and tried at the very last to stay alive.”
- Hitchens, Christopher. Hitch-22 . Grand Central Publishing. Kindle Edition.

Blood alcohol concentrations in victims of sharp force injuries in the Stockholm area
1983-92



Blood Alcohol Content at the Time of Suicide

Anestis, Joiner, Hanson, & Gutierrez
(2014, *J Abnormal Psychology*):

92 studies, 167,894 decedents, same
pattern of findings.

Time frame is key to
understanding.

The Varieties of Suicidal Experience

- Murder-suicide
- Suicide-by-cop
- Suicide Terrorism
- Spree Killing
- Death Row Volunteering
- Physician-Assisted Suicide

Joiner, T. (2024). *The Varieties of Suicidal Experience*.
New York: NYU Press.

Suicide in Anorexia Nervosa

- We pitted these two accounts against each other, in a study of 239 women with AN, followed over ~15 years.
- 9 died by suicide, the leading cause of death among the sample.
- Of these 9, were they mostly highly lethal methods or not?

Suicide in Anorexia Nervosa

- The *least* lethal method: Ingestion of a powerful household product, along with alcohol (BAC = 0.16%). Cause of death was gastric hemorrhaging due to the product's ingredients.

- Next behavior: Called 911.

Holm-Denoma, Witte, Gordon, Herzog, Franko, D.L., Fichter, Quaflied,
& Joiner (2008).

Suicidal Behavior by Preschool Children

Perihan A. Rosenthal, M.D., and Stuart Rosenthal, M.D.

Sixteen suicidal preschoolers age 2½ to 5 years who were referred to a university child psychiatry outpatient clinic were compared with 16 behaviorally disordered preschoolers matched by age, sex, race, and parental marital and socioeconomic status. The suicidal group showed significantly more nonsuicidal self-directed aggression, loss of interest, morbid ideas, depression (according to the Weinberg criteria, but not DSM-III), impulsivity and hyperactivity, and running away behavior. They also showed significantly less pain and crying after injury; more of the children were unwanted and abused or neglected by parents. Four subgroups of suicidal motivation are identified and discussed.

(Am J Psychiatry 141:520-525, 1984)

In 1978 only two of the more than 32 million children under 10 years of age in the United States committed suicide, according to Shaffer and Fisher (1). They concluded that childhood suicide, which they defined as "a self-inflicted death occurring before a child's fifteenth birthday," is a rare condition. Most childhood suicides Shaffer (2) reviewed were planned ones caused by asphyxiation by gas, by hanging, or by use of firearms. Shaffer and Fisher (3) dismissed the contention that younger children's belief in the reversibility of death reduces their constraints on suicidal

children listed for evaluation at a child psychiatry outpatient clinic; 33% displayed suicidal ideas, threats, or attempts. Cohen-Sandler and Berman (unpublished 1980 data) reported that about 12,000 children age 5 to 14 are admitted annually to psychiatric hospitals because of suicidal behavior. They suggested that suicide attempts may be masked as accidents, may be concealed by parents, or may elude physicians. Green (5) showed that 40% of a sample of abused children exhibited life-threatening behavior; he later documented a marked increase over a 14-year period in the overall incidence of child abuse (6). Cohen-Sandler and associates (7) compared suicidal children age 5 to 14 years with depressed children and controls; the suicidal group had higher stress scores in the year before admission.

The literature is scantier for reports of suicidal behavior in preschoolers. Only a few cases in 4- and 5-year-olds were reported (8, 9) until we described (10) seven cases of suicidal attempts in children age 4 and under. In 1981 the National Safety Council (11) reported that the leading cause of death per 100,000 population for children under 5 years was accidents (29%) followed by congenital anomalies and cancer. Some specific causes listed were motor vehicle accidents (11%), fires and burns (6%), drownings (5%), ingestion of food or an object (1%), falls (1%), and other accidents (5%). Suicides among preschoolers probably go unrecognized given the incredulity of

Rosenthal, P. A., & Rosenthal, S. (1984). Suicidal behavior by preschool children. *The American Journal of Psychiatry*, 141, 520-525.

Sample

- 16 suicidal preschoolers
- 16 non-suicidal preschoolers with behavior problems (i.e., unmanageable behavior, aggressiveness towards others, & hyperactivity)
- Ages 2.5 years to 5 years old (median age 3.5 years)

*Preferred Suicide Methods Endorsed by **Adult** Participants across Prompts*

Suicide Method	N	%
Own Prescription Medications	4,216	34.3
Illicit Drugs	579	4.7
Over-the-Counter Drugs	1,170	9.5
Poison	311	2.5
Firearms	1,123	9.1
Immolation	74	0.6
Hanging	548	4.5
Sharp Object	1,306	10.6
Auto Exhaust	371	3.0
Other Gases	49	0.4
Train/Car	568	4.6
Jump from Height	406	3.3
Drowning	211	1.7
Suffocation	36	0.3
Others' Prescriptions	355	2.9
Other Method	960	7.8

TABLE 1. Suicidal Behavior of 16 Preschool Children

Method Used	Initial Behavior		Subsequent Behavior	
	N	%	N	%
Setting self on fire deliberately	1	6	2	13
Ingesting drugs	4 ^a	25	2	13
Jumping from high places	3 ^b	19	2	13
Cutting, stabbing self	1 ^b	6	2	13
Running into fast traffic	5 ^b	31	5	31
Drowning	0		2	13
Banging head with deadly intent	0		1	6
Throwing self down stairs	2	13	2	13

^aThree children used this method exclusively.

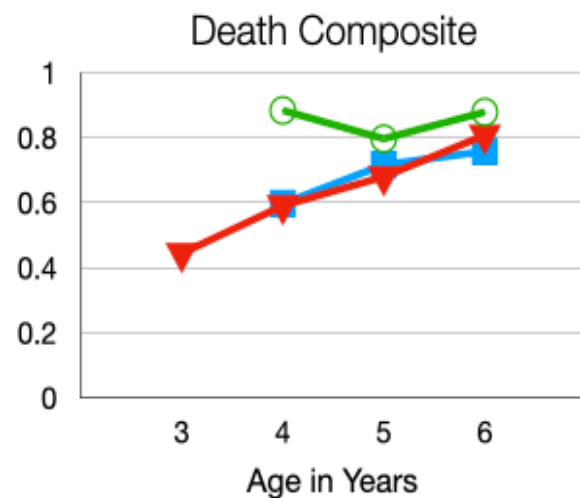
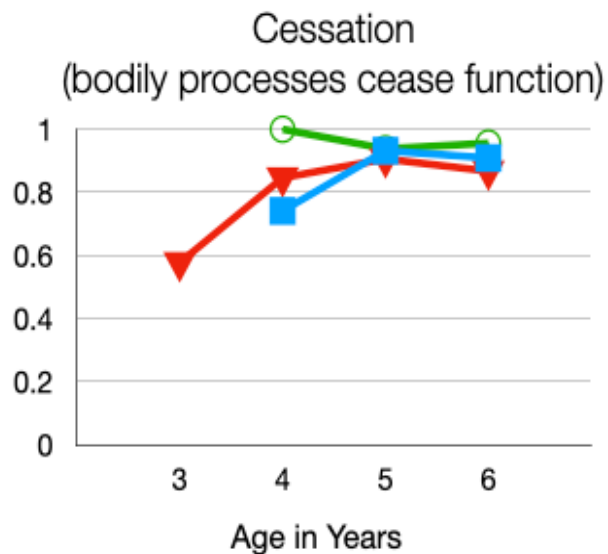
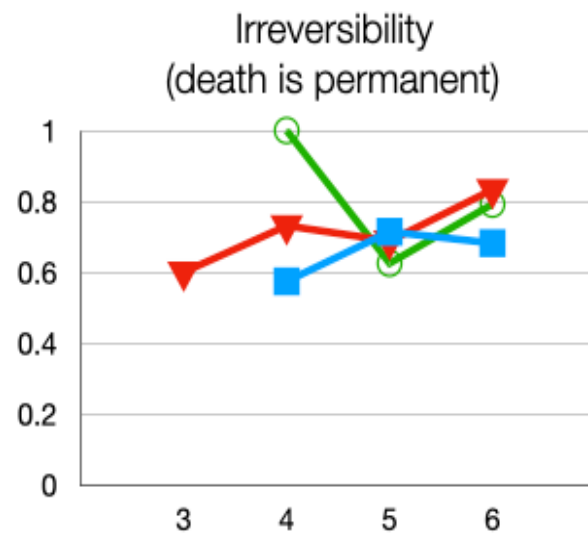
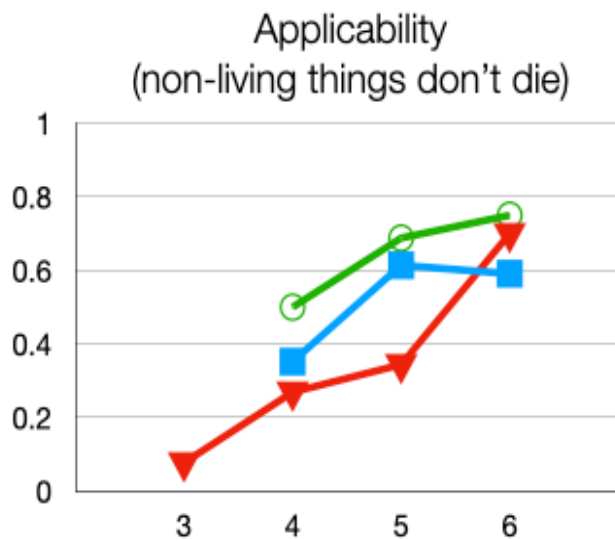
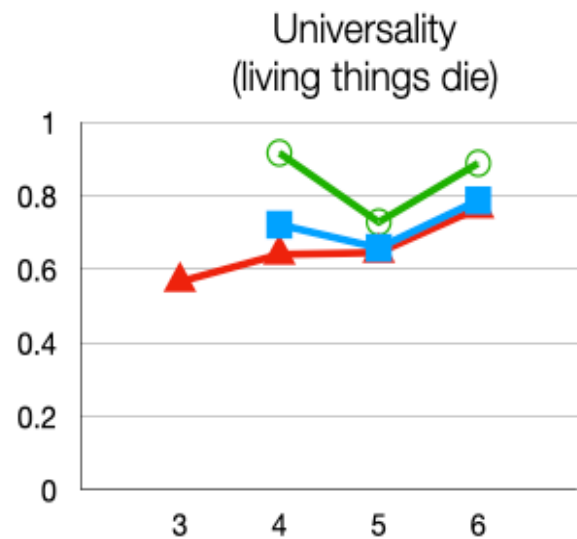
^bOne child used this method exclusively.

TABLE 2. Significant Differences Between 16 Suicidal Preschool Children and 16 Preschool Children With Behavior Problems

Type of Difference	Suicidal Group		Behavior Problems Group		Significance ^a	
	N	%	N	%	χ^2	p
Behavior						
Impulsivity and hyperactivity	8	50	15	94	5.56	.025
Running away from home	11	56	2	12	8.29	.005
Pain, crying after injury	4	25	16	100	16.13	.001
Nonsuicidal aggression to self	13	81	5	31	6.22	.025
Depressive symptoms						
Loss of interest	6	38	0		5.13	.025
Morbid ideas	8	50	0		8.17	.005
Depression, Weinberg criteria (15)	9	56	2	13	4.99	.05
Parental behavior						
Child unwanted	13	81	4	25	8.03	.005
Child abused or neglected	13	81	6	38	4.66	.05
Anger displaced onto child	4	25	11	69	4.52	.05

^adf=1, Yates' correction used.

● MDD+SI ▼ MDD-SI ■ HC



(Hennefield et al., 2019)

Story Stem

spilled juice



bed time



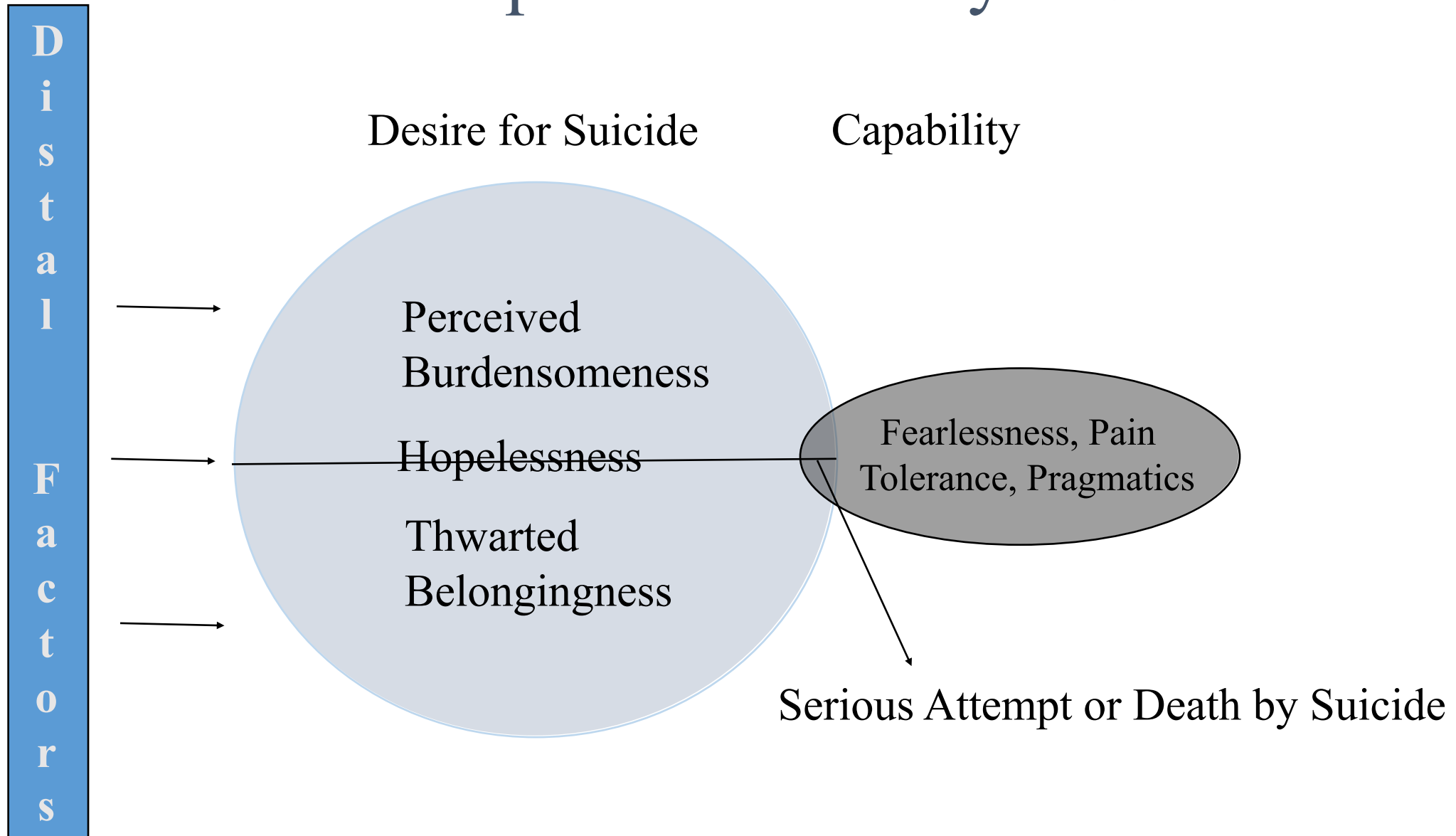
sad mom



band-aid



The Interpersonal Theory of Suicide



Empirical Support for the Interpersonal Theory of Suicide

Chu et al. meta-analysis (2017,
Psychological Bulletin, continued):

“...the interaction between thwarted belongingness and perceived burdensomeness was significantly associated with suicidal ideation...”

Empirical Support for the Interpersonal Theory of Suicide

Chu et al. meta-analysis (2017,
Psychological Bulletin, continued):

“...However, effect sizes for these interactions were modest.”

Thank you for your attention

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