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The Suicidal Mode: A Cognitive-Behavioral Model of Suicidality

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This article discusses the theoretical foundation and potential clinical application of the suicidal mode, a cognitive behavioral theory of suicidality. The model presented represents a specific elaboration of Beck's modal theory of psychopathology. In addition to discussing the fundamental requirements of a theory of suicidality, the theoretical assumptions of the suicidal mode are identified, its component parts defined, its inherent strengths emphasized, and its application in clinical settings detailed. Definition of a modal theory of suicidality represents the growing influence of cognitive-behavioral theory in efforts at psychotherapeutic integration in clinical suicidology.

EXISTING THEORETICAL MODELS OF SUICIDAL BEHAVIOR: A BRIEF OVERVIEW

The study of suicide and suicidal behavior has been approached from a wide range of theoretical and empirical models. To date, however, there are only a handful of controlled studies available addressing treatment outcome ($N = 25$, Rudd & Joiner, in press; Rudd, Joiner, Jobes, & King, 1999). The studies that are available are compromised by small samples, among a host of other methodological problems, including questions about inclusion and exclusion criteria, the diagnostic composition and representativeness of samples, the actual nature of the treatment interventions used, the appropriateness of assessment instruments employed, and the adequacy of follow-up procedures (for review see Rudd, in press; Rudd and Joiner, in press). As a result, a solid empirical base simply does not yet exist in the suicidality treatment literature.

A broad range of theories have driven both clinical practice and empirical studies. Included among the most frequently cited theoretical approaches to suicidality are the following: (1) epidemiological (e.g., Dublin, 1963), (2) philosophical (e.g., Battin, 1982), (3) sociocultural (e.g., Hendin, 1964), (4) sociological (Durkheim, 1897/1951), (5) psychiatric (e.g., Kraeplin, 1883/1915), (6) psychodynamic (e.g., Freud, 1917/1957), (7) psychological (e.g., Shneidman, 1985), and (8) biological (e.g., Bunney & Fawcett, 1965). Naturally, each approach has emphasized a distinctive feature, aspect, or characteristic of suicide and suicidal behavior, frequently at the purposeful exclusion of others.

Epidemiological approaches have focused on demographic characteristics, philosophical theorists have attempted to answer difficult questions about the nature and pur-

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pose of life, and sociocultural and sociological researchers have emphasized the critical role played by societal and cultural variables. Similarly, psychiatric, psychodynamic, psychological, and biological researchers have stressed the importance of mental illness, unconscious conflicts and emotional processes, psychological pain and unmet psychological needs, and biochemical imbalances, respectively. Only recently has a concerted effort been made toward theoretical integration in suicidology (Maris, Berman, Maltsberger, & Yufit, 1992). Despite a rich and broad research literature, the narrow and exclusive focus of most theoretical approaches has greatly limited their clinical and practical utility. Accordingly, practitioners often struggle to apply research findings in a meaningful way in their daily clinical work with suicidal patients, opting instead to use multiple theoretical paradigms to understand, explain, and ultimately treat different aspects of a single patient's presentation. This occurs despite the strong possibility of violating stated fundamental assumptions and principles upon which the theoretical approaches were developed.

Empirically derived models have also tended to be restrictive and somewhat exclusionary in focus. Although not specific to suicidality, a number of models have been explored and validated for depression, the most extreme manifestation of which incorporates a suicidal component. Researchers have explored the role of a broad range of variables in depression, including attributional style (e.g., Abramson, Metalsky, & Alloy, 1989), hopelessness (Weisshaar, 1996), problem solving (Nezu, Nezu, & Perri, 1989), interpersonal relationships and social reinforcement (e.g., Lewinsohn, 1975), and cognitive rigidity and distortion (e.g., Beck, Rush, Shaw, & Emery, 1979). The majority of the models proposed that are specific to suicide and suicidal behavior are, essentially, variations of the diathesis–stress–hopelessness paradigm, well articulated by Schotte and Clum (1982, 1987). A range of variables have been identified as underlying diatheses, or vulnerabilities, triggered by stress, both acute and chronic. Among the most frequently cited diatheses are dysfunctional assumptions (Beck, Steer, & Brown, 1993; Bonner & Rich, 1987; Ellis & Ratliff, 1986, Ranieri, Steer, Lavrence, Rissmiller, Piper, & Beck, 1987), cognitive distortions (Prezant & Neimeyer, 1988), interpersonal problem solving deficits (Linehan, Camper, Chiles, Strosahl, & Shearin, 1987; Orbach, Rosenheim, & Hary, 1987; Rotheram-Borus, Trautman, Dopkins, & Shrout, 1990; Schotte & Clum, 1982, 1987) and cognitive rigidity (Neuringer, 1968; Neuringer & Lettieri, 1971).

APPLICATION OF THEORY AND EMPIRICAL FINDINGS IN TREATMENT: THE PROBLEM OF LIMITED CLINICAL RELEVANCE

The narrow focus of theoretical and empirically derived models is understandable and entirely warranted. Good science is characterized by specificity in theory, investigation, and application. Theoretical discussions and arguments, and empirical findings to date, all have greatly benefited the clinician sitting in the office, one on one with the suicidal patient. However, one of the primary difficulties for practitioners attempting to employ these models in treatment is their *limited clinical relevance*. They oftentimes are difficult to apply in individual treatment cases given subtle but important distinctions and nuances presented by individual patients. Most clinicians agree that suicidal patients are the most diagnostically complex and therapeutically challenging patients they see (e.g., Pope & Tabachnick, 1993). This is consistent with the complexity of suicidality itself, a problem that is inarguably the result of a complex web of factors, with precise interrelationships varying from individual to individual. This is true despite consistency in empirical studies regarding the roles of variables like life stress, problem solving, hopelessness, and emotion regulation (Rudd, Joiner, Jobes, & King, 1999).

As a result, the nature of treatment provided will vary somewhat and is not uniform across all cases of suicidality that any one clinician treats. Undeniably, different variables

have different meanings and varying levels of importance for different cases in clinical practice. At times, practitioners are faced with what appears to be a disparate group of predictor variables and correlates of suicidality that are not woven together in a coherent and clinically accessible model that can be applied with some uniformity *across* different cases.

To date, efforts to apply the existing theoretical and empirical literature in suicidology in clinical settings have resulted in several identifiable and consistent problems. First, there is the narrow conceptual focus discussed earlier, resulting in cumbersome and imprecise application both within and across individual cases. Although the narrow focus of many theoretical models allows for considerable depth and detail in explaining *specific aspects* of suicidality, the models tend to be paradoxically simplistic when applied clinically. As a result, they do not provide a meaningful and comprehensive explanatory framework for patients, despite affording the clinician a general conceptual guide for treatment. It is difficult to account for the individual differences both among and within patients and model them in a precise and meaningful way using the majority of the conceptualizations currently available. It is not uncommon for practitioners to employ multiple paradigms to explain and address different aspects of a single patient's presentation (e.g., Axis I and Axis II comorbidity). For example, hopelessness might be approached from a cognitive perspective, employing standard techniques and interventions. Conversely, prominent depressive symptoms might be explained biologically, with medication as the primary treatment intervention. Problems potentially consistent with an Axis II component, such as persistent emotional dysphoria, a chronic desire to die, and interpersonal conflict, might be explained and treated from a psychodynamic point of view. The net result is an unusual mixture of potentially conflictual paradigms, with little acknowledgment of underlying inconsistency in theory and fundamental assumptions, nor of the resultant impact on treatment process, duration, or outcome.

A second problem is the potential confusion and lack of clarity for the patient as to what exactly is being targeted in treatment, how it is explained, and how it is to be ameliorated. Mixing and matching paradigms and problems can result in considerable difficulty communicating in a coherent and consistent fashion with patients. Third, as hinted at earlier, many models lack specificity in terms of identifiable treatment targets across *all* domains of human functioning including the cognitive, biological, emotional, behavioral, and interpersonal (i.e., situational and environmental) domains. Rather, there has been a tendency, consistent with the narrow focus of some approaches, to target isolated although critical variables. This results in a fourth problem: difficulty in comprehensive treatment-outcome monitoring and a corresponding lack of clarity for patients as to what actually denotes treatment success or progress. If the treatment approach is exclusionary and narrow in focus, progress in one domain can simply go unnoticed, regardless of how significant. Similarly, the use of multiple paradigms can result in broad categorizations and related confusion that does not lend itself to specific treatment targets.

In the end, what is needed is somewhat of a compromise: an inclusive conceptual framework that allows for direct clinical application of empirical findings across *specific* areas of functioning (i.e., cognitive, emotional, biological, behavioral, and interpersonal domains). Such a model would address the broad range of factors empirically validated as relevant, incorporating Axis I and Axis II diagnostic components. Cognitive theory and therapy offers a unique foundation for such integrative efforts (e.g., Alford & Beck, 1997). There are consistencies in both theory and empirical findings that provide the necessary foundation for an integrative cognitive-behavioral model of suicidality, one that is flexible enough for application in day-to-day clinical practice and rigorous enough for experimental investigation. An impressive trend is emerging regarding the efficacy of cognitive-behavioral therapy (CBT) for the treatment of suicidality, both over the short- and long-term (Rudd & Joiner, in press). In terms of treatment out-

come studies, it is simply the only observable trend in a very limited database.

BASIC ASSUMPTIONS OF COGNITIVE THEORY AND THERAPY: IMPLICATIONS FOR SUICIDALITY

In applying cognitive theory to the psychopathology of suicidality and subsequent psychotherapy, it is critical to be aware of the fundamental assumptions that are operative. Essentially, the inherent assumptions guide the nature of the clinical work itself, determining treatment content, the nature of its application and the course followed, subsequent therapeutic process, and the definition and conceptualization of treatment outcome and related monitoring. Clark (1995) recently summarized the fundamental assumptions of cognitive therapy as the following: (1) individuals actively participate in the construction of their reality, (2) cognitive therapy is a mediational theory, (3) cognition is knowable and accessible, (4) cognitive change is central to the human change process, and finally (5) cognitive therapy adopts a present time frame. These assumptions are relatively broad in nature but, nonetheless, provide a conceptual framework for cognitive theory and its application to suicidality.

In their statement of a formal cognitive theory, Alford and Beck (1997) have gone far beyond the fundamental assumptions summarized by Clark (1995) and offered considerable detail with the 10 axioms listed in Table 1.

As evidenced by the fundamental assumptions offered by Clark (1995) and the axioms detailed by Alford and Beck (1997), application of cognitive theory and therapy to suicidality requires us to be detailed and specific in our thinking and approach.

Available empirical findings in suicidology are well suited to a cognitive-behavioral theoretical framework. Although cognitive theory and therapy purports that the *central pathway to psychological functioning* is cognition (i.e., meaning-making structures identified as schemas), the approach is mediational in nature, consistent with an integrative and interactional model essential to suicidality. As noted in Axiom 3, the relationship between the cognitive and other systems (e.g., biological/physiological, emotional, behavioral) is interactive. At the most fundamental level, the cognitive-behavioral model asserts reciprocal determinism between the environment and person (e.g., Bandura, 1977). An individual does not live in isolation but in a dynamic context, with reciprocal influence, interaction, and interdependent outcome across the previously noted domains (i.e., cognitive, emotional, behavioral, biological/physiological, interpersonal). Some of the more consistent and clinically relevant empirical findings can easily be woven into a meaningful explanatory model using this framework.

The 10 axioms of cognitive theory offered by Alford and Beck (1997) translate into a number of identifiable *fundamental assumptions* when applied to suicidality and related psychotherapeutic treatment. They are as follows:

1. The central pathway for suicidality is cognition, that is, the *private* meaning assigned by the individual. Suicidality is secondary to maladaptive meaning constructed and assigned regarding the self, the environmental context, and the future (i.e., the cognitive triad, along with related conditional assumptions/rules and compensatory strategies, referred to as the *suicidal belief system*).
2. The relationship between the suicidal belief system (i.e., cognitive triad specific to the *suicidal mode*, discussed later) and the other psychological (e.g., behavioral, emotional, attentional, memory) and biological/physiological systems is interactive and interdependent.
3. The suicidal belief system will vary from individual to individual, depending on the content and context of the various psychological systems (i.e., cognitive content specificity). Nonetheless, there will be some uni-

TABLE 1
Axioms of Cognitive-Behavioral Theory

1. The central pathway to psychological functioning or adaptatino consists of the meaning-making structures of cognition, termed *schemas.*
2. The function of meaning assignment (at both automatic and deliberate levels) is to control the various psychological systems (e.g., behavioral, emotional, attentional, and memory).
3. The influences between cognitive systems and other systems are interactive.
4. Each category of meaning has implications that are translated into specific patterns of emotion, attention, memory, and behavior. This is termed *cognitive content specificity.*
5. Although meanings are constructed by the person, rather than being preexisting components of reality, they are correct or incorrect in relation to a given context or goal. When *cognitive distortions* or *bias* occurs, meanings are dysfunctional or maladaptive. Cognitive distortions include errors in cognitive content (meaning making), cognitive processing (meaning elaboration), or both.
6. Individuals are predisposed to specific faulty cognitive constructions (cognitive distortions). These predispositions to specific distortions are termed *cognitive vulnerabilities.* Specific cognitive vulnerabilities predispose persons to specific syndromes; cognitive specificity and cognitive vulnerability are interrelated.
7. Psychopathology results from maladaptive meanings constructed regarding the self, the environmental context (experience), and the future (goals), which together are termed the *cognitive triad.* Each clinical syndrome has characteristic maladaptive meanings associated with the components of the cognitive triad.
8. There are two levels of meaning: (a) the objective or *public meaning* of an event, which may have few significant implications for an individual; and (b) the *personal or private meaning.* The personal meaning, unlike the public one, includes implications, significance, or generalizations drawn from occurrence of the event.
9. There are three levels of cognition: (a) the preconscious, unintentioanal, *automatic* level (automatic thoughts), (b) the conscious level, and (c) the metacognitive level, which includes realistic or rational (adaptive) responses. There serve useful functions, but the conscious levels are of primary interest for clinical improvement in psychotherapy.
10. Schemas evolved to facilitate adaptationof the person to the environment, and are in this sense *telenomic* structures. Thus, a given psychological state (constituted by the activation of systems) is neither adaptive nor maladaptive in itself, but only in relation to or in the context of the larger social and physical environment in which the person resides.

Note. Reprinted by permission from Alford, B. A., and Beck, A. T. (1997). *The integrative power of cognitive therapy.* New York: Guilford Press, pp. 15–17.

formity in terms of identified *categories* (i.e., helplessness, unlovability, poor distress tolerance; all discussed in more detail later), which are all tinged by a pervasive sense of hopelessness.

4. Individuals are predisposed to suicidality as a function of cognitive vulnerabilities, or *faulty cognitive constructions,* which covary with specific syndromes. Accordingly, different cognitive vulnerabilities are consistent with different syndromes and patterns of comorbidity, both Axis I and Axis II.
5. Suicidality and the suicidal belief system reside at three distinct levels, the preconscious or *automatic* level, the conscious level, and the metacognitive (i.e., unconscious) level, with the conscious levels most amenable to psychotherapeutic change. The structural content of the suicidal belief system, at all three levels, is contained within the *suicidal mode,* a concept defined later.

The assumptions summarized offer a foundation from which to articulate a conceptual model to treat all aspects of the suicidal

patient by cutting across multiple domains and incorporating a broad range of empirical work, but also allowing flexibility to address the considerable individual differences encountered in clinical settings.

THE ESSENTIAL REQUIREMENTS FOR A CBT MODEL OF SUICIDALITY: INTEGRATING EMPIRICAL FINDINGS AND ENSURING CLINICAL RELEVANCE

Based on the theoretical framework discussed so far and the assumptions summarized in the preceding section, a cognitive-behavioral CBT model of suicidality needs to incorporate, or account for, the major and most consistent empirical findings in the field. Additionally, in order to have clinical relevance, it needs to be understandable, flexible, and modifiable for application in day-to-day clinical settings. In short, the following 10 requirements are essential to a comprehensive and clinically relevant CBT model of suicidality:

1. The model needs to address those variables (across all domains of functioning, including cognitive, affective, behavioral, and motivational) in a fashion unique to the patient's presentation and in a manner understandable to the patient. In other words, the model will serve as a parsimonious explanatory *map* of the presenting psychopathology. It needs to account for and communicate to both therapist and patient the symptomatic presentation, relevant developmental history and trauma, prominent maladaptive personality traits, identifiable stressors, and behavioral responses in an integrative, rather than isolated, fashion. Consistent with the notion of a *treatment map*, it needs to explain for the therapist and patient how the latter got from point A (nonsuicidal) to point B (suicidal) and how to get to point C (recovery).
2. The model needs to communicate the transient, time-limited nature of suicidal crises, even for those exhibiting recurrent and chronic suicidal behavior. By definition, crises are self-limiting. Even those individuals that present with chronic suicidality are at imminent risk for only limited periods of time, consistent with Litman's (1990) idea of the *suicide zone*.
3. The model needs to identify individual vulnerabilities that predispose to multiple suicidal crises or recurrent behavior, acknowledging the importance of Axis I and II diagnoses, and related comorbidity, along with developmental trauma and personal history.
4. The model needs to provide a means of distinguishing among suicidal, self-destructive, and self-mutilatory behaviors, accounting for distinct differences in the three across each domain of functioning.
5. The model needs to integrate the role of triggering events, accounting for acute and chronic stressors, as well as personality disturbance. In particular, the model needs to acknowledge the potentially significant role of *internal triggers* (i.e., thoughts, images, feelings, and physical sensations).
6. The model needs to integrate the importance of emotion regulation, emotional dysphoria, and distress tolerance in the suicidal process.
7. The model needs to address the importance of interpersonal factors and social reinforcement in maintaining the behavior or facilitating recovery.
8. The model needs to provide sufficient explanatory detail so as to translate into a specific treatment plan, that is, identifiable treatment targets across all domains of functioning.

9. The model needs to facilitate self-monitoring and self-awareness, providing flexibility in explaining day-to-day functioning. This can only be accomplished if the model is straightforward and easy to understand, relying on well-defined theoretical constructs.
10. The model needs to account for the process of change in suicidality over time, not just in terms of presenting symptoms. It needs to incorporate the idea of skill acquisition, development, and refinement (i.e., personality change). It needs to reflect this change at multiple levels and across multiple domains of functioning.

THE SUICIDAL MODE AS A CBT MODEL OF SUICIDALITY: AN ELABORATION AND SPECIFIC APPLICATION OF BECK'S THEORY OF MODES AND PSYCHOPATHOLOGY

Beck (1996) recently offered a refinement of his original cognitive therapy model in response to a growing body of empirical studies and theoretical discourse that highlighted a number of shortcomings in efforts to explain more complex theoretical constructs and related interactions and to validate them experimentally (e.g., Haaga, Dyck, & Ernst, 1991). The model is consistent with the axioms noted earlier and builds on the concept of schemas and simple linear schema processing in a number of important ways. The theory is built around the concept of the *mode*, the structural or organizational unit that contains schemas. Beck (1996) has defined *modes* as the following: "specific suborganizations within the personality organization [that] incorporate the relevant components of the basic systems of personality: cognitive (information processing), affective, behavioral, and motivational" (p. 4). He went on to note that, consistent with the original theory, each system is composed of structures identified as *schemas* (e.g., affective schemas, cognitive schemas, behavioral schemas, and motivational schemas). Beck has integrated the physiological system as separate but noted its unique and significant contribution to the overall functioning of the mode. Of particular importance to the concept of the mode is the previously noted issue of reciprocal determinism and synchrony of action. Beck (1996) has described the mode as an "integrated cognitive-affective-behavioral network that provides a synchronous response to external demands and provides a mechanism for implementing internal dictates and goals" (p. 4).

The *cognitive system* is described as involving all aspects of information processing, including selection of data, attentional process (i.e., meaning assignment and meaning making), memory, and subsequent recall. Incorporated within this system is the notion of the *cognitive triad*, integrating beliefs regarding self, others, and the future. For our discussion of the *suicidal mode*, the representative cognitive triad, along with the associated conditional assumptions/rules and compensatory strategies, is referred to as the suicidal belief system. Consistent with Axiom 6 (Alford & Beck, 1997), three levels of cognition are assumed, with the majority of therapeutic efforts targeting the more conscious levels. This does not negate, however, the importance of preconscious and metacognitive processing. Additionally, it provides a means of integrating research and theory on implicit learning and tacit knowledge (e.g., Dowd & Courchaine, 1996).

The *affective system* produces emotional and affective experience. Beck (1996) noted the importance of the affective system, emphasizing its role in reinforcing adaptive behavior, through the experience of both positive and negative affect (Beck, Emery, & Greenberg, 1985). This makes both conceptual and logical sense. He went on to state that negative affective experiences serve to "focus the attention" of individuals on circumstances or situational contexts that are not in our best interest or that serve "to diminish [us] in some way" (p. 5). As a result, a negative

valence is created for that event, situation, or experience, increasing sensitivity of the mode to being triggered or activated in the future under comparable circumstances. This helps to explain low threshold for activation for some suicidal patients, as well as generalization across similar but not entirely identical situations or circumstances. Multiple attempters, then, would not only have a lower activation threshold but also a broader range of internal and external triggers.

Finally, the *motivational and behavioral systems* allow for autonomic activation or deactivation of the individual for response. Although Beck noted that the motivational and behavioral systems are, for the most part, automatic in activation, they can be consciously controlled under some conditions. The *physiological system* is comprised of the physiological symptomatology accompanying the mode. For a threat mode, for example, this would include autonomic arousal, along with motor and sensory system activation, which serve to orient the individual for action such as fight or flight. The synchronous and simultaneous interaction of multiple systems and potential cognitive misinterpretation during a threat mode lead to escalation and expansion of physical symptoms (e.g., perception of threat from panic symptoms, such as "I'm having a heart attack"). Again, each system is comprised of structures or schemas specific to that system. Accordingly, the suicidal belief system is comprised of beliefs or schemas within each of the identified systems (i.e., affective schemas, behavioral schemas, and motivational schemas).

Additionally, Beck (1996) distinguished more *primal modes* as reflexive and oriented toward survival, safety, and security. Each of the clinical disorders can be distinguished by a specific primal mode. This is in contrast to *habitual* or prevailing modes representative of prominent personality traits, adaptive and maladaptive, that are a constant in the individual's life. As a means of explaining excessive reaction in clinical disorders, Beck asserts that a mode can become highly *charged*, an idea essentially consistent with the concept of a low threshold for activation or negative valence for maladaptive modes such as the suicidal mode. In contrast, *minor modes* are not highly charged, allow for higher thresholds before activation, and are under more flexible conscious control.

Beck's (1996) theory of modes and psychopathology offers a number of advantages over earlier versions of simple linear schematic processing, particularly for understanding suicidality:

1. It provides a means to explain specific Axis I disorders as the result of maladaptive activation and heightened sensitivity of primal modes.
2. Personality disorders are viewed as dysfunctional modes that are in operation the majority of the time or, conversely, have a low threshold for activation and are triggered by a wider array of stimuli (i.e., facilitating modes). This is consistent with findings noting different typologies for ideators, those making single attempts, multiple attempters, and those completing suicide (e.g., Orbach, 1997; Rudd, Joiner, & Rajab, 1996).
3. The cognitive *structures* comprising modes are consistent with previous cognitive conceptualizations incorporating the cognitive triad, associated core beliefs, conditional rules/assumptions, and compensatory strategies, all tinged by hopelessness (e.g., Beck, 1995). Accordingly, the resultant conceptualizations make sense and represent a refinement over earlier efforts, bolstered by the integration of empirical findings.
4. The construct of mode provides a means to understand the diversity of symptoms experienced and the diagnostic complexity and comorbidity representative of multiple systems interacting in synchrony and to acknowledge the implicit complexity of phenomena such as suicidality.
5. Modes help explain observed deficits in skill acquisition, development, and

refinement over time, consistent with progressive personality change and evolution in treatment (e.g., Linehan, 1993). In other words, as individuals recover it becomes more difficult to trigger the suicidal mode (i.e., a higher threshold for activation and reduced sensitivity and reactivity to identified triggers), facilitating modes are deactivated, and adaptive modes are created and exercised.

6. Finally, modes explain the low threshold for triggering some suicidal crises, observed sensitization to activating stressors, and apparent habituation in the recovery process.

DEFINING THE SUICIDAL MODE: CHARACTERISTICS OF THE VARIOUS SYSTEMS

Although he mentioned a suicidal mode, Beck (1996) did not articulate the details nor elaborate on the proposed mode. Before doing so, several points need to be restated and considered in more detail. First, as others have argued, it is critical for any model of suicidal behavior to clearly articulate the crucial role of *intent* (e.g., O'Carroll et al., 1996), distinguishing among suicidal, self-destructive, and self-mutilatory behaviors. Second, the model needs to account for observed variations in suicidality over time, addressing differences between those making a single attempt with no recurrence, versus recurrent and chronic suicidality or what Maris (1991) called *suicidal careers.* And third, the model needs to account for, and incorporate, the empirical findings summarized previously. Among those variables with the most importance are the somewhat mixed symptom picture often presented (e.g., considerable Axis I and II comorbidity), the clear role of stressors (both acute and chronic) in suicidality, identifiable skill deficits or diatheses, the potentially protective role of social support, and the pervasiveness of hopelessness. The concept of the mode provides a means to do so, incorporating into an interdependent network what at times have been viewed and studied as disparate variables.

Table 2 provides a summary of the suicidal mode, outlining the characteristic features of each system. As indicated, the cognitive system is characterized by the suicidal belief system, incorporating the cognitive triad as well as associated conditional rules/assumptions and compensatory strategies. The core beliefs that permeate the cognitive triad fall within the two primary domains originally identified by Beck (1995), helplessness (e.g., "I can't do anything about my problems") and unlovability ("I don't deserve to live; I'm worthless"). A third category has also been proposed: poor distress tolerance ("I can't stand feeling this way anymore") (see Figure 1). All core beliefs voiced by a given suicidal patient will cut across these three categories or cluster in one or two categories. More often than not, though, suicidal patients present with core beliefs that cut across all three. Also as indicated, the future orientation is hopelessness, the primary pervasive feature of an active suicidal mode.

As discussed in more detail later, when hopelessness abates the active intent to die simultaneously diminishes, and the suicidal mode is no longer predominant. Other facilitating modes are active, consistent with longstanding personality disturbance and related self-destructive, self-defeating, and/or self-mutilatory behaviors. It is clear that individuals can shift in and out of the suicidal mode with great frequency and for variable periods of time. As mentioned earlier, it is easier to trigger the suicidal mode for those evidencing chronic suicidality. That is, they have lower activation thresholds and are hypersensitive to a wider array of stimuli.

The affective system is distinguished by emotional dysphoria, that is, a mixture of negative emotions. This is in contrast to the sadness characteristic of depression. Empirical findings regarding the often mixed symptom picture present dysphoria as including feelings of sadness, anxiety, anger, guilt, shame, and humiliation, among a host of potential others. The behavioral (and motivational) impulse is to die, which is indicative of clear intent to commit suicide regardless of any subsequent

TABLE 2
System Characteristics for the Suicidal Mode

System	Structural content (Example of thought/belief)
Cognitive	Suicidal belief system: Suicidal thoughts (*I want to kill myself; I'm going to commit suicide.*) 1. Components of Cognitive Triad (beliefs about the self, others, the future) incorporate core belief categories: unlovability, helplessness, poor distress tolerance: a. Self: inadequate, worthless, incompetent, helpless, imperfect, unlovable, defective. (*I'm worthless. Everyone else would be better off if I were dead. I can't change any of this.*) b. Others: rejecting, abusing, abandoning, judgmental. (*Nobody really cares about me.*) c. Future (potential for change): hopeless. (*Things will never change and I can't tolerate these feelings.*) 2. Conditional rules/assumptions: (*If I'm perfect then people would accept me. If I do what everyone wants then they'll have to like me.*) 3. Compensatory strategies: Overcompensation, perfectionism, subjugation in relationships.
Affective	Dysphoria (mixed negative emotions): for example, sadness, anger, anxiety, guilt, depression, hurt, suspiciousness, fearfulness, tenseness, loneliness, embarassment, humiliation, shame.
Behavioral (motivational)	Death-related behaviors (intent to suicide): preparatory behaviors, planning, rehearsal behaviors, attempts.
Physiological	Arousal: autonomic, motor, sensory, systems activation.

outcome (e.g., a suicide attempt with injuries or no injuries).[1] Questionable intent is manifest by variations in the behavioral impulse. For example, the desire for revenge, punishment of a significant other, or the relief of tension, agitation, or pain without the desire to die (e.g., self-destructive behavior such as illicit drug use or self-mutilatory behavior such as self-cutting, burning, or piercing) is consistent with *facilitating modes*, but not an active suicidal mode.

During a period in which the suicidal mode is active, the physiological system is aroused, with autonomic, motor, and sensory system activation.[2] As is suggested by this con-

1. The behavioral (motivational) systems help differentiate among suicidal, self-destructive, and self-mutilatory behaviors and their respective modes. When activated, the suicidal mode is characterized by behavior (and motivation) expressing an intent to die by suicide. For self-mutilatory or self-destructive behavior the motivation (intent) is different. For example, the motivation might be revenge, punishment of a significant other, or affect regulation. For each, the intent is not death. Self-destructive and self-mutilatory behaviors are characteristic of facilitating modes.

2. By definition, the suicidal mode is acute (i.e., time limited) in nature and characterized by autonomic activation and arousal. Chronic suicidality is characterized by low threshold for activation of the suicidal mode and broader range of potential triggers, along with habitual (or facilitating modes) modes that are active and representative of underlying individual vulnerabilities during intercurrent periods.

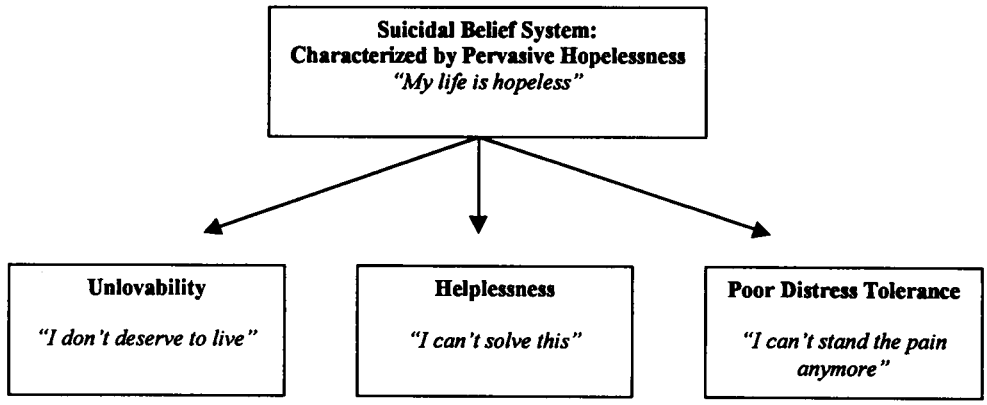

Figure 1. Suicidal belief system core belief categories.

ceptualization, the suicidal mode is essentially self-limiting. That is, the physiological arousal necessary can only be maintained for limited periods, with variations likely dependent on the chronicity of the problem (i.e., single attempters versus multiple attempters) and the complexity of the Axis I and II diagnostic picture. The duration of time for an active suicidal mode may vary in accordance with the chronicity of the behavior. In other words, multiple attempters are likely to experience longer periods of activation of the suicidal mode in comparison to single attempters. Actually, some of our work is consistent with this possibility. We found that multiple attempters experienced suicidal crises of significantly longer duration in contrast to single attempters when an identifiable precipitant was present (Joiner & Rudd, in press).

By definition then, suicidal crises are acute and time limited in nature, even for those evidencing chronic disturbance and recurrent suicidal behavior. This idea is consistent with the concept of the *suicide zone* defined by Litman (1990). Essentially, the suicide zone represents a convergence of multiple factors (e.g., situational stress, acute emotional dysphoria, psychiatric disturbance, impaired cognitive functioning, deficient problem solving, and limited social support resources) that temporarily raise the risk of suicide significantly. In other words, the potential for suicide becomes imminent. This level of risk, however, cannot be maintained for an indeterminate period, and at some point in the future, as the contributing factors subside, risk diminishes. The notion of the suicide zone, although less theoretically precise, is consistent with the construct of the suicidal mode, with activation of interdependent systems that result in heightened potential for a tragic outcome over a limited period of time.

For those evidencing chronic suicidality, the suicidal mode can be characterized by two distinctive features. The threshold for activation of the suicidal mode is lower for potential triggers, both internal and external. Beck (1996) utilized the construct of the *orienting schema* to explain activation. Essentially, orienting schemas are dependent on individual history and development. The orienting schema assigns preliminary meaning to the stimulus situation, activating appropriate modes. For the chronically suicidal person, the threshold for activation of the suicidal mode by orienting schema is lower in comparison to nonsuicidal individuals. Second, the former can be thought of as possessing a broader range of orienting schema that serve to activate the suicidal mode in response to a greater number of situations, experiences, and environmental stimuli. In other words, suicidality is easier to trigger among multiple attempters in comparison to others. More than likely, this is the function of a gradual process of generalization from trigger to trigger. For

example, to begin with, interpersonal conflict only in intimate relationships might trigger the suicidal mode. Over time, however, interpersonal conflict in general might trigger the suicidal mode, regardless of the intimacy inherent in the relationship. In other words, the stimulus generalizes from intimate relationships to all relationships.

This conceptualization helps explain variations in risk over time, acknowledging that heightened risk endures for limited periods and then recurs, all depending on activation of the suicidal mode. Although deactivated at some point, habitual personality modes (i.e., predisposing vulnerabilities) are still operative, raising chronic or long-term risk. These modes can be thought of as facilitating modes, increasing the probability of future suicidal episodes. Facilitating modes can take many forms. In terms of the literature on suicidality, there are those modes represented by prior Axis I and II diagnoses; earlier suicidal behavior; developmental trauma, abuse, or neglect; and parental modeling. Essentially, the chronically suicidal person shifts between facilitating and suicidal modes recurrently over time, depending on situational context. Therefore, effective and efficient treatment has to recognize the critical and enduring role of prominent personality traits.

The suicidal mode is a conceptual model easily understood and followed by patients, incorporating relevant empirical findings into the identified systems, and translating them into a framework to both articulate the content of and guide treatment. Figure 2 provides a graphic illustration of the proposed suicidal mode. As is evident, there is reciprocal interaction and interdependence of the various systems. Although the model as presented potentially appears somewhat linear and sequential in nature, it is important to note the synchronous interaction of the systems described by Beck (1996), and it is consistent with cognitive theory and the 10 axioms offered by Alford and Beck (1997).

Predisposing vulnerabilities include those static variables previously identified as raising risk for activation of the suicidal mode, including a previous psychiatric diagnosis (Axis I and II), prior history of suicidal behavior, traumatic developmental history, and potential parental modeling. These factors are represented by the construct of the facilitating mode, a mode that facilitates or raises the potential for eventual activation of the suicidal mode. Again, this idea is consistent with Beck's (1996) notion of habitual or prevailing modes that are present most of the time or have a low threshold for activation and are indicative of personality psychopathology. The primary difference is that facilitating modes, although they may vary in nature from individual to individual in terms of those associated with suicidality, are thought to heighten the risk specifically for activation of the suicidal mode.

The triggers, both internal and external, are compatible with Beck's concept of the orienting schema. Depending on individual history (and predisposing vulnerabilities), there are a range of internal (i.e., thoughts, images, physical sensations, emotions) and external (i.e., stressors, situations, circumstances, people) factors that trigger the orienting schema (which assigns preliminary meaning) and activate the suicidal mode. This provides a conceptual role for *stressors* in the suicidal process. Once activated, the suicidal mode is fairly consistent across individual cases, with a few important distinctions. During active phases of suicidality, the cognitive system or the suicidal belief system is consumed with thoughts of death by suicide, with hopelessness pervading every component of the cognitive triad. The behavioral (and motivational) systems are characterized by an impulse to die, with related behaviors evident, such as preparatory behaviors, planning, and practice or rehearsal for suicide. The affective system is characterized by dysphoria, an aversive mixture of negative emotions in varied proportions and intensities, including anger, sadness, anxiety, and guilt, among others. Corresponding physiological arousal is experienced, consistent with autonomic, motor, and sensory system activation. All of this occurs in synchrony and endures for a limited time, the duration of which is highly questionable. Identifying clinically relevant time

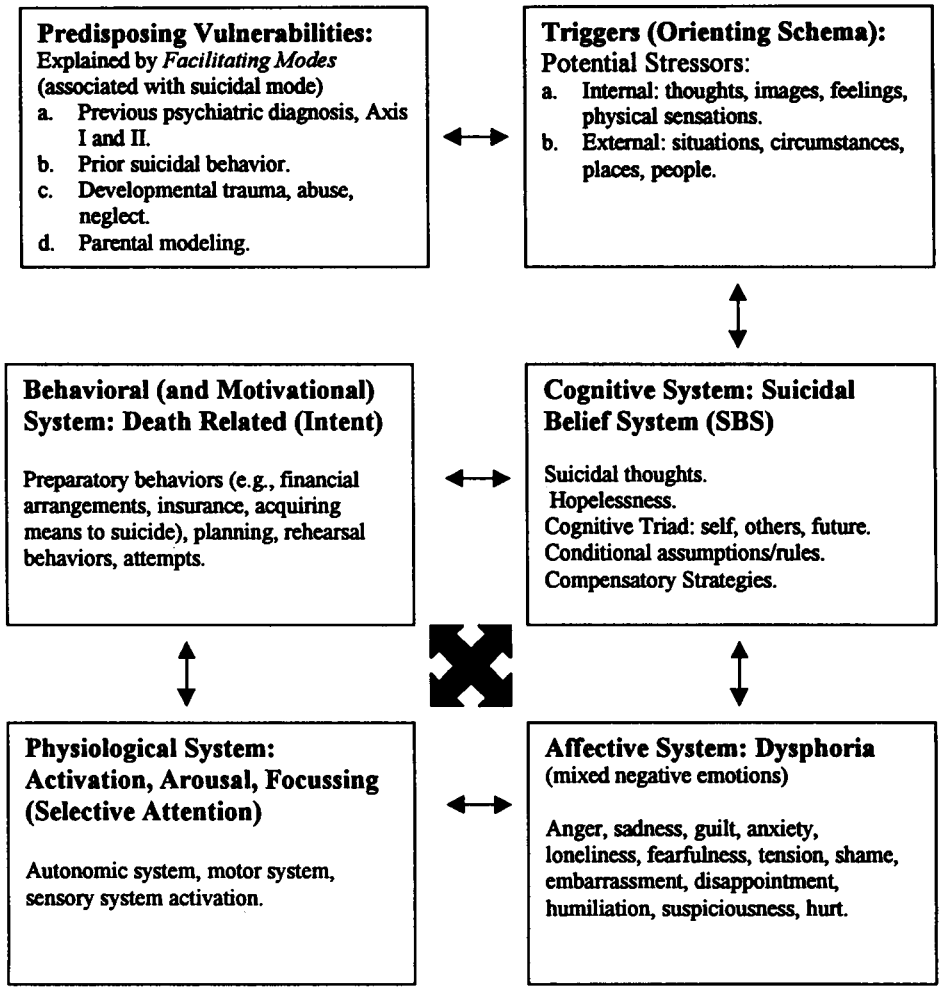

Figure 2. A CBT model of suicidality: The suicide mode.

frames (e.g., minutes, hours, or days) for risk is an area in considerable need of study that to date is very poorly understood (Rudd & Joiner, 1998).

It is important to distinguish between suicidal and nonsuicidal modes during the course of treatment, that is, those more consistent with self-destructive behaviors but not representative of clear intent to die. These modes are best described as facilitating modes, incorporating cognitions, affect, and behavior that serve to heighten the risk for activation of the suicidal mode. Recovery is dependent on *compensatory modes* that allow for behaviors that lower risk, hasten affective recovery, and provide competing cognitions essential for cognitive restructuring. Accordingly, an accurate depiction of the patient's suicidal process would include both the active suicidal mode as well as associated facilitating modes, which are more pervasive and active more often and which comprise the bulk of treatment over the long term.

THE SUICIDAL MODE AND IMPLICATIONS FOR CLINICAL PRACTICE

The CBT model offered has some fairly practical implications for the organization, content, and process of treatment. Beck (1996)

identified three "approaches to treating dysfunctional modes, including deactivating them, modifying their structure and content, and constructing more adaptive modes to neutralize them" (p. 15). This approach, which recognizes the multiple and varied tasks essential to treating suicidality, is consistent with that discussed by Rudd and Joiner (in press) which identifies three treatment components (i.e., symptom management, skill building, and personality development), each with a specific treatment agenda and content, despite the existence of considerable overlap. As evidenced by the components of the suicidal mode and the 10 axioms of cognitive theory, cognitive restructuring is only one component of treatment, despite its central role.

The idea is that, for the most part, permanent cognitive restructuring cannot occur without activation of the suicidal mode and each component system. That is, affective experience and mobilization of the mode is essential to treatment progress, incorporating meaningful skill development and lasting personality change. Enduring change is structural change, and structural change is dependent on affective and behavioral impulse, both signifying sincere activation of the mode. In accordance with this model, suicidal crises will be a necessary and expected part of treatment if the suicidal mode is to be permanently altered both in content and threshold for activation, as well as in subsequent restriction in the range of potential triggers. Otherwise, initial treatment efforts are likely to focus on facilitating modes that, although critical, are simply not at the core of the suicidal problem. Paradoxically, once suicidality is effectively diffused, the bulk of treatment will address facilitating modes (i.e., enduring personality psychopathology) and the development and refinement of competing and more adaptive modes for living.

THE SUICIDAL MODE: THEORETICAL FLEXIBILITY FOR PSYCHOTHERAPY INTEGRATION

Aside from the conceptual and clinical advantages summarized, the primary strength of the suicidal mode and the CBT model proposed is its flexibility for psychotherapy integration. Alford and Beck (1997) have fully detailed the integrative power of cognitive theory and therapy. Their argument holds true for the conceptualization and treatment of suicidality as well. The majority of approaches to the psychotherapeutic treatment of suicidality can easily be integrated into and addressed within the framework offered, including psychodynamic (e.g., Maltsberger, 1986), existential and self-psychology, family systems, and Shneidman's model (1993, 1996) discussing the context of *the suicidal mind.*

For example, Shneidman (1993) has distilled existing theory and research down to one simple and definitive statement: "suicide is caused by psychache" (p. 51). More specifically, psychache is defined as "psychological pain in the psyche, the mind" (p. 51). This is an elaboration of his earlier conceptual model of suicide noting the convergence of "pain, perturbation, and press" (Shneidman, 1993, pp. 42–43). In accordance with this approach, suicide and suicidal behavior are viewed as intrinsically psychological phenomena, a function of individual pain and tolerance, both of which are determined, influenced, and modified by a multitude of factors (e.g., epidemiological, philosophical, sociological, sociocultural, familial, psychiatric, and biological). Shneidman (1996) noted that the practicing clinician can best understand, assess, manage, and treat suicidal behavior by attending specifically to these two variables, the patient's experienced (and expressed) pain and demonstrated pain tolerance. As Shneidman (1993, 1996) has aptly noted, psychological pain is inextricably tied to psychological/emotional needs (e.g., see Murray, 1938). Psychache is the result of frustrated psychological needs and, in recognition of the multidimensional nature of suicidal behavior itself, there are innumerable potential causes for the blocked need(s). Shneidman distinguished between modal, or day-to-day, needs and vital needs—those that when frustrated produce intolerable psychological pain and, if unchecked and under the right circumstances, can lead to suicidal behavior or suicide. He also emphasized the variable nature of vital needs from individ-

ual to individual, but nonetheless, the consistent fact is that we all have psychological/emotional needs that are more important and meaningful than others, and when frustrated or blocked, result in more intense psychological/emotional pain.

Shneidman's (1993, 1996) model can easily be understood within the CBT framework provided. Essentially, what he describes are the various components of the suicidal mode, with a particular focus on affective schemas (i.e., emotional pain and pain tolerance). Suicidal behavior, or behavioral schemas, according to this theory, represent a means of quelling emotional pain and are a function of poor pain tolerance. Other theoretical approaches can similarly be integrated within the CBT model, each emphasizing a different system or component of the suicidal mode.

FUTURE RESEARCH AND CLINICAL APPLICATION

A detailed discussion of the suicidal mode is available in a treatment-oriented book by Rudd and Joiner (in press). At present, we are in the process of further refining the modal theory of suicidality, as well as attempting to validate the theory experimentally. Of particular interest are efforts to explore cognitive content specificity of the suicidal belief system, examine modal differences depending on Axis I and II comorbidity, develop and validate a distress tolerance scale based on modal theory, and explore fundamental differences in distress tolerance levels between single and multiple attempters.

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