

Toward a parsimonious understanding of suicide: comparing the Three Step Theory to Malhi and colleagues' Integrated Model

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I appreciate very much the thoughtful and careful effort by Malhi et al.¹ to develop an integrative model of suicide in bipolar disorder. The pursuit of parsimonious models and theory is difficult, yet absolutely critical for any field that wishes to have a scientific basis. The model developed by Malhi et al. is a worthy contribution to this effort.

To be useful, a model or theory must achieve a tricky balance: it must be complex enough to account for the large variety of factors that contribute to suicide risk, yet simple enough to be clear and actionable. The model offered by Malhi et al. leans toward complexity more than simplicity. It delineates eight components on the pathway to suicide (distal risk factors, proximal risk factors, current state, appraisal, defeat and entrapment, ideation, intent, attempt), and uses them to organize about three dozen risk and protective factors (e.g., help-seeking, humiliation, attachment, religious beliefs, pain desensitization, etc.). This somewhat complex model has the advantage of being more comprehensive than simpler models in its coverage of suicide-relevant factors. Yet, it of course is not completely comprehensive. For example, the Malhi et al. model does not emphasize negative life events, even though these frequently serve as proximal triggers for suicide ideation, attempts, and death.² Nonetheless, by embracing a complex structure, Malhi et al. were able to integrate several suicide theories and numerous types of risk factors into a single model.

There are also benefits to embracing simplicity in constructing models and theories. In the ideal scenario, a theory is both (i) simple and (ii) able to account for tremendous individual variation and complexity. After all, the story of suicide risk in an 84-year-old widow is not the same as that in a 13-year-old boy. The remainder of this commentary describes how a relatively parsimonious theory of suicide—the Three-Step Theory (3ST³)—handles variability and complexity within its simple structure.

For a detailed description of the 3ST and its rationale, please see Klonsky and May³ and Klonsky et al.⁴ In brief, the 3ST states that: (i) suicidal desire develops in response to pain and hopelessness; (ii) suicidal desire escalates when pain exceeds or overwhelms connectedness; and (iii) the progression from suicidal desire to potentially lethal suicide attempts is facilitated by practical, acquired, and dispositional contributors to the capability for suicide. Thus, the 3ST explains suicide risk in terms of just four factors: (i) pain, (ii) hopelessness, (iii) connection, and (iv) suicide capability.

On the surface, it may seem that a focus on four factors is insufficient. After all, there are hundreds of potential causal factors supported by large empirical and theoretical literatures. However, the 3ST does not preclude the importance and relevance of these other factors. On the contrary, the 3ST provides a framework for contextualizing and explaining their contributions to suicide risk. From the perspective of the 3ST, any variable will increase suicide risk to the extent that it increases pain, increases hopelessness, reduces connection, and/or increases suicide capability. Conversely, any variable will reduce suicide risk to the extent that it reduces pain, increases hope, increases connection, and/or reduces suicide capability.

Consider the example of humiliation, which is highlighted by the Integrated Model of Bipolar Disorder as a motivational factor with proximal relevance for suicide risk. Humiliation is not explicitly included in the 3ST. However, the 3ST can contextualize and explain the relevance of humiliation to suicide risk. Humiliation is an extremely aversive experience that increases pain. In some cases, the circumstances leading to humiliation represent an ongoing and difficult situation that can leave one feeling hopeless about achieving a better future. Humiliation also has an interpersonal context, and thus may be an indicator of damaged connectedness. Thus, the 3ST not only accommodates humiliation as a potential risk factor, but also helps to explain its relevance

to suicide risk through its impact on pain, hopelessness, and/or connection.

The 3ST also helps to contextualize and explain the relevance of distal risk factors. For example, Rappaport et al.⁵ recently found that the temperament dimension of neuroticism correlates positively with suicidal ideation, but negatively with a history of suicide attempts among individuals with ideation. This pattern is easily understood in the context of the 3ST. A hallmark of neuroticism is the increased presence of negative emotions such as anger, sadness, anxiety, and fear. In other words, neuroticism is a marker for increased emotional pain, which from the perspective of the 3ST increases risk for suicidal desire. At the same time, a higher susceptibility to negative emotions makes it harder to suppress the fears of pain, injury, and death that are barriers to making a suicide attempt. Thus, from the perspective of the 3ST, neuroticism is a dispositional factor that reduces capability for suicide, and thereby decreases the chances that someone with ideation will make a suicide attempt. In sum, the simple structure of the 3ST not only accommodates other risk factors, but helps to explain the mechanisms by which these factors influence suicide risk.

I hope that Malhi et al. continue their valuable work, and I would like to express my gratitude for their contribution. It is only through

these kinds of efforts and conversations that the field can achieve more accurate and actionable perspectives on suicide.

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REFERENCES

1. Malhi GS, Outhred T, Das P, Morris G, Hamilton A, Mannie A. Modeling suicide in bipolar disorders. *Bipolar Disord.* 2018;20:334-348.
2. Liu RT, Miller I. Life events and suicide ideation and behavior: a systematic review. *Clin Psychol Rev.* 2014;34:181-192.
3. Klonsky ED, May AM. The Three-Step Theory (3ST): a new theory of suicide rooted in the "Ideation-to-Action" framework. *Int J Cogn Ther.* 2015;8:114-129.
4. Klonsky ED, Saffer BY, Bryan CJ. Ideation-to-action theories of suicide: a conceptual and empirical update. *Curr Opin Psychol.* 2018;22:38-43.
5. Rappaport LM, Flint J, Kendler KS. Clarifying the role of neuroticism in suicidal ideation and suicide attempt among women with major depressive disorder. *Psychol Med.* 2017;47:2334-2344.