

## Integrating Motivational Interviewing and Self-Determination Theory With Cognitive Behavioral Therapy to Prevent Suicide

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*Cognitive behavioral therapy (CBT) has been found to be effective in preventing suicide-related behavior. However, it is often difficult to engage patients who are at-risk in treatment. Motivational Interviewing (MI) has been shown to increase treatment engagement and improve treatment outcomes when it is used to complement other treatments. As a general theory of human motivation that is consistent with MI, Self-Determination Theory (SDT) provides a framework for understanding how MI may be integrated with CBT to increase treatment engagement and outcome. In this paper, we use SDT to explain how MI may complement CBT to reduce suicide-related behavior, provide a case example of using MI with a suicidal patient before CBT-based treatment, and explore future directions for research.*

IN the United States, over 300,000 people died by suicide between 1995 and 2005, making suicide a major public health concern (Centers for Disease Control and Prevention, 2008). Although an estimated 90% of individuals who die from suicide suffer from one or more mental disorders, up to 65% never receive psychological or psychiatric treatment (Cavanagh, Carson, Sharpe, & Lawrie, 2003). Psychosocial interventions such as cognitive behavioral therapy (CBT) are effective in reducing suicide-related behaviors (Tarrrier, Taylor, & Gooding, 2008); thus, it is important to use theoretically and empirically supported methods to ensure that at-risk clients receive effective mental health treatment. Motivational Interviewing (MI; Miller & Rollnick, 2002) has been shown to increase treatment engagement and improve treatment outcomes when it is used to complement other treatments (Hettema, Steele, & Miller, 2005). However, MI is a clinical approach that currently lacks an underlying theory to explain the mechanisms by which it functions. As a general theory of human motivation that is consistent with the underlying principles of MI, Self-Determination Theory (Deci & Ryan, 2002) provides a framework for understanding the manner in which MI can be integrated with CBT to increase treatment

engagement and effectiveness (Joiner, Sheldon, Williams, & Pettit, 2003; Markland, Ryan, Tobin, & Rollnick, 2005; Ryan & Deci, 2008b). In this paper, we provide a rationale for integrating MI with CBT approaches to reduce suicide-related behavior, use Self-Determination Theory to explain the manner in which MI may complement CBT, and explore future directions for research and practice.

### CBT to Reduce Suicidal Behavior

In a recent meta-analysis of 28 randomized controlled trials (RCTs), CBT was found to reduce suicide-related behavior (i.e., death by suicide, suicide attempts, suicide intent and/or plans, and ideation) in the 3 months following treatment (Tarrrier et al., 2008). The primary cognitive behavioral interventions that were represented in the study included dialectical behavior therapy (DBT), problem-solving therapy, and cognitive therapy (CT). Although the findings were promising, a review of the major studies suggested that attrition was a common problem. For example, in Brown's RCT of CT for suicide-related behavior (Brown, Ten Have, et al., 2005), CT was effective in reducing suicide-related behavior in individuals with a previous suicide attempt, relative to usual care. When the completion of the study was threatened by the high rate of attrition, the researchers responded by using intensive case managers to maintain contact with clients through a community phone-mail account, and by calling clients' friends, family, clergy, probation officers,

and other mental health providers when contact was lost. Another example of treatment engagement is evident in Linehan's DBT (Linehan, 1993), which has been found to be an effective treatment for reducing suicide related-behavior in individuals with borderline personality disorder in multiple studies (Linehan et al., 1999; Linehan et al., 2006). In DBT, suicide-related behavior is conceptualized as maladaptive problem-solving. DBT uses group therapy to teach clients coping skills and individual therapy to help them apply their new coping skills to real-life problems. The first target of DBT, however, is actually decreasing suicidal behavior because only living clients can benefit from treatment, and the second target is reducing therapy-interfering behavior because clients are unlikely to benefit from therapy if they do not attend sessions or are not engaged when they do (Linehan, 1993). Thus, retention and participation in treatment have been recognized by cognitive behavioral researchers as crucial for effective treatment.

### **Motivation as a Central Issue in Suicide Prevention**

One would think that overwhelming psychological pain coupled with thoughts of suicide would be sufficient to motivate anyone to engage in treatment, but they are not. One hypothesis is that many people who think about suicide are difficult to engage in treatment because they lack motivation to live and therefore lack interest in and energy for treatment. Research shows that many individuals who think about suicide are ambivalent; they want to die, but they also want to live with less pain. Ambivalence about dying and living has been observed along the continuum of suicide risk, from clients in treatment to address suicidal ideation (Jobs & Mann, 1999) to individuals who died by suicide and left behind suicide letters (Shneidman & Fareberow, 1957). The ratio of the strength of the wish to die to the wish to live has been found to be a critical determinant of future suicide-related behavior. When the wish to die is stronger than the wish to live, individuals who make a suicide attempt are more intent on dying (Kovacs & Beck, 1977), and are more likely to die by suicide (Brown, Steer, Henriques, & Beck, 2005). Resolving this ambivalence by increasing the motivation to live may be critical to reducing engagement in life-threatening behavior, and may also increase engagement in life-sustaining behavior such as treatment.

A second hypothesis is that individuals who are thinking about suicide often have numerous reasons for not participating in treatment. The very factors that increase risk for suicidal ideation and attempts may also serve as barriers to engaging in treatment: these include low socioeconomic status, which is associated with impediments in affording transportation and treatment; depression, which is characterized by low motivation; and borderline personality disorder, which is associated with

difficulty interacting with others (Kessler, Borges, & Walters, 1999). Social stigma associated with mental illness may also increase people's reluctance to enter and stay in treatment (Britt et al., 2008; Golberstein, Eisenberg, & Gollust, 2008). The ability to overcome these hurdles may be further compromised by the restricted cognitive functioning that is often associated with the suicidal state (for reviews, see Baumeister, 1990, and Wenzel, Brown, & Beck, 2009). It can also be argued that it is critical to address motivation for treatment because it may be associated with long-term risk for suicide-related behavior and can be very different from the motivation to live. For example, a client's primary reason for thinking about suicide may be that he is tired of living with severe chronic pain, but his reason for living is that he values his autonomy and has pushed through difficult times in the past. The same client's principal reason not to go to treatment is that he considers himself autonomous and has always been able to resolve his problems on his own, but he is willing to consider treatment because he wants to manage his severe chronic pain. In this scenario, the client's reason for living is aligned with his reason not to seek treatment. Enhancing the client's reasons for living may reduce short-term risk by increasing his motivation to live but may inadvertently increase long-term risk by decreasing his motivation for treatment. The primary point is that people considering suicide may have different motivations for wanting to live and wanting treatment and it may be important to untangle and address both.

Although various therapeutic tools, including intensive case management and conjoint individual and group therapy, have been shown to help clients overcome barriers to living and engaging or continuing to participate in treatment, they may not be appropriate for every setting. A large number of patients who are thinking about or have already engaged in suicidal behavior are often seen in acute settings such as psychiatric emergency departments and acute inpatient units, which may not provide the time or resources necessary for complex and expensive treatments. Private practitioners also treat suicidal patients and are often unable to access treatment components that are only available in large health care systems. Clinicians from different settings, therefore, may benefit from having practical tools and methods to address the motivation to live, as well as the motivation for treatment.

### **MI**

MI is a therapeutic approach that was developed to help individuals with alcohol-related problems find the motivation to change problematic drinking behavior (Miller & Rollnick, 2002). Among the important insights that led to the development of MI was the recognition that

individuals with substance use disorders are often ambivalent about their substance use. Although they often have reasons to change their use, such as medical, legal, or relational problems, they also have reasons to continue using, such as the difficulty of changing habitual behavior or the social benefits of substance use. MI was developed to help clients align with their reasons for stopping a harmful behavior, or engaging in a beneficial behavior, and to increase the likelihood that they will. MI is a client-centered method, and its fundamental principles include *expressing empathy* for clients' experiences, *rolling with resistance* rather than confronting and escalating conflict, *developing discrepancy* between actual and desired behavior, and *promoting self-efficacy* that change is achievable. It is directive, however, in that clinicians have a desired outcome, such as reduced substance use, and they strategically guide their clients toward the desired outcome. Specific techniques, such as *reflective listening* to ensure that clients feel understood, *open-ended questions* to encourage client elaboration, *affirmations* to support clients' self-efficacy, and *summaries* to help clients integrate and reinforce what was discussed, are strategically used to build the client's motivation and commitment to change. Explicitly directive techniques, such as providing information and making recommendations, are appropriate from an MI perspective, but only with the client's permission. Although originally developed for individuals with substance use behaviors, MI has been applied to other health-related behavior, such as diet, exercise, medication adherence, and treatment engagement (Hettema et al., 2005).

Given the significant ambivalence in individuals who are thinking about suicide and MI's focus on resolving ambivalence, MI is uniquely suited for work with clients who are considering suicide. In MI, clinicians strategically attend to both sides of clients' ambivalence to ensure that clients perceive that the clinician understands the complexity of their situation. If a clinician, for instance, only encourages discussion about reasons for living, an ambivalent client may express his reasons for dying to ensure that the clinician understands how he feels. According to Self-Perception Theory, people who are ambivalent about an issue determine what they believe by listening to themselves (Bem, 1967). Thus, by exclusively talking about reasons for living, clinicians may inadvertently pressure clients to talk about reasons for dying, providing them with the opportunity to convince themselves that they indeed have reasons to die. To avoid this outcome, clinicians who use MI would elicit and reflect clients' reasons for dying, which frees them to explain their reasons for living. To build their motivation to live, clinicians help clients explore their reasons for living in greater depth. After exploring their reasons for dying and living, clients often come to the realization that they want

to live, but that they need to make some changes to ensure that their lives will be worth living. When clients are ready to talk about making changes, clinicians explore potential changes including their participation in treatments that address their reasons for dying.

### Self-Determination Theory (SDT)

Although it is fairly easy to describe MI in terms of its principles and techniques, it is much more difficult to explain why it is effective. As a broad psychological theory whose major assumptions and tenets are largely consistent with the principles and techniques of MI (Markland et al., 2005; Vansteenkiste & Sheldon, 2006), SDT offers a perspective to understand how MI interventions may improve treatment engagement and outcome. SDT is a dialectical theory of human motivation that takes into account individual and socio-environmental influences on human behavior. As a general theory of motivation, SDT accounts for both the direction and energization of behavior (Deci & Ryan, 1985). SDT assumes that people are innately oriented toward growth and well-being, and thus possess intrinsic energy for life (i.e., vitality; Ryan & Deci, 2008a). According to the theory, there are three basic psychological needs necessary for optimal growth, development, and functioning. These needs include *autonomy*, the need to feel volitional and perceive one's self as the originator of one's actions; *competence*, the need to feel capable of achieving desired outcomes; and *relatedness*, the need to feel close to and understood by important others. To the extent that individuals believe that these needs are fulfilled, they feel more focused and energized. In the context of treating suicidal clients, increased vitality may manifest as reduction in psychological suffering, increased motivation to live, and improved motivation for treatment. Theorists have posited that MI may work specifically through the support of basic psychological needs (Markland et al., 2005; Vansteenkiste & Sheldon, 2006). For example, the MI techniques of expressing empathy and reflective listening convey to the client that the clinician understands the client's perspective, which may support the client's need for *relatedness*. Techniques such as promoting self-efficacy through affirmations may support the client's need for perceived *competence*. Finally, rolling with resistance rather than confronting and escalating conflict, developing discrepancy between actual and desired behavior, and the use of open-ended questions to elicit the client's perspective may serve to engage the client in the therapeutic process by supporting the client's need for *autonomy*. Thus, SDT speaks to the critical role that clinicians play in creating a supportive therapeutic environment for their clients.

From an SDT perspective, MI may provide a social environment that meets people's psychological needs and provides them with the energy that is required to

participate in treatment and other growth-promoting behaviors. People who suffer from acute or chronic lack of support for their psychological needs develop relatively extrinsic life goals and often experience decreased vitality as well as increased depression, anxiety, and somatization (Kasser & Ahuvia, 2002; Kasser & Ryan, 1996; Schmuck, Kasser, & Ryan, 2000). By supporting clients' fundamental needs, SDT-based interventions have been shown to increase vitality and intrinsic aspirations, which may represent a direct approach to increasing life-sustaining behavior (e.g., Niemiec, Ryan, Deci, & Williams, 2009; Williams, Niemiec, Patrick, Ryan, & Deci, 2009). SDT-based interventions, for example, have been shown to reduce life-threatening behaviors, such as the use of tobacco (Williams, McGregor, Sharp, Ruth, et al., 2006), and increase life-enhancing behaviors such as exercise (Fortier, Sweet, O'Sullivan, & Williams, 2007). Although CBT treatments for suicide prevention often provide clients with adaptive coping strategies, there is often insufficient guidance concerning how to create a therapeutic environment that enables clients to learn the strategies and make use of them (Joiner et al., 2003). To the extent that MI supports clients' fundamental psychological needs, it is expected to reduce their suffering and increase the energy they have to dedicate to treatments such as CBT.

### MI as a Complement to CBT

Interestingly, research suggests that MI may actually work best when it is added as a complement to other treatments (Hettema et al., 2005). The most comprehensive meta-analysis of MI-based interventions to date included 72 studies (Hettema et al.). In 7 of the studies, MI was added to other treatments, including medication and cognitive behavioral interventions, to increase compliance with alcohol and drug treatments and improve outcome. For treatment compliance, the effect size was medium (Cohen's  $d$ ; 95% Confidence Interval:  $d = .75$ ; 0.41–1.09) at 0 to 3 months after the end of treatment, and large across all follow-up points ( $d = .80$ ; 0.64–0.97). For alcohol- and drug-related outcomes respectively, the effect size was small ( $d = .28$ ; 0.03–0.54) and medium ( $d = 0.53$ ; –0.05–1.12) at 0 to 3 months, and remained small ( $d = 0.33$ ; 0.23–0.44) and medium ( $d = 0.53$ ; –0.05–1.12) across all follow-up points. Since 2005, we identified 8 additional studies examining the effectiveness of MI as a complement to other treatments. Three studied the effect of MI plus CBT on treatment engagement, all 8 studied the effect of MI plus CBT on substance abuse, and 1 also studied the effect of MI plus CBT on HIV viral load (Parsons, Golub, Rosof, & Holder, 2007). The 3 studies that examined the effect of MI on engagement showed an increase in participation (Bellack, Bennett, Gearon, Brown, & Yang, 2006; Carroll et al., 2006; Parsons et al., 2007), and 6 of the 8 found at

least one positive effect for outcome (Baker et al., 2006; Baker et al., 2005; Bellack et al., 2006; Parsons et al., 2007; Stein, Herman, & Anderson, 2009), suggesting that MI complements other treatments by improving both engagement and outcome.

The use of MI with suicidal clients is a logical antecedent to CBT for suicide prevention. CBT for suicidal patients (Wenzel et al., 2009) is an active, short-term intervention that is divided into three phases—an early phase that is focused on treatment engagement, an intermediate phase that is focused on the application of cognitive and behavioral strategies, and a later phase that is focused on relapse prevention. In the early phase of treatment, clinicians use cognitive strategies to identify and evaluate negative attitudes toward treatment, as research shows that negative attitudes toward treatment are associated with poorer treatment outcome in clients who engage in suicidal behavior (Wenzel, Jeglic, Levy-Mack, Beck, & Brown, 2008). Furthermore, clinicians use problem-solving strategies to identify obstacles to engagement in treatment and ways to overcome those obstacles. In the intermediate phase of treatment, clinicians use cognitive strategies to help clients identify and mobilize reasons for living. For example, one specific strategy for achieving this aim is to work with clients in developing a Hope Kit, which is a collection of reminders of reasons for living (e.g., pictures of loved ones, Bible verses). In the later stage, clinicians use guided imagery to create a context for clients to imagine and articulate the manner in which they would use the strategies acquired in treatment to prevent a future suicidal crisis. Clients who receive MI before beginning CBT for suicide prevention will have begun to examine their motivation for living and for participating in the more intensive CBT. Because reasons for living and treatment engagement are critical to both MI and CBT approaches, clients who receive MI will also be oriented to CBT.

Although interest in the use of MI to complement CBT is growing, researchers are just starting to study potential moderators of its effectiveness. The combination of MI and CBT, for example, may be effective for clients with substance use disorders, but may or may not be effective for clients who are thinking about suicide. Another issue that may be important to consider, but is not often discussed, is the different strategies for integrating MI and CBT. In most studies, one or two sessions of MI are added *before* treatment to help clients explore and resolve ambivalence for the desired change. Other, less frequently used strategies include adding a course of MI *until the client is motivated* to transition to CBT, incorporating one or two sessions of MI into treatment *when motivation wanes*, and assimilating principles of MI *within* CBT. Researchers are even starting to study the importance of MI-related principles within CBT (Aharonovich et al., 2008). Because



MI has been conceptualized and most often tested as a brief intervention, we will focus on using a brief course of MI *before* the clients begin CBT or when motivation for living or treatment begins to wane. It is important to note that from an SDT perspective, assimilating MI principles into CBT is expected to enhance clients' sense of relatedness and autonomy, which may increase their vitality, reduce their suffering, and have a positive effect on their ability to actively engage in CBT exercises.

### MI to Address Suicidal Ideation (MI-SI)

Interest in applying MI to suicide prevention (Britton, Williams, & Conner, 2008; Zerler, 2008) has led to the development of an adaptation of MI to address suicidal ideation (MI-SI). MI-SI consists of three phases and was originally developed to provide psychiatric emergency department clinicians with a method for accessing and enhancing clients' motivation to live and engage in life-enhancing activities in one session. In *Phase 1*, clinicians provide clients with the opportunity to present and explore the presenting problem and their reasons for thinking about suicide. *Phase 2* is focused on eliciting and exploring reasons for living in order to build the motivation to live. In *Phase 3*, clinicians help strengthen clients' commitment to live by developing a personal plan to make life worth living. The phases are not intended to serve as a checklist, but instead as an outline to help clinicians structure MI-SI sessions. This distinction is important, as MI studies that used a manual were shown to be less effective than studies that did not (Hettema et al., 2005). Strict adherence to manuals may actually interfere with the basic tenets of MI, thereby weakening its effectiveness. For instance, persuading clients to explore reasons for dying in great detail when they have only briefly mentioned reasons for dying may be counterproductive. Similarly, coaxing clients to develop a plan to make life more worth living when they are not ready to do so may impede progress, perhaps by undermining their sense of autonomy. To illustrate how the phases of MI-SI can be used, we provide a fictional case example that was based on sessions with real veterans.

### A Case Example

Mr. Smith is a 65-year-old Caucasian male, divorced, father of three. He had called the Veteran Suicide Hotline and told the counselor he was thinking about killing himself, was referred to his local VA Medical Center, and was triaged to an acute inpatient unit, where he was seen for this interview. Mr. Smith had been in the Marines during Vietnam, completed 3 tours, and had developed severe PTSD. After his discharge from the Marines, Mr. Smith was a long-haul truck driver for over 20 years and subsequently developed severe back and leg pain. Tormented by his PTSD symptoms and physical pain,

Mr. Smith started drinking heavily, lost his job due to an arrest for driving under the influence, and alienated his family and friends.

### Phase 1: Exploring the Presenting Problem and Motivation to Die

In Phase 1 of MI-SI, the clinician's goal is to encourage the client to discuss the presenting problem as well as reasons for thinking about suicide so that the clinician can begin to understand why the individual is thinking about suicide, the client perceives that he is cared for and understood, and he can begin to think about reasons for living. This phase is critical and sometimes requires a great deal of patience, as clients may not be fully aware of their reasons for dying or ready to discuss reasons for living. At the same time, the clinician's goal is to elicit reasons for living and begin to build the motivation to live, which will set the stage for the work that will be done in CBT. In most cases, the client will show the clinician when he is ready to discuss his reasons for living. Premature attempts to do so are often followed by additional reasons to die, whereas timely attempts are followed by exploration. Although many clients will be able to describe their reasons for living and are willing to explore them, some will need gentle assistance to move beyond their reasons for dying. Reflecting both reasons for dying and living whenever they are mentioned provides a context in which the client feels free to explore his or her ambivalence without fear of judgment. Once the client appears ready to discuss reasons for living, the clinician can summarize reasons for dying, reintroduce reasons for living that have already been mentioned, or inquire about reasons for living if the client has not yet introduced any. The process of fully eliciting and reflecting the client's reasons for dying in a nonjudgmental manner supports the client's fundamental needs for autonomy and relatedness. Consider the case of Mr. Smith.

#### Phase 1: Case Study

CLINICIAN: I looked in your chart and saw that you were brought to the hospital because you were thinking of killing yourself. I'd like to take a little bit of time to talk about why you were thinking about killing yourself and what you feel you need to get back to where you want to be. What do you think about that? (*giving information, open-ended question*)

MR. SMITH: Ok...Well, things are really messed up... my back and my knees are killing me, I have nightmares about Vietnam sometimes, and I started drinking again. I just can't take it anymore...and, I drank too much the other night and did something stupid.

CLINICIAN: What happened? (*open-ended question*)

MR. SMITH: I have a gun, and I got it and locked myself in the bathroom. I don't keep my gun loaded but I knew where the bullets were, and I was thinking about loading it, but I didn't. I was in there for a while thinking about what to do and I called the hotline and they sent me here.

CLINICIAN: You're tired of the pain and dreams, and you feel overwhelmed. You started drinking again to ease the pain, felt bad about that too, and then you started to think about killing yourself. (*summary*)

MR. SMITH: I'm just tired of it all. I remember horrible things that I can't talk to anyone about because I'm afraid of what they would think of me. And I can barely walk, and there is nothing that can be done about it.

CLINICIAN: You're afraid nothing will help. (*reflection*)

MR. SMITH: My doctors have me on too much medication, and it doesn't do a damn thing. So I drink, which helps in the moment but kind of makes things worse too. My drinking was definitely worse in the past. There were times when I drank too much almost everyday. My wife didn't want to live with me anymore, and that was when she left and took the kids with her.

CLINICIAN: You feel bad about the impact your drinking has had on your family. At the same time, you don't know how else to deal with the pain. (*reflection*)

MR. SMITH: This is no way to live...waking up sweating, looking around my room, the house is empty, so it's too quiet. I try to get out of bed and my knees and back kill.

CLINICIAN: You...

MR. SMITH: It happens every night and I really don't know what else to do. I mean, I love my kids... I just don't know what to do.

CLINICIAN: Your kids have kept you from killing yourself. (*reflection*)

MR. SMITH: I don't know, maybe they are better off without me. I don't want them to ever have to take care of me. I don't want to be a burden.

CLINICIAN: You wonder if your kids really are better off with you. (*reflection*)

MR. SMITH: They don't need me as much as they did when they were young, but I know that they still need me and want me to be alive. I know it, but it's

hard to remember when you wake up in the middle of the night after a bad dream and you are in pain. It doesn't matter then.

CLINICIAN: Sometimes you are in so much pain that you start doubting that your kids do need you, even though you really know they do. (*reflection*)

MR. SMITH: It's not just about my kids needing me... sometimes I think about my kids and what they are going to be like when they grow up. My youngest son Jimmy is a real good kid. He's shy, but he's good in school. He's a good kid.

CLINICIAN: So you can't escape your memories of Vietnam, your back and legs really hurt you, your wife and kids left and you're lonely and you are thinking about killing yourself to escape these problems that you can't imagine solving. At the same time, there are reasons why you haven't killed yourself yet, like your kids. They need you, and you're curious about who they will be when they grow up (*summary*)

MR. SMITH: Yeah, and it's not an easy thing to do. I thought it would be easy, you know, but I couldn't even load my gun. I just couldn't do it. I kept thinking about Jimmy. I can't imagine not seeing him grow up...

## Phase 2: Building the Motivation to Live

Phase 2 begins when the client appears ready to discuss reasons for living. Early in the exchange, the clinician reflected that the client's kids are one of his reasons for living. Mr. Smith showed the clinician that he was not ready to discuss reasons for living by explaining that his fear of being a burden on his children was another reason for thinking about suicide. The clinician reflected the client's concern about being a burden, and the client responded by beginning the exploration of his reasons for living marking the start of Phase 2. For clients who are ambivalent and have both reasons to die and reasons to live, the goal is to enhance their reasons to live and resolve their ambivalence in the direction of living. From an SDT perspective, supporting the client and acknowledging the complexities of the client's life will increase the client's sense of autonomy and relatedness and increase the client's sense of vitality. This increase in life energy and vitality, in turn, is expected to result in starting to shift the balance of the ambivalence he feels toward wanting to live and away from wanting to die. In this example, the client's natural areas of vitality appear to revolve around his relatedness to his children. For clients who are not ambivalent, the clinician's task is to elicit hidden or forgotten reasons to live to build the motivation to live.

Among the strategies that can be used to both elicit reasons for living and tip the balance toward living is an adaptation of the “readiness to change ruler,” which is commonly used in MI to assess and enhance importance of changing and confidence in the ability to change (Miller & Rollnick, 2002). It can be used in a similar manner to assess and enhance the client's importance of living and confidence in the ability to establish a life that is worth living (see Fig. 1).

*Phase 2: Case Study*

CLINICIAN: Suicide is scary, and there's something special about your youngest son, that's worth staying around for. *(reflection)*

MR. SMITH: Yeah, he's just one of those kids who knows what he wants and does it, and he's smart too. He wants to be a doctor, and is a senior in high school. He's always studying and wants to go to college and medical school.

CLINICIAN: You've done a good job with him. *(affirmation)*

MR. SMITH: The one thing his mom and I tried hard not to do is take our differences out on our kids. We've had plenty of problems, but we've done a pretty good job of keeping them out of it.

CLINICIAN: You feel good about that, and you want to continue being there for him and see that he has a chance to be what he wants to be. *(affirmation, reflection)*

MR. SMITH: I do. He works really hard.

CLINICIAN: What about your other kids? *(open-ended question)*

MR. SMITH: The other kids are older and had more problems with the divorce. They saw all the problems their mom and I had when we were living together, so it's affected them and how they think of me. It's not all me, my ex is crazy too, so her being a mess and me being a mess has been hard on them. Johnny's like me, he's real angry and never went to college and has started drinking, and I'm afraid he'll join the military like I did. And Leslie, she's good, takes after her mom and is in nursing school, so they're real close.

CLINICIAN: Your older son Johnny might need you to help him avoid problems you've had. *(reflection)*

MR. SMITH: I'm concerned about him. He's a spitting image of me. He looks like me, acts like me. He scares me.

<p><b>Step 1:</b> Provide the client with the following instructions.</p> <p style="text-align: center;"><i>On a scale of 0 to 10, where 0 is not important at all and 10 is extremely important, how important is living to you right now?</i></p>										
0	1	2	3	4	5	6	7	8	9	10
Not at all Important									Extremely Important	
<p><b>Step 2:</b> After the client responds, ask the client:</p> <p style="text-align: center;"><i>What made you choose a (client's number) and not a zero?</i></p> <p><b>Note:</b> It is critical that the clinician ask the client why a higher and not a lower number was chosen. When clients are asked to compare a higher number to a lower number, they begin to talk about reasons for living, which is the goal of this exercise. When clients are asked to compare a lower number to a higher number, they will talk about reasons for thinking about suicide, which would be counter to the goal of the exercise.</p>										
<p><b>OPTIONAL:</b></p> <p><b>Step 3:</b> If the client gives a zero ask:</p> <p style="text-align: center;"><i>What would have to change for you to choose a (higher number, i.e. 5)?</i></p> <p><b>Note:</b> Clients who give a zero have difficulty identifying reasons for living. When clients are asked what would have to change for the client to choose a higher number, they begin to talk about areas that they may need to make changes in, which is consistent with the goal of MI-SI.</p>										

**Figure 1.** Importance of Living Ruler.

CLINICIAN: You've mentioned wanting to see Jimmy grow up, wanting to help Johnny avoid the same problems you had, and the difficulty of killing yourself. Is there anything else that kept you from doing it? (*summary, open-ended question*)

MR. SMITH: It's really my kids.

CLINICIAN: Hmmmm...

MR. SMITH: Yeah, my kids, and I don't get to see them as often as I'd like to. They come and visit and call me when they need some money, but it's not enough. It's not like living with them.

CLINICIAN: You'd like them to be around more. (*reflection*)

MR. SMITH: Of course. They are the reason I'm still alive.

CLINICIAN: Right. Okay, I've got a question for you. On a scale of 0 to 10, where 0 is not strong at all and 10 is extremely strong, how important is living to you right now? (*importance of living ruler*)

MR. SMITH: I don't know. I'd say a 5.

CLINICIAN: What made you choose a 5 and not a zero? (*open-ended question*)

MR. SMITH: Hmmmm...There were times when I was happy before we had the kids, when I was drinking less and my wife and I were getting along and my legs and back didn't hurt so bad. We had some good times.

CLINICIAN: You are happier when you are in less pain, drinking less, and are in a good relationship. (*reflection*)

MR. SMITH: Yeah, life was definitely better. But I can't go back and it's not like I'm a catch. Who wants to start a relationship with a crippled vet with a drinking problem who has a crazy ex-wife and three kids? You can't tell me that women are looking for a guy like me.

CLINICIAN: At the same time you think about what life might be like if you could resolve some of your problems. (*reflection*)

MR. SMITH: Who doesn't? It's not like I really want to die. If things were better there's no way I would want to die. If I really felt that strongly I'd be dead.

CLINICIAN: You're not willing to kill yourself to escape the pain. (*reflection*)

MR. SMITH: I don't want to die, but I can't go on living this way.

### Phase 3: Strengthening the Commitment to Live

During Phase 2, the client shared that his children and memories of a time when his relationship with his wife was better and he was not in as much physical and emotional pain helped him push through difficult times. Although the client mentioned that he had little hope that he could get back to the point where life was less painful, the clinician segued into Phase 3 by reflecting the client's reluctance to kill himself to avoid the pain. In Phase 3, the clinician's goal is to help the client identify the changes or treatments that he thinks may help him develop a life that is worth living. Reasons for dying discussed in Phase 1 often serve as a starting point for exploring the changes or treatments that may be needed. The clinician begins Phase 3 with the understanding that the client is an expert on what he needs for his life to be worth living, and the clinician is an important resource with valuable knowledge concerning interventions and treatments that can help the client bring about the changes he feels he needs to make. Phase 3 also provides clinicians with the opportunity to share information, such as providing a list of interventions that are available and have been found to be effective (e.g., such as CBT for suicide prevention), but only if the client gives permission. From an SDT perspective, Phase 3 centers largely around supporting the client's need for competence through discussing strategies for positive change and autonomy by providing a menu of treatment options from which the client may choose. It is important that the clinician supports strategies that the client feels willing to consider trying (e.g., the he or she is autonomous) because if the client feels the clinician is trying to control or coerce him into therapy it may undermine the client's autonomy, which would be expected to lead to less vitality. Phase 3 ends with a summary that conveys the clinician's understanding of where the client is and what he feels he needs to do to make life worth living, which, from an SDT perspective, further supports the client's need for autonomy and relatedness.

#### Phase 3: Case Study

CLINICIAN: So what now? (*open-ended question*)

MR. SMITH: If I knew how to make my life better, I wouldn't be thinking about killing myself, I would be doing those things. But it's been this way for years, and I've tried so many things and nothing has worked. I don't know what to do.

CLINICIAN: You can't do this alone. (*reflection*)

MR. SMITH: What do you think I should do?



CLINICIAN: I think it really depends on what you feel needs to change. What do you think would make your life worth living? (*open-ended question*)

MR. SMITH: I just can't live with the pain anymore, and I have to find a way to get rid of it because I can't use work to get away from it, drinking doesn't work, and I've been seeing my doctor here in the VA for my pain, and the medication doesn't work either. Then I get depressed and I start thinking about killing myself.

CLINICIAN: Okay, so the pain is the most important problem and you're already seeing a physician. (*reflection*)

MR. SMITH: Right, I already have some appointments to get my back and my knees checked out again and maybe get some new meds. It hasn't worked before, but who knows, maybe they'll figure something out this visit. That's why I keep going back. What else can I do?

CLINICIAN: That makes sense. It also seems like you're really frustrated. What do you think about talking with somebody about how to cope in ways other than thinking about suicide? (*affirmation, open-ended question*)

MR. SMITH: I don't know if it'll work but I can't live like this anymore. I guess I'll give it a shot.

CLINICIAN: So you're seeing a doctor for the pain and you are willing to talk to a counselor about how to cope with your problems in other ways than thinking about suicide. What else do you think you need?

MR. SMITH: Anything that really helps. I spend so much time alone and I know that it's not good for me.

CLINICIAN: You kind of live in a cave. (*reflection*)

MR. SMITH: Right. I have to get out more, find people to talk to, but not people who are drinking because I'll want to drink. Maybe I'll start going to AA again, I don't want to go to stay some place for my drinking, but I've been to AA before and it worked so I should probably go back.

CLINICIAN: That sounds like a good idea. AA has worked for you in the past and you can imagine it working in the future. It'll help both with your drinking and you'll meet people. (*affirmation, reflection*)

MR. SMITH: The nightmares too, but I have to deal with the other stuff first.

CLINICIAN: That makes sense. It would be too much at once. Anything else? (*affirmation, open-ended question*)

MR. SMITH: That's about it.

CLINICIAN: What about the gun?

MR. SMITH: Well, I already got rid of that. I called the sheriff and he came by and picked it up.

CLINICIAN: That was a good idea... So, we're coming to the end of the session. Do you mind if I summarize what we talked about? (*affirmation, open-ended question*)

MR. SMITH: Go ahead.

CLINICIAN: You have been dealing with a lot of physical and emotional pain. You're troubled by nightmares about Vietnam, you started having trouble in your marriage, took a job as a long-haul driver to get away, started drinking which really disrupted your relationships with your wife and children, and started to have severe back and leg problems. For years you've been trying to resolve these problems and you were able to change your drinking, but lately things have gotten worse and you've started to think about suicide. At the same time there are a few things that have kept you alive, and you really do want to live. You're really excited about watching Jimmy grow up, and you want to continue to support him so that he has a chance to become a doctor. You are also concerned about Johnny. He seems to be following in your footsteps and you'd like to help him avoid some of the problems you've had. Although you can't imagine living in constant pain as you have these past few years, you sometimes think about times in the past when your life was better. You've had some good times, plus killing yourself is really a hard thing to do. You've given your gun to the sherrif, you've decided to continue to see your doctor who is trying to help you manage your pain, you are thinking about seeing a counselor to help you figure out how to cope with your pain without drinking or thinking about suicide, you've decided to go to back to AA to address your drinking and to help you meet people. How does that sound? (*summary, open-ended question*)

MR. SMITH: Yeah...that's pretty much everything.

In this example, the clinician helps the client identify the problems that he believes need to be addressed as well as the solutions that he believes would provide the best opportunity for success. The client suggests that he needs treatment for his pain and substance use. Although he

expresses ambivalence concerning the expected outcome of his treatment, and is reluctant to try treatment for PTSD, he has removed his gun from his home and appears committed to continuing to see his doctors to address his pain, see a clinician for CBT for suicide prevention, and return to AA. Although the clinician makes some suggestions, he does so only after the client gives the clinician permission, supporting the client's autonomy. The clinician also recognizes that change is a process and does not push the client to start treatment for his PTSD. Instead, the clinician reflects the client's belief that addressing all of his problems at once might be overwhelming, again supporting the client's autonomy. The session ends with a summary during which the clinician links the client's reasons for thinking about suicide, reasons for living, and plan to make life worth living.

### Research Examining MI-SI

We are not aware of any published research examining the application of MI to individuals who have engaged in self-injurious behavior, attempted suicide, or are at acute risk for suicide. However, some pilot work has been conducted in this vein. In 2007 we conducted a feasibility pilot of MI-SI in the psychiatric emergency department at a university medical center in Upstate New York. Recruitment spanned 7 1/2 months (5/31/06–12/18/06), and 28 clients received a training or study grade MI-SI interview. Intending to recruit clients with serious suicidal ideation, the mean (*SD*) on the Beck Scale for Suicidal Ideation (SSI; Beck, Kovacs, & Weissman, 1979) was 12.1 (5.9) for current and 14.8 (7.5) for worst-point ideation, suggesting the sample had severe suicidal ideation. We were interested in demonstrating that MI could be used with suicidal patients and coded 20 minutes from 15 interviews using the Motivational Interviewing Treatment Integrity (MITI) coding system. Summary variables used to determine MI proficiency (Miller & Mount, 2001) indicated that the clinicians indeed used MI with suicidal patients. The average MI spirit was 5.20 (.94) on a 7-point scale, 95% of clinician utterances were MI consistent, clinicians used 7.73 reflections to every question, 52% of questions were open-ended, and 67% of reflections were complex rather than simple. Finally, we used a modified version of the Client Satisfaction Questionnaire (CSQ-8; Attkisson & Zwick, 1982) to assess clients' satisfaction with treatment. Items on the CSQ-8 are rated on a 4-point scale with 3 indicating "mostly satisfied" and 4 "very satisfied." For our sample, the mean (*SD*) was 3.45 (.46), indicating our clients were mostly to very satisfied with the intervention. A study using the CSQ-14 in a psychiatric emergency department produced a mean of 3.08 (*SD* not available; Tacchi, Joseph, & Scott, 2003). The studies are not directly comparable due to the use of different

versions of the CSQ, but our findings suggest that clients were satisfied MI-SI. Given the absence of a control group, we were unable to demonstrate that the intervention improved treatment engagement or outcome; however, clinicians reported that the intervention facilitated the discussion of both reasons for dying and reasons for living. No adverse events were reported by the clinicians or unit staff.

### Future Directions

The clinical approach espoused in this paper is based on principles of MI and SDT that have been supported by large bodies of research with clients with substance use disorders and other problems (Fortier et al., 2007; Hettema et al., 2005; Williams, McGregor, Sharp, Levesque, et al., 2006). Although data show that principles and tenets of MI (and perhaps SDT) appear to improve treatment engagement and outcome when it is added to CBT, there is no evidence that it does so for individuals who are thinking about suicide. The theoretical and empirical arguments made in this and previous papers (Britton et al., 2008; Joiner et al., 2003) and the dearth of studies examining the efficacy or effectiveness of MI or SDT-based interventions as an additive to CBT-based treatments suggests the need for an RCT. Studies examining the effect of MI-SI and SDT-based approaches added to CBT treatments that have already been shown to reduce suicide-related behavior would help researchers and clinicians determine whether MI or SDT-based approaches can be used effectively with suicidal patients. By assessing process mechanisms and mediators such as those identified by SDT (i.e., autonomy, competence, relatedness, aspirations, and vitality), researchers might be able to identify why MI improves engagement and/or outcome in CBT and potentially improve its effectiveness.

If MI and SDT-based approaches are found to be effective, future research should explore its effectiveness with different populations. MI-SI was originally developed to be used in short-term settings typically populated by individuals who are at higher risk for suicidal behavior, such as acute inpatient psychiatric or psychiatric emergency departments (Harris & Barraclough, 1997). It could also be tested in other settings that treat high-risk clients, such as substance use and outpatient treatment programs. Furthermore, MI-SI was developed for individuals who are thinking about suicide and could also be applied to populations that may be at even greater risk, such as individuals with a plan (Joiner Jr., Rudd, & Rajab, 1997) or a recent attempt (Cavanagh et al., 2003).

MI focused on treatment engagement could also be used to engage clients who are struggling with psychiatric disorders that are associated with suicide-related behavior

(Cavanagh et al., 2003; Kessler et al., 1999) but have not yet developed suicidal ideation or made suicide attempts. For example, MI could be used to motivate depressed clients in primary care into mental health treatment, which could reduce their long-term risk for suicidal behavior. In the Improving Mood-Promoting Access to Collaborative Treatment (IMPACT) study (Unutzer et al., 2006), depressed older adults in primary care were randomized to a collaborative depression treatment that included an algorithm using medication, problem-solving therapy, and other mental health interventions such as Electro Convulsant Therapy (ECT), or to treatment as usual (TAU). Clients receiving collaborative depression treatment experienced greater reductions in suicidal ideation for up to 2 years compared to those receiving TAU, suggesting that improving access to effective treatments can have a significant effect on suicide risk. These promising findings serve as further support for the need for additional research.

Research examining the mechanisms through which MI functions is also needed. It is possible that neither MI nor CBT-based interventions change or satisfy clients' perceived autonomy, competence, or relatedness, as there are aspects of SDT interventions that are outside of MI. To support autonomy, SDT clinicians provide clients with a menu of available and effective options for change, which is sometimes but not always part of MI. SDT clinicians may also provide advice, which is accepted in SDT interventions, but is only congruent with MI when clients give permission. In addition, changing autonomy is not easily accomplished and often requires repeated intervention over time. SDT-based interventions that have been specifically developed to change perceived autonomy and competence may be needed. Only well-conducted studies will demonstrate whether MI, CBT, and SDT-based intervention function in a similar manner.

In this paper, we argued that suicidal patients are often difficult to engage in treatment, necessitating the development of tools and methods to increase participation in treatments that are effective in reducing suicidal behavior such as CBT. Suicidal individuals may not be motivated for treatment because they are ambivalent about living and/or treatment. MI is a brief intervention that has been shown to increase treatment engagement and outcome when it is added to other treatments, and it can be used to address motivation to live and participate in treatment. SDT is a theory of human motivation that may explain how MI could be used to increase motivation to live, thereby improving treatment engagement and participation. RCTs are needed to explore the utility of adding MI to CBT for suicide prevention and to understand the mechanisms by which it works.

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