Chapter 13
Applied Resiliency and Suicide Prevention: A Strengths-Based, Risk-Reduction Framework

Jameson K. Hirsch, Jessica Kelliher Rabon, and Edward C. Chang

As our authors have highlighted, suicide is a major public health concern, with a multi-factorial etiology that necessitates a broad approach to its treatment. Historically, the treatment for suicidal behavior has focused on the reduction of risk factors, and there is solid evidence to suggest that a risk-reduction paradigm has a beneficial effect on mental health outcomes. Psychopathology, such as depression, and negative cognitions and emotions, such as hopelessness and perceptions of loneliness and isolation, are robust predictors of suicide risk, and interventions to attenuate their impact generally result in reductions in suicidal behavior (Abramson et al., 2002; Chang, Sanna, Hirsch, & Jeglic, 2010). Cognitive-behavioral and interpersonal therapies, for instance, are focused on the resolution of relationship-based difficulties and errors in thinking and acting and are effective in the reduction of suicide risk (Bryan et al., 2018). Yet, as our authors have pointed out, this may be a one-sided approach, which generally neglects aspects of resilience, growth, and adaptivity or addresses them as a by-product of the reduction of risk. We argue, therefore, that a new paradigm in the prevention and treatment of suicide is needed, which both addresses risk while simultaneously and purposefully enhancing resilience, offering a balance of risk-reduction and resilience-promotion. Conceptualized as a translational "applied resilience," we have developed a new descriptive term for this approach—Positive Suicidology.

Emerging in the 1980s with concepts such as spirituality and religiousness, reasons for living, and adaptive problem-solving, suicidologists began to emphasize

J. K. Hirsch (✉)
Department of Psychology, East Tennessee State University, Johnson City, TN, USA
e-mail: hirsch@etsu.edu

J. Kelliher Rabon
Greenville Hospital System Children's Hospital, Greenville, SC, USA

E. C. Chang
Department of Psychology, University of Michigan, Ann Arbor, MI, USA

J. K. Hirsch et al. (eds.), *A Positive Psychological Approach to Suicide*,
Advances in Mental Health and Addiction,
https://doi.org/10.1007/978-3-030-03225-8_13

concepts such as a "light at the end of the tunnel" or "grasping for hope," and began to frame suicide prevention as a "fight" against death; in other words, a motivational process to move out of a state of despair and into long-term well-being and health (Ellis & Smith, 1991; Hirsch & Ellis, 1998; Rudd, Rajab, & Dahm, 1994). Yet, these early theories on suicide were themselves based on theories acknowledging self-actualization and adversarial growth as processes of change (Heisel & Flett, 2004). For example, early humanistic therapeutic strategies posited movement from the actual to ideal self as a positive form of growth, and classic existential and gestalt theories were long concerned with spirituality, holistic well-being, and interpersonal concerns in the context of death (Sellin, Asp, Wallsten, & Wiklund Gustin, 2017; Orbach, 2007), setting the stage for current work in Positive Suicidology.

To introduce this paradigm of Positive Suicidology, our authors have provided a review of the literature on adaptive, positive psychosocial factors that might be used to reduce suicide risk across the lifespan, and at the differing levels of the individual, relationships, community, and culture. Numerous themes of importance have emerged, which are both interpersonal and intrapersonal in nature; indeed, many of the constructs discussed in this volume are multi-dimensional and cross sociocultural, temporal, and existential boundaries.

In this chapter, we briefly highlight the contributions of our authors, noting their unique perspectives on applying resiliency-based conceptualizations and strategies to the understanding and treatment of suicide. We also note thematic patterns that emerged. For example, our authors emphasized care for the self and others, engagement with support systems, and becoming emotionally balanced via temporal and holistic growth as important personal and clinical objectives. Such efforts, in turn, provide impetus toward meaningful future goals, thereby enhancing psychological well-being and reducing risk for suicide. Our authors also discuss barriers to such growth and well-being, including sociocultural stressors and bias and poor physical health, and we strategize here about potential means for overcoming these intervention challenges. Finally, we envision where the concepts of "applied resiliency" and "positive suicidology" have been, where they are currently, and where they must go in the future to be successful in terms of training and education, research and prevention, and intervention strategies. We begin by discussing the emergent, broad themes of interpersonal and intrapersonal processes which, although they are independent contributors to health outcomes, may also converge to synergistically impact well-being, including suicide-related outcomes. Recognizing the overlap between inter- and intrapersonal processes, we address how positive psychological interventions might address both realms simultaneously to promote well-being. We also examine additional emergent themes, including existential and temporal perspectives on suicide, and paradigms focused on health-related, sociocultural, and environmental factors.

Interpersonal Factors

Supporting historical and current research trends in the field of suicidology (Hirsch & Ellis, 1995), our chapter authors clearly indicate that the realm of interpersonal functioning is critical for the prevention of suicide. In Chap. 7, Kleiman and colleagues highlight the role of thwarted interpersonal needs, acknowledging the damage caused by a lack of social belongingness and feelings of burdensomeness, per the Interpersonal Theory of Suicide (Joiner et al., 2009). Kleiman also addresses other deficit-oriented social constructs, such as loneliness and social isolation, as well as conflict with others.

From the time of Durkheim, and extending to Joiner, many theorists and therapists have noted the critical role of social support, or its absence, in the development and maintenance of psychopathology and suicidality, including its interaction with sociocultural determinants of health to contribute to suicide risk (Recker & Moore, 2016; Van Orden et al., 2010). For example, the absence of social interactions and support are associated with risk for development and worsening of anxiety, depression, substance misuse and suicidal thoughts and behavior, whereas the presence of adaptive social problem-solving and support-offering relationships are related to better physical and mental health, better academic and vocational functioning, and less suicide risk (Leung, Chen, Lue, & Hsu, 2007; Stice, Ragan, & Randall, 2004).

Conversely, Kleiman and colleagues note that enhancement of and integration into social networks, as well as bolstering social support, are resiliency-based strategies for reducing suicide risk. Empirically supported therapies, such as Interpersonal Therapy, and efficacious strategies, such as enhancement of social problem-solving skills, have been shown to reduce suicidal behavior and risk, suggesting the importance of addressing social relations to prevent suicide (Overholser, 1995; Townsend et al., 2001). Further, encouraging interpersonal growth, by fostering attachment and connectedness, as well as social communication and engagement, are approaches with a growing evidence base of support for their application to psychopathology and suicide risk, and should be the focus of ongoing clinical trials to assess their therapeutic value.

Yet, interpersonal elements of importance are not limited to social support or the satisfaction of interpersonal needs, but also occur in the forms of forgiveness (e.g., of and by others; Chap. 3), gratitude (e.g., for things others have done; Chap. 5), reasons for living (e.g., importance of family and friends; Chap. 4), and the pursuit of purpose and meaningfulness (e.g., intergenerational engagement; Chap. 10). Even as a public health strategy, Kral and Kidd note, in Chap. 12, that for modern suicide prevention efforts to be effective, they must involve community-level engagement and communication. A common theme that seems to be vital to suicide prevention efforts, therefore, is that there is much value in the promotion of healthy, reciprocal, and supportive relationships, whether at the interpersonal, institutional, or community levels. As a collective group, the authors in this volume encourage continued clinical and research efforts to ameliorate loneliness, social isolation, and feelings of burdensomeness, but also prompt healthcare providers and researchers

to focus on strengths-based approaches. Applied resiliency, in the form of positive suicidology, is a novel, evidence-based approach with growing support, and may include pro-active and adaptive cognitive-emotional and behavioral strategies, such as improving social problem-solving abilities, strengthening perceived social networks, satisfying relatedness needs, and repairing damaged relationships and social functioning via application of positive psychological principles, such as altruism, gratitude, and forgiveness. We transition to a discussion of these other-related, yet internalized and individual-level, protective factors, in the sections below.

Intrapersonal Factors

In addition to evidence linking interpersonal risk factors (e.g., social conflict) to suicidality, there is also a rich history of investigation of the role of intrapersonal characteristics as risk factors for suicide, ranging from psychache to hopelessness to existential despair, all of which, incidentally, are negatively valenced factors that require reduction (Abramson et al., 2002; Shneidman, 1993). Not to discredit the fact that these risk factors may need to be reduced, but our authors have indicated the importance of recognizing an array of adaptive strengths and virtues that should be independently, and perhaps simultaneously, increased. As individual factors, this spectrum of positive psychological variables is impressive, but a top-down perspective reveals several emergent patterns: that is, (1) our past, present, and future are each important contributors to mental well-being; (2) suicide often emerges from deep, internal yearnings—for others, as noted above, and for purpose; and (3) suicide must be addressed not only at the psychological level of the individual, but also at the physical and environmental levels, including social functioning and community engagement, and the exploration of culturally relevant risk and protective factors. In the following sections, we discuss these thematic positive psychological patterns as they relate to suicide research and prevention.

Temporal Factors

At the intrapersonal level, an interesting theme to emerge is that of temporal well-being, including having an adaptive view of the past, present, and future, which appears to be related to reduced suicide risk (Boniwell & Zimbardo, 2015). In addition to future orientation, research indicates that adaptive forms of other time focal-points (e.g., past positive, present positive) are also beneficially related to physical and mental health, including less suicidal behavior (Hamilton, Kives, Micevski, & Grace, 2003; Laghi, Baiocco, D'Alessio, & Gurrieri, 2009). Our authors in this volume extend suicide prevention to include other temporal constructs, such as forgiveness (e.g., for *past* transgressions), gratitude (e.g., for *past* and *present* acts of kindness extended), and mindfulness (e.g., engagement in the *present* moment).

Knowing what we do about "dwelling in the past," which may contribute to depression, and "fear of the future," which may contribute to anxiety, it seems that mental health interventions and suicide prevention strategies must take temporal holism into account (Deyo, Wilson, Ong, & Koopman, 2009; Seligman, 2011).

In Chap. 2, Kirtley, Melson, and O'Connor acknowledge the importance of classic temporally related constructs, such as hopelessness and pessimism, as robust predictors of suicide risk, but also distinguish these from their counterparts of hope and optimism, citing the importance of addressing both in research and clinical work (O'Keefe & Wingate, 2013). Although a positive future-outlook is important, the mechanism of action of this protective effect is multi-faceted and involves cognitions about a changeable future, motivational strivings, self-efficacious and agentic behaviors, and problem-solving abilities (Britton, Van Orden, Hirsch, & Williams, 2014; Chang et al., 2013; Chu et al., 2018). On the surface, this approach adheres well to traditional therapeutic approaches for psychopathology, which attempt to reduce negative, ruminative thoughts of the present and past, and to reduce worrisome thoughts about the present and future (Beck, 1989). Our approach, however, maintains that this is not sufficient—that to simply reduce these deficits without simultaneously promoting their "opposing," or complementary, adaptive counterparts may only be representing a portion of the available options for the successful treatment of psychopathology and suicide (Duckworth, Steen, & Seligman, 2004).

Indeed, in Chap. 9, Yu and colleagues describe three different therapeutic approaches designed to reduce suicide risk, all of which are focused on the cultivation of future-oriented thoughts, emotions, and goals. Hope Therapy, for instance, emphasizes the development of problem-solving abilities (e.g., pathways thinking), the identification of adaptive future goals, and the promotion of goal motivation (e.g., agentic thinking) to thwart maladaptive, suicidal goals and replace them with adaptive, life-affirming goals. These hope-based efforts are focused across several life domains, including: social and romantic relationships, family life, academics and work, and leisure activities. Future Directed Therapy (FDT), similarly, is focused on the reduction of the suicide risk factor of depression and emphasizes the generation of future-oriented motivational goals which, in turn, promote goal-directed behaviors, leading to better well-being, including feelings of optimism and hope. FDT is also focused on thriving, and on re-orienting our expendable cognitive-emotional resources from usage toward maladaptive goals, toward a focus on adaptive, meaningful life outcomes. Finally, Yu and colleagues discuss Future Oriented Group Training (FOGT), which highlights the deleterious role of hopelessness in the suicidal process, as well as deficits in problem-solving and social efficacy. Often found to be one of the most robust predictors of suicide, hopelessness is a temporal construct, comprising a negative orientation toward the identification and completion of future goals, including the ability to harness interpersonal and problem-solving abilities to reach such goals (Brown, Beck, Steer, & Grisham, 2000). Thus, FOGT not only attempts to correct an unbalanced time perspective, but also promotes pro-active environmental and social engagement to reduce suicide risk.

Finally, although broad in scope, Reasons for Living are discussed in Chap. 4 by Calati, Olié, Ducasse, and Courtet and can be noted to have at least some temporal

components. Focused on what might keep a person alive, in the moment, were they considering suicide, reasons for living reflect just that—a reason to stay alive for another moment of the present and into the future (Linehan, Goodstein, Nielsen, & Chiles, 1983). We tend to think of reasons for living as symbolic of the elements that have meaning and value in life, overlooking the temporal aspects of the construct (Bagge, Lamis, Nadorff, & Osman, 2014). Yet, upon consideration, responsibility to family and child-related concerns, two domains of reasons for living, are also temporally derived, as they are based on distress about what one's suicide might do to a family or children, and how loved ones might fare in the future after a suicide death. Similarly, the survival and coping subscale implies the process of overcoming, and moving past and beyond, current stressors, reflecting an implicit focus on transitioning from the present to the future. Finally, the subscale of moral beliefs provides a measure of not only religious prohibitions against suicide, but also consideration of an afterlife; that is, even issues of morality may include elements of temporality.

Again, a temporal perspective seems to adhere closely to traditional and historical models of psychotherapy that examine, among other factors, adverse childhood experiences (ACEs) and relationships (e.g., Interpersonal Therapy) from the past, current stressors (e.g., Problem-Solving Therapy), and anxiety about the future (e.g., Cognitive-Behavioral Therapy; Cuijpers, de Wit, Kleiboer, Karyotaki, & Ebert, 2018; Hofmann & Smits, 2008; Soleimanpour, Geierstanger, & Brindis, 2017). In this volume, our authors suggest that we must also address temporally positive factors, such as hope and optimism, increasing their salience to buffer against suicide risk. As we continue to conduct research on, and develop interventions for, suicidal behavior, we should take care to investigate the strong importance of not only a client's current presenting problem, which is in the here-and-now, but also the burdens of their past and their fears of the future to help them to develop a more-holistic and balanced temporal perspective. Delving into the past and the future is truly a person-centered therapeutic endeavor, and one that often touches on private moments, troubling times, and deep fears; that is, reconciling our temporality often requires exploration of humanistic and existential topics, including purposefulness, motivation and goals, and the search for meaning, which we discuss in the following sections.

Humanistic and Existential Factors

Because many of the constructs discussed in this volume span thematic boundaries, they can also be addressed at multiple levels; for instance, not just at the temporal level, but also at the humanistic and existential levels. As an example, although the act of forgiveness does include a temporal element, it is not limited by time and can be enacted at any time of choosing (Jacinto & Edwards, 2011). Further, forgiveness is often addressed within the realms of religiousness and spirituality, or as a process of existential growth and recovery (Webb, Hirsch, & Toussaint, 2015). Similar constructs, such as gratitude and reasons for living, can

also be conceptualized within this person-centered theme; that is, they embody the pursuit of values, purpose, and meaning, and engagement in the processes of growth, thriving, and resiliency (Hill, Allemand, & Roberts, 2013; West, Davis, Thompson, & Kaslow, 2011).

In Chap. 3, Webb identifies a model outlining the associations between forgiveness of self, of others, and by God, as well as "unforgiveness" and physical and mental health outcomes, particularly addiction and suicide. With between 70–90% of the global population expressing a belief in God or a higher power, the ubiquity of religious and spiritual characteristics makes them an easily accessible target for therapeutic intervention, and one that is often palatable to clients (Rippentrop, Altmaier, Chen, Found, & Keffala, 2005). For instance, more than 70% of patients report that they wish their healthcare providers would address spiritual issues within the context of treatment (Wilson, Milosevic, Carroll, Hart, & Hibbard, 2008). It is feasible, then, that many suicidal patients would also welcome the introduction of some form of spirituality into their personal and therapeutic recovery processes.

Regarding psychopathology, a growing body of research indicates that forgiveness, particularly self-forgiveness, is beneficially associated with reduced levels of depression, anxiety, and substance abuse, and preliminary findings indicate a salubrious association between forgiveness and suicide risk (Webb, et al., 2015). Webb and colleagues have proposed a forgiveness-based model of suicide risk, positing several mechanisms of action, including via health-related behaviors, such as addiction, and via existential distress, including hopelessness and psychache (Dangel, Webb, & Hirsch, 2018). Thought to act on rumination and resentment, forgiveness may help ease psychological distress, including use of substances to cope with distress, thereby decreasing suicide risk. Forgiveness may also reduce suicide risk through its beneficial impact on other positive psychological variables, akin to the processes outlined by the Broaden and Build Model proposed by Fredrickson (Fredrickson & Joiner, 2002), whereby positive emotions evoke cognitive-emotional expansion. For instance, in a sample of primary care patients, forgiveness was related to greater future orientation and, in turn, to reduced suicidal behavior (Kelliher Rabon, Webb, Chang, & Hirsch, 2018). Yet, it is the humanity of forgiveness, and its spiritual and existential characteristics, that make it so widely accepted as a form of religious coping. Forgiveness is often a profound act, laden with meaning, addressing sensitive issues of shame and guilt—an act so simple, yet so complex and difficult, but with the power to change an individual, relationships, and even communities (Witvliet, Ludwig, & Vander Laan, 2001).

Similarly, the characteristic of gratitude, as described by Krysinka in Chap. 5, can be experienced internally or expressed simply, yet has beneficial effects for both the provider and recipient of thankfulness. Like forgiveness, gratitude, or thankfulness, is often focused on another person or group, and is mutually beneficial, in that both the recipient and deliverer of gratitude appear to manifest emotional and health benefits (Mills et al., 2015). Conceptualized as a prosocial motive, an affective trait, and as a general, positive appreciation for life and others, gratitude is beneficially related to self-concept and self-esteem, and to processes of self-growth, suggesting that it is a dynamic agent in emotional and behavioral

functioning, and one that could be harnessed for suicide prevention efforts (Wood, Froh, & Geraghty, 2010). Gratitude also contributes to a sense of meaningfulness in life, a classic existential construct and human pursuit, and appears to have beneficial effects at the emotional (e.g., greater positive affect), cognitive (e.g., use of active and adaptive coping), and interpersonal levels (e.g., warmer, reciprocal relationships; Emmons & McCullough, 2003).

In a therapeutic context, however, it cannot be presumed that these adaptive characteristics will automatically arise as a by-product of a treatment process that functions via reduction of psychological deficits (e.g., depression, anxiety). The authors in this volume posit that the long-standing tradition of viewing cognitive-emotional opposites (e.g., happiness versus sadness, optimism versus pessimism) as bipolar, rather than as coexistent or orthogonal, is somewhat outdated, lacks empirical support, and may contribute harm to the therapeutic process (Larsen, McGraw, & Cacioppo, 2001; Scheier, Carver, & Bridges, 1994). For example, just because someone is not sad does not mean they are happy, and just because someone is optimistic about their family relationships does not preclude them from being pessimistic about their health. As clinicians, we cannot assume that reducing the presence and intensity of suicide risk factors automatically increases the motivation and will to live, or to be resilient and thrive. In other words, these characteristics must be actively sought and, in the context of therapy and suicide prevention efforts, must be actively promoted in a process of applied resiliency.

One positive psychological factor that has been employed with some success toward the prevention of suicide is mindfulness, a component of the broader construct of self-compassion, which is discussed in Chap. 11 by Le and colleagues. In previous research, engaging in mindfulness is associated with less chronic pain, greater psychological well-being, less hopelessness, and less suicidal behavior, perhaps due to the beneficial effects of mindfulness on executive functioning processes such as impulse control, emotion regulation, and the ability to be aware of and redirect thoughts (Grossman, Niemann, Schmidt, & Walach, 2004). By tempering automatic reactivity, and by de-coupling emotions from cognitions, strategies such as Mindfulness-Based Cognitive Therapy (MBCT) are effective at decreasing suicide risk (Chesin et al., 2015).

Le and colleagues also note that secular mindfulness techniques, although beneficial, neglect other aspects of mindfulness that may be important for suicide prevention. Therefore, these authors propose a "6 R's" Framework of suicide prevention, where remembering, redirecting, and replacing are aspects reflected in traditional mindfulness-based therapeutic approaches, such as MBCT, and emphasize a "reflect and resolve" approach, whereby negative emotions are acknowledged, "released" or reframed, and positive emotions are promoted in their place (Keng, Smoski, Robins, Ekblad, & Brantley, 2012). The final trio of R's include reflecting (e.g., contemplating pleasure-seeking and unpleasantness-avoidance), resolving (e.g., strong motivation to cultivate new habits), and retracing (e.g., reflecting on sociocultural determinants of phenomena), which serve a somewhat different purpose, to reify the self through contemplation of the nature of dissatisfaction, one's relationship with others in the world, and the historical roots of one's discontent. Together, the 6 R's

comprise both an etic and emic approach to suicide prevention and self-evaluation, looking within to resolve intrapersonal distress but also looking outward, with motivational agency, in the service of integrating with others, one's experiences, and the environment; that is, resolving "problems" in a somewhat traditional deficit-reduction approach, but also broadening and building one's perspective in a process of meaning-making and growth through critical mindfulness. Although the terminology may be somewhat different, the commonalities are clear, as the 6 R's approach adheres to the broaden and build model (Fredrickson, 2000), and clearly emphasizes hopefulness (e.g., motivational agency), social integration (e.g., caring, reciprocal relationships) and problem solving (e.g., resolving stress via meaning-making), as potential strategies for preventing suicide (Cheavens, Cukrowicz, Hansen, & Mitchell, 2016; Chu et al., 2018; Range & Penton, 1994).

This self-actualizing, growth-based trajectory is described as a treatment paradigm by Heisel and colleagues in Chap. 10, where they note that meaning-based therapeutic strategies may be of particular importance for some vulnerable populations, such as those who have suffered a loss or who are struggling with their own existential concerns, such as aging, retirement, loss of abilities, or end of life concerns. Feelings of emptiness, termed an "existential vacuum," may result from such losses or age-based changes in routine, such as retirement, and may result in maladaptive attempts to fill this existential void, perhaps with negative health behaviors (e.g., substance abuse) or resulting in feelings of despair and hopelessness (Reker, Peacock, & Wong, 1987). Indeed, the absence of meaning in life is related to an array of poor health outcomes, including reduced quality of life and suicide risk, whereas the presence of meaningfulness is linked to reduced anxiety, depression, and substance misuse (Heisel & Flett, 2004). Heisel and colleagues describe a treatment approach designed for older adults that seeks to enhance meaningfulness and self-growth in order to reduce suicide risk. Based on Frankl's work, this multifaceted approach encourages meaning-making across several life domains, by emphasizing engagement in creative activities and meaningful experiences, and the cultivation of healthy attitudes toward challenges and questioning one's greater purpose in life (Frankl, 1984). Administered in a group format, Meaning Centered Men's Groups target suicide risk by focusing on meaning-making in vocation, leisure, and relationships and, existentially, on matters of generativity, transcendence, and spirituality. Preliminary evidence suggests that this treatment paradigm based on "applied resiliency" can have a beneficial impact on suicide risk and, importantly, that it is feasible and acceptable for delivery to a vulnerable population.

Self in Context: Sociocultural and Environmental Factors

It is also important to recognize that suicide prevention must occur within the context of the physical body and its existence in a series of biopsychosocial and environmental systems and levels (Kim, Baek, Han, Lee, & Yurgelun-Todd, 2015). Our authors have asserted that physical health, including behavioral activation, and

community engagement may play a role in the prevention of suicide. Further, the goal-oriented motivations that accompany hopefulness and future orientation are linked to behaviors occurring within the context of interpersonal relationships, sociocultural vulnerabilities, and environmental barriers (Chang & Banks, 2007; Cheavens et al., 2016; Hirsch, Visser, Chang, & Jeglic, 2012). Finally, by definition, the act of engaging with a community to prevent suicide, whether as a researcher, clinician, or other healthcare provider, stakeholder, or consumer, requires a physical presence, even if online, and, thus, human behavior. This approach aligns well with sociocultural models of behavior, as well as with agentic theories, which propose that the physical body is an organism of change, ever-adapting and responding to a changing world of relationships, communities, organizations, cultures, and governments (Suls & Rothman, 2004).

It is sometimes easy to forget that theoretical assumptions often exist in an ideal world, and that processes of adaptation and resilience can be damaged and hindered by deleterious life experiences, such as poverty, stigma and discrimination, and abuse (Davis, Cook, & Cohen, 2005). It is in the presence of such difficult circumstances where we might see both the most and least successful manifestations of resiliency; that is, many persons seem to thrive under difficult circumstances, manifesting psychospiritual growth; whereas, others may falter, manifesting distress and psychopathology (Bonanno, 2004). The need for an "applied resiliency" approach is often visible in disparaged communities and populations that are deemed "at risk" for suicide, in which their everyday lives are particularly harsh, cruel, or unjust, leaving them vulnerable to psychological injury, but with little opportunity for psychological respite. When we think of at-risk groups, such as transgender persons suffering stigma and discrimination, veterans experiencing moral injury, persons with chronic illness or pain, or persons in poverty, it is our compassionate first response to consider reducing hurtful deficits—to get rid of pain and ameliorate feelings of stigmatization and distress (Dekel, Ein-Dor, & Solomon, 2012; Meyer, 2015). Often, it is only as an afterthought, or as an ancillary strategy, that we, as mental health professionals, attempt to engage our clients in acts of striving and thriving, yet the authors in this volume have asserted that positive psychological approaches may be useful as primary approaches to the treatment of psychopathology and suicidal behavior, including in cultural and ethnic minorities.

In Chap. 6, Cole and Wingate explore the role of diversity, including culture and ethnicity, in the application of positive psychological principles to the prevention of suicide in minority individuals. They note that, first, research on positive suicidology must be inclusive of minority individuals, and that there is a need for cultural sensitivity in the application of positive psychology to mental health treatment and suicide prevention. Ongoing bias, racism, and discrimination, as well as historical trauma, often impact the well-being of members of minority groups and contribute to risk for suicide (Castle, Conner, Kaukeinen, & Tu, 2011). What is unknown, in many instances, is the suitability of current forms and measures of positive psychological principles for minority individuals. Existing research suggests that constructs such as hopefulness, optimism, grit, social support, mindfulness, and religiousness and spirituality are related to reduced suicide risk and behaviors in a

diverse array of minority samples (Pedrotti, Edwards, & Lopez, 2012). Culture-specific protective factors may also exist; for instance, embrace of cultural values and customs, as well as a strong sense of ethnic identity, and even biculturalism, may help to attenuate the impact of risk factors on health and well-being, including mental health and suicide (Allen et al., 2006; Utsey, Bolden, Lanier, & Williams, 2007). Cole and Wingate note, importantly, that positive psychology as a field is poised to be inclusive in its approach and application, given its basis in humanistic, person-centered, and growth-oriented principles, as well as its frequent grounding in, and acceptance of, non-Western approaches, including Eastern philosophies and Native American wisdom (Walsh & Shapiro, 2006).

Again, the characteristic of "applied resiliency" comes to mind, which is not simply a reservoir of positive psychological attributes that somehow balances out the "negative side" of a person or improves untenable sociocultural situations but, instead, requires purposeful and pragmatic implementation to be maximally beneficial. As an example, a growing body of research supports the premise that, to be unrealistically hopeful or optimistic, perhaps in unescapable or unremitting circumstances (e.g., in situations involving discrimination), may be counter-productive (Mattis, 2002; Weinstein, 1987). Similarly, to focus on the cultivation of positive emotions, to the exclusion of recognition and acceptance of negative emotions, is to see only one side of the equation (Gruber, Mauss, & Tamir, 2011). Therefore, clinicians, healthcare providers, and policymakers must embrace a therapeutic model that not only addresses psychosocial deficits, but also enhances psychosocial strengths.

Just as with critical mindfulness, Kral and Kidd, in Chap. 12, advocate for a "critical suicidology," which similarly challenges policymakers, prevention specialists, and communities to investigate the sociocultural and structural determinants of suicide, and to utilize research and intervention strategies that are empowering. Building on the needs and strengths of a community and engaging stakeholders at all levels in a process of evaluation and growth can help to identify meaningful strategies for intervention, which have value and importance for community members. By promoting community involvement in this meaning-making prevention process, empowerment of the community and its members might emerge and, with empowerment, enhanced investment in intervention efforts, facilitation of sustainment efforts, and reduction of suicide risk may follow (Laverack & Labonte, 2000; Varia, Ebin, & Stout, 2014).

At the individual level, this may be accomplished through the processes of physical engagement and behavioral activation, including wellness practices and exercise, as noted by Davidson and colleagues in Chap. 8. From a public health perspective, preventing suicide must be accomplished in a way that can reach the most people, at the least cost, and with the most effectiveness (Conwell & Duberstein, 1995); therefore, interventions that can be performed at home, without supervision and with minimal or no expense, and that have demonstrable effects on well-being are highly desirable. Davidson and colleagues assert that focusing on physical activity, behavioral activation, nutrition, health-related quality of life, stress reduction, and reduction of substance misuse might be effective broad-based approaches to

ameliorating suicide risk, which can be implemented as prevention, rather than intervention, techniques. Whether early in the lifespan or early in the suicide etiological process, employing empowering health-promotion strategies can be used to cope with active distress, but can also be promoted, in advance, as a reservoir of health-focused coping ability to be employed as a form of "applied resilience" in times of distress (Kalra et al., 2012; Smith, Baugh Littlejohns, & Thompson, 2001).

The approach advocated for by Davidson and colleagues emphasizes the promotion of health-related quality of life, which is a subjective assessment of functioning across life domains, including interpersonal relationships, physical and mental health, and degree of impairment; importantly, improved perceptions of HRQL often translate into healthy behaviors, as well as improved morbidity and mortality (Taillefer, Dupuis, Roberge, & LeMay, 2003). As the old saying goes, "healthy body, healthy mind," and the authors of this chapter note that, through strategies such as stress reduction and less use of substances, better HRQL can be attained, including less suicide risk (Brausch & Gutierrez, 2009; Choi, DiNitto, Marti, & Segal, 2017). Importantly, both health promotion and positive psychological exercises can often be conducted independently, at no or low cost, thereby overcoming some of the sociocultural barriers that might otherwise preclude seeking treatment. Yet, when patients do seek treatment, often from medical rather than psychiatric providers, encouragement of positive psychosocial and physical activities seems to be a natural fit as a proscriptive recommendation for improvement of both general health and suicide risk (Paluska & Schwenk, 2000; Richardson et al., 2005). By cultivating health-related volition and a message of health-engagement for laypersons, patients, and providers, a set of prevention strategies might be developed that is broad and comprehensive, integrative across multiple types of healthcare settings and population-level groups, and that can be customized to fit the life circumstances, values, and preferences of the individual client or patient (Chambers et al., 2005).

Conclusion

We have come together, as clinicians and practitioners, academicians and researchers, to better understand the potential contributions of positive psychological factors as a means of reducing suicide risk. In doing so, we also recognize the effectiveness of deficit reduction strategies and the criticality of reducing risk factors, such as depression and hopelessness, to alleviate suicide risk. We are not challenging these clinically supported strategies that embrace the reductionistic medical model of treatment but, rather, are encouraging the development of resiliency-based interventions that can be implemented complementarily and simultaneously to promote well-being and to reduce psychopathology and suicide risk. Burgeoning from early humanistic and existential theories, with a person-centered and self-actualizing approach, the principles of positive psychology have already been successfully applied to numerous domains, including business and management, public health,

and education. In this volume, our authors have applied positive psychological principles to the field of suicidology, in an approach we conceptualize as "applied resilience" in the service of preventing suicide; that is, Positive Suicidology.

Although not exhaustive, our authors have provided a broad overview of the potential of Positive Suicidology, including its breadth and depth, and its translational applicability in the form of development and implementation of therapeutic strategies. Ranging from the promotion of healthy, reciprocal interpersonal relationships, to the cultivation of meaningful interpersonal characteristics, such as gratitude and forgiveness, to encouraging healthy bodies and communities, the constructs and strategies offered in this volume provide insight into the vast possibilities for harnessing empowerment, motivation, and self-growth to reduce suicidal behavior and death by suicide. The fact that our cumulative effort is not exhaustive is encouraging as there are countless other adaptive, protective, and growth-centered constructs that can be investigated for this purpose. For instance, qualities such as grit and courage, experiences such as awe and flow, and the cultivation of religious and spiritual activity are but a few additional possibilities for engendering resiliency and, thereby, preventing suicide. We encourage future researchers and clinicians to continue this journey, solidifying empirical evidence for the Positive Suicidology approach, while expanding the scope of applicability of "applied resiliency" strategies. Human thriving is complex, and understanding the innate, learned and socially determined contributors to well-being and quality of life is an evolving science, yet our authors have provided an initial foray into these areas and have provided strong recommendations for the future of this work.

However, our authors also agree that more research is needed, including prospective and longitudinal studies and randomized controlled trials, utilizing gold-standard measures and diverse samples, to substantiate the role of positive psychological constructs in the prevention of suicide. Thus far, only one study has examined the impact of positive psychological interventions in a suicidal psychiatric sample (Huffman et al., 2014) and, although research is promising, much of Positive Suicidology is based on inferences derived from related constructs (e.g., depression, hopelessness) or basic associations between positive psychological factors and suicidality. The lack of randomized control trials and longitudinal studies highlights the need for more research in this area, but also offers a promising and unexplored area for future research. In addition to basic associations, it is important to investigate the mechanisms of action underlying these linkages, such as cognitive-emotional (e.g., emotion regulation and problem-solving abilities) and executive functioning processes (e.g., decision-making). As well, by investigating the relation of protective factors to known risk factors, a better understanding of the intertwining effect of predictors can be produced; for instance, the beneficial effect of future orientation on suicide may be hindered by factors such as perfectionism and rumination, but simultaneous reduction of rumination and perfectionism paired with bolstering future orientation may provide maximal benefit.

Direct comparisons of those with and without a specific protective characteristic are also important, as such differences may be directly or indirectly related to suicide risk. As an example, what makes a person more likely to be forgiving or

have more gratitude and, in turn, how are those etiological differences related to suicide risk? As well, can "profiles of protection" be delineated, and then cultivated therapeutically? The answers to such questions lie at the intersection of basic research, qualitative investigation, and intervention development, which requires attention from policymakers and funding bodies, and from future generations of researchers willing to boldly examine what, at times, might seem paradoxical. That is, the relation between positive psychology and psychopathology, which are in many respects at odds with one another, may be causally and irrevocably intertwined, requiring their conjunctive attention when addressed therapeutically. Finally, many authors suggest investigation of alternative forms of protective characteristics that might buffer against suicide risk, such as future orientation focused on the afterlife, optimism for specific (rather than general) life goals, or forgiveness of things yet to occur.

Understanding these intricacies is important for clarity and conceptualization, but it is also necessary to elevate protective characteristics from the level of theory, from the realm of well-being, and from healthy populations. Additional studies with clinical samples, including those at risk for suicide, as well as those recovering from suicidal ideation or attempt and, as we have suggested, with non-suicidal persons in a preventive manner, are needed to better understand the potential protective effects of positive psychology for suicide prevention. For instance, Heisel and colleagues suggest promoting meaning-making in a proactive manner, in anticipation of known, potentially stressful events (e.g., retirement) and for persons with sub-clinical symptoms. Such preemptive skill building, resulting in a reservoir of protective characteristics to be drawn upon in times of distress, may be a critical breakthrough for suicide prevention; as such, "applied resiliency" may be sufficient to disrupt the pathways of classic diathesis-stress models, perhaps preventing the transition from suicide ideation to attempt to death by suicide.

In closing, it is the hope of all authors in this volume that suicide—the most preventable of all causes of death—can be reduced, globally and across the lifespan, via the application of strengths-based, adaptive prevention and intervention efforts. We have discussed the history of positive psychology and supported its integration into the field of suicidology, in what we have termed this emerging field of Positive Suicidology. As Seligman and Csikszentmihalyi (2000) declared, if we only focus on the maladaptive side of human behavior to understand psychopathology, we are missing out on a significant portion of human behavior. Therefore, although we assert that reductionistic, deficit-oriented approaches certainly have a role in suicide prevention, given their past successes in reducing suicide risk, we devote our efforts toward the independent investigation and promotion of protective characteristics, in the form of applied resiliency, as both a complementary and primary approach to suicide prevention and intervention.

References

Abramson, L., Alloy, L., Hogan, M., Whitehouse, W., Gibb, B., Hankin, B., & Cornette, M. (2002). The hopelessness theory of suicidality. In T. E. Joiner & M. D. Rudd (Eds.), *Suicide science: Expanding the boundaries* (pp. 17–32). Norwell, MA: Kluwer Academic.

Allen, J., Mohatt, G. V., Rasmus, S. M., Hazel, K. L., Thomas, L., & Lindley, S. (2006). The tools to understand: Resilience in the study of minority stress and health of sexual and gender minorities. *Journal of Prevention & Intervention in the Community, 32*(1–2), 41–59. https://doi.org/10.1300/J005v32n01_04

Bagge, C. L., Lamis, D. A., Nadorff, M., & Osman, A. (2014). Relations between hopelessness, depressive symptoms and suicidality: Mediation by reasons for living. *Journal of Clinical Psychology, 70*(1), 18–31. https://doi.org/10.1002/jclp.22005

Beck, A. T. (1989). Cognitive therapy for depression and panic disorder. *Western Journal of Medicine, 151*(3), 311.

Bonanno, G. A. (2004). Loss, trauma, and human resilience: Have we underestimated the human capacity to thrive after extremely aversive events? *American Psychologist, 59*(1), 20–28. https://doi.org/10.1037/0003-066X.59.1.20

Boniwell, I., & Zimbardo, P. G. (2015). Balancing time perspective in pursuit of optimal functioning. In *Positive psychology in practice: Promoting human flourishing in work, health, education, and everyday life* (2nd ed., pp. 223–236). Hoboken, NJ: Wiley. https://doi.org/10.1002/9781118996874.ch13

Brausch, A. M., & Gutierrez, P. M. (2009). The role of body image and disordered eating as risk factors for depression and suicidal ideation in adolescents. *Suicide and Life-Threatening Behavior, 39*(1), 58–71. https://doi.org/10.1521/suli.2009.39.1.58

Britton, P. C., Van Orden, K. A., Hirsch, J. K., & Williams, G. C. (2014). Basic psychological needs, suicidal ideation, and risk for suicidal behavior in young adults. *Suicide and Life-Threatening Behavior, 44*(4), 362–371. https://doi.org/10.1111/sltb.12074

Brown, G. K., Beck, A. T., Steer, R. A., & Grisham, J. R. (2000). Risk factors for suicide in psychiatric outpatients: A 20-year prospective study. *Journal of Consulting and Clinical Psychology, 68*(3), 371–377 Retrieved from ISI:000087651500001.

Bryan, C. J., Wood, D. S., May, A., Peterson, A. L., Wertenberger, E., & Rudd, M. D. (2018). Mechanisms of action contributing to reductions in suicide attempts following brief cognitive behavioral therapy for military personnel: A test of the interpersonal-psychological theory of suicide. *Archives of Suicide Research, 22*(2), 241–253. https://doi.org/10.1080/13811118.2017.1319313

Castle, K., Conner, K., Kaukeinen, K., & Tu, X. (2011). Perceived racism, discrimination, and acculturation in suicidal ideation and suicide attempts among black young adults. *Suicide and Life-Threatening Behavior, 41*(3), 342–351. https://doi.org/10.1111/j.1943-278X.2011.00033.x

Chambers, D. A., Pearson, J. L., Lubell, K., Brandon, S., O'Brien, K., & Zinn, J. (2005). The science of public messages for suicide prevention: A workshop summary. *Suicide and Life-Threatening Behavior, 35*(2), 134–145. https://doi.org/10.1521/suli.35.2.134.62871

Chang, E. C., & Banks, K. H. (2007). The color and texture of hope: Some preliminary findings and implications for hope theory and counseling among diverse racial/ethnic groups. *Cultural Diversity and Ethnic Minority Psychology, 13*, 94–103.

Chang, E. C., Sanna, L. J., Hirsch, J. K., & Jeglic, E. L. (2010). Loneliness and negative life events as predictors of hopelessness and suicidal behaviors in hispanics: Evidence for a diathesis-stress model. *Journal of Clinical Psychology, 66*(12), 1242–1253. https://doi.org/10.1002/jclp.20721

Chang, E. C., Yu, E. A., Lee, J. Y., Hirsch, J. K., Kupfermann, Y., & Kahle, E. R. (2013). An examination of optimism/pessimism and suicide risk in primary care patients: Does belief in a changeable future make a difference? *Cognitive Therapy and Research, 37*(4), 796–804. https://doi.org/10.1007/s10608-012-9505-0

Cheavens, J. S., Cukrowicz, K. C., Hansen, R., & Mitchell, S. M. (2016). Incorporating resilience factors into the interpersonal theory of suicide: The role of hope and self-forgiveness in an older adult sample. *Journal of Clinical Psychology, 72*(1), 58–69.

Chesin, M. S., Sonmez, C. C., Benjamin-Phillips, C. A., Beeler, B., Brodsky, B. S., & Stanley, B. (2015). Preliminary effectiveness of adjunct mindfulness-based cognitive therapy to prevent suicidal behavior in outpatients who are at elevated suicide risk. *Mindfulness, 6*(6), 1345–1355. https://doi.org/10.1007/s12671-015-0405-8

Choi, N. G., DiNitto, D. M., Marti, C. N., & Segal, S. P. (2017). Adverse childhood experiences and suicide attempts among those with mental and substance use disorders. *Child Abuse & Neglect, 69*, 252–262. https://doi.org/10.1016/J.CHIABU.2017.04.024

Chu, C., Walker, K. L., Stanley, I. H., Hirsch, J. K., Greenberg, J. H., Rudd, M. D., & Joiner, T. E. (2018). Perceived problem-solving deficits and suicidal ideation: Evidence for the explanatory roles of thwarted belongingness and perceived burdensomeness in five samples. *Journal of Personality and Social Psychology., 115*(1), 137–160. https://doi.org/10.1037/pspp0000152

Conwell, Y., & Duberstein, P. R. (1995). Prevention of late-life suicide—When, where, why and how. *Psychiatry and Clinical Neurosciences, 49*, S79–S83. Retrieved from ISI:A1995RK10900005.

Cuijpers, P., de Wit, L., Kleiboer, A., Karyotaki, E., & Ebert, D. D. (2018). Problem-solving therapy for adult depression: An updated meta-analysis. *European Psychiatry: The Journal of the Association of European Psychiatrists, 48*, 27–37. https://doi.org/10.1016/j.eurpsy.2017.11.006

Dangel, T. J., Webb, J. R., & Hirsch, J. K. (2018). Forgiveness and suicidal behavior: Cynicism and Psychache as serial mediators. *Journal of Psychology: Interdisciplinary and Applied, 152*(2), 77–95. https://doi.org/10.1080/00223980.2017.1408555

Davis, R., Cook, D., & Cohen, L. (2005). A community resilience approach to reducing ethnic and racial disparities in health. *American Journal of Public Health, 95*(12), 2168–2173. https://doi.org/10.2105/AJPH.2004.050146

Dekel, S., Ein-Dor, T., & Solomon, Z. (2012). Posttraumatic growth and posttraumatic distress: A longitudinal study. *Psychological Trauma: Theory, Research, Practice, and Policy, 4*(1), 94–101. https://doi.org/10.1037/a0021865

Deyo, M., Wilson, K. A., Ong, J., & Koopman, C. (2009). Mindfulness and rumination: Does mindfulness training Lead to reductions in the ruminative thinking associated with depression? *EXPLORE: The Journal of Science and Healing, 5*(5), 265–271. https://doi.org/10.1016/j.explore.2009.06.005

Duckworth, A., Steen, T. A., & Seligman, M. E. P. (2004). Positive psychology in clinical practice. *Annual Review of Clinical Psychology, 1*(1), 629–651.

Ellis, J., & Smith, P. C. (1991). Spiritual well-being, social desirability and reasons for living: Is there a connection? *International Journal of Social Psychiatry, 37*(1), 57–63.

Emmons, R. A., & McCullough, M. E. (2003). Counting blessings versus burdens: An experimental investigation of gratitude and subjective well-being in daily life. *Journal of Personality and Social Psychology, 84*(2), 377–389. https://doi.org/10.1037/0022-3514.84.2.377

Frankl, V. E. (1984). *Man's search for meaning*. New York: Simon & Schuster.

Fredrickson, B. (2000). Cultivating positive emotions to optimize health and well-being. *Prevention and Treatment, 3*, 1–25.

Fredrickson, B., & Joiner, T. (2002). Positive emotions trigger upward spirals toward emotional well-being. *Psychological Science, 13*(2), 172–175.

Grossman, P., Niemann, L., Schmidt, S., & Walach, H. (2004). Mindfulness-based stress reduction and health benefits: A meta-analysis. *Journal of Psychosomatic Research, 57*(1), 35–43.

Gruber, J., Mauss, I. B., & Tamir, M. (2011). A dark side of happiness? How, when, and why happiness is not always good. *Perspectives on Psychological Science, 6*(3), 222–233. https://doi.org/10.1177/1745691611406927

Hamilton, J. M., Kives, K. D., Micevski, V., & Grace, S. L. (2003). Time perspective and health-promoting behavior in a cardiac rehabilitation population. *Behavioral Medicine, 28*(4), 132–139.

Heisel, M., & Flett, G. (2004). Purpose in life, satisfaction with life, and suicide ideation in a clinical sample. *Journal of Psychopathology and Behavioral Assessment, 26*(2), 127–135. https://doi.org/10.1023/B:JOBA.0000013660.22413.e0

Hill, P. L., Allemand, M., & Roberts, B. W. (2013). Examining the pathways between gratitude and self-rated physical health across adulthood. *Personality and Individual Differences, 54*(1), 92–96. https://doi.org/10.1016/J.PAID.2012.08.011

Hirsch, J. K., & Ellis, J. B. (1995). Family support and other social factors precipitating suicidal ideation. *International Journal of Social Psychiatry, 41*(1), 26–30. https://doi.org/10.1177/002076409504100103

Hirsch, J. K., & Ellis, J. B. (1998). Reasons for living in homosexual and heterosexual young adults. *Archives of Suicide Research, 4*(3), 243–248. https://doi.org/10.1023/A:1009696608895

Hirsch, J. K., Visser, P. L., Chang, E. C., & Jeglic, E. L. (2012). Race and ethnic differences in hope and hopelessness as moderators of the association between depressive symptoms and suicidal behavior. *Journal of American College Health, 60*(2), 115–125.

Hofmann, S. G., & Smits, J. A. J. (2008). Cognitive-behavioral therapy for adult anxiety disorders: A meta-analysis of randomized placebo-controlled trials. *The Journal of Clinical Psychiatry, 69*(4), 621–632. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/18363421

Huffman, J. C., DuBois, C. M., Healy, B. C., Boehm, J. K., Kashdan, T. B., Celano, C. M., ... & Lyubomirsky, S. (2014). Feasibility and utility of positive psychology exercises for suicidal inpatients. *General Hospital Psychiatry, 36*(1), 88–94.

Jacinto, G. A., & Edwards, B. L. (2011). Therapeutic stages of forgiveness and self-forgiveness. *Journal of Human Behavior in the Social Environment, 21*(4), 423–437.

Joiner, T. E., Van Orden, K. A., Witte, T. K., Selby, E. A., Ribeiro, J. D., Lewis, R., & Rudd, M. D. (2009). Main predictions of the interpersonal psychological theory of suicidal behavior: Empirical tests in two samples of young adults. *Journal of Abnormal Psychology, 118*(3), 634.

Kalra, G., Christodoulou, G., Jenkins, R., Tsipas, V., Christodoulou, N., Lecic-Tosevski, D., … European Psychiatry Association. (2012). Mental health promotion: Guidance and strategies. *European Psychiatry: The Journal of the Association of European Psychiatrists, 27*(2), 81–86. https://doi.org/10.1016/j.eurpsy.2011.10.001

Kelliher Rabon, J., Webb, J. R., Chang, E. C., & Hirsch, J. K. (2018). Forgiveness and suicidal behavior in primary care: Mediating role of future orientation. *Journal of Spirituality in Mental Health*, 1–13.

Keng, S. L., Smoski, M. J., Robins, C. J., Ekblad, A. G., & Brantley, J. G. (2012). Mechanisms of change in mindfulness-based stress reduction: Self compassion and mindfulness as mediators of intervention outcomes. *Journal of Cognitive Psychotherapy, 26*(3), 270–280.

Kim, S. M., Baek, J. H., Han, D. H., Lee, Y. S., & Yurgelun-Todd, D. A. (2015). Psychosocial-environmental risk factors for suicide attempts in adolescents with suicidal ideation: Findings from a sample of 73,238 adolescents. *Suicide and Life-Threatening Behavior, 45*(4), 477–487. https://doi.org/10.1111/sltb.12143

Laghi, F., Baiocco, R., D'Alessio, M., & Gurrieri, G. (2009). Suicidal ideation and time perspective in high school students. *European Psychiatry: The Journal of the Association of European Psychiatrists, 24*(1), 41–46. https://doi.org/10.1016/j.eurpsy.2008.08.006

Larsen, J. T., McGraw, A. P., & Cacioppo, J. T. (2001). Can people feel happy and sad at the same time? *Journal of Personality & Social Psychology, 81*, 684–696.

Laverack, G., & Labonte, R. (2000). A planning framework for community empowerment goals within health promotion. *Health Policy and Planning, 15*(3), 255–262. https://doi.org/10.1093/heapol/15.3.255

Leung, K. K., Chen, C. Y., Lue, B. H., & Hsu, S. T. (2007). Social support and family functioning on psychological symptoms in elderly Chinese. *Archives of Gerontology and Geriatrics, 44*(2), 203–213.

Linehan, M. M., Goodstein, J. L., Nielsen, S. L., & Chiles, J. A. (1983). Reasons for staying alive when you are thinking of killing yourself: The reasons for living inventory. *Journal of Consulting and Clinical Psychology, 51*(2), 276–286.

Mattis, J. S. (2002). Religion and spirituality in the meaning-making and coping experiences of African American women: A qualitative analysis. *Psychology of Women Quarterly, 26*(4), 309–321.

Meyer, I. H. (2015). Resilience in the study of minority stress and health of sexual and gender minorities. *Psychology of Sexual Orientation and Gender Diversity, 2*(3), 209–213. https://doi.org/10.1037/sgd0000132

Mills, P. J., Redwine, L., Wilson, K., Pung, M. A., Chinh, K., Greenberg, B. H., … Wood, A. (2015). The role of gratitude in spiritual well-being in asymptomatic heart failure patients. *Spirituality in Clinical Practice, 2*(1), 5.

O'Keefe, V. M., & Wingate, L. R. (2013). The role of hope and optimism in suicide risk for American Indians/Alaska natives. *Suicide and Life-Threatening Behavior, 43*(6), 621–633. https://doi.org/10.1111/sltb.12044

Orbach, I. (2007). Existentialism and suicide. In A. Tomer, G. T. Eliason, & P. T. Wong (Eds.), *Existential and spiritual issues in death attitudes* (pp. 281–316). Mahwah, NJ: Lawrence Erlbaum. Retrieved from https://books.google.com/books?hl=en&lr=&id=7BY4UtRFcE4C&oi=fnd&pg=PA281&dq=existential+therapy+suicide&ots=jFgXTe3XAW&sig=C3Hb4vNwzdOCzdaC7CrxuT3gJZ0#v=onepage&q=existential therapy suicide&f=false

Overholser, J. (1995). Cognitive-behavioral treatment of depression, part II: Techniques for improving social functioning. *Journal of Contemporary Psychotherapy, 25*(3), 205–222. https://doi.org/10.1007/BF02306629

Paluska, S. A., & Schwenk, T. L. (2000). Physical activity and mental health. *Sports Medicine, 29*(3), 167–180. https://doi.org/10.2165/00007256-200029030-00003

Pedrotti, J. T., Edwards, L. M., & Lopez, S. J. (2012). Positive psychology within a cultural context. In *The Oxford handbook of positive psychology* (pp. 49–57). Oxford: Oxford University Press. https://doi.org/10.1093/oxfordhb/9780195187243.013.0006

Range, L. M., & Penton, S. R. (1994). Hope, hopelessness, and suicidality in college students. *Psychological Reports, 75*(1), 456–458.

Recker, N. L., & Moore, M. D. (2016). Durkheim, social capital, and suicide rates across US counties. *Health Sociology Review, 25*(1), 78–91. https://doi.org/10.1080/14461242.2015.1101703

Reker, G. T., Peacock, E. J., & Wong, P. T. P. (1987). Meaning and purpose in life and well-being: A life-span perspective. *Journal of Gerontology, 42*(1), 44–49. Retrieved from http://geronj.oxfordjournals.org/content/42/1/44.abstract

Richardson, C. R., Faulkner, G., McDevitt, J., Skrinar, G. S., Hutchinson, D. S., & Piette, J. D. (2005). Integrating physical activity into mental health services for persons with serious mental illness. *Psychiatric Services, 56*(3), 324–331. https://doi.org/10.1176/appi.ps.56.3.324

Rippentrop, A. E., Altmaier, E. M., Chen, J. J., Found, E. M., & Keffala, V. J. (2005, August). The relationship between religion/spirituality and physical health, mental health, and pain in a chronic pain population. *Pain, 116*(3), 311–321. Retrieved from http://linkinghub.elsevier.com/retrieve/pii/S0304395905002216

Rudd, M. D., Rajab, M. H., & Dahm, P. F. (1994). Problem-solving appraisal in suicide ideators and attempters. *American Journal of Orthopsychiatry, 64*(1), 136–149. https://doi.org/10.1037/h0079492

Scheier, M. F., Carver, C. S., & Bridges, M. W. (1994). Distinguishing optimism from neuroticism (and trait anxiety, self-mastery, and self-esteem): A reevaluation of the life orientation test. *Journal of Personality and Social Psychology, 67*(6), 1063–1078. Retrieved from ISI:A1994PW57800009.

Seligman, M. E. P. (2011). Building resilience. *Harvard Business Review, 89*(4), 100–106. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/21510522

Seligman, M. E., & Csikszentmihalyi, M. (2000). Positive psychology: An introduction. *American Psychological Association, 55*(1), 5.

Sellin, L., Asp, M., Wallsten, T., & Wiklund Gustin, L. (2017). Reconnecting with oneself while struggling between life and death: The phenomenon of recovery as experienced by persons at risk of suicide. *International Journal of Mental Health Nursing, 26*(2), 200–207.

Shneidman, E. S. (1993). Commentary: Suicide as psychache. *The Journal of Nervous and Mental Disease, 181*(3), 145–147. Retrieved from http://journals.lww.com/jonmd/Fulltext/1993/03000/Commentary__Suicide_as_Psychache.1.aspx

Smith, N., Baugh Littlejohns, L., & Thompson, D. (2001). Shaking out the cobwebs: Insights into community capacity and its relation to health outcomes. *Community Development Journal, 36*(1), 30–41. https://doi.org/10.1093/cdj/36.1.30

Soleimanpour, S., Geierstanger, S., & Brindis, C. D. (2017). Adverse childhood experiences and resilience: Addressing the unique needs of adolescents. *Academic Pediatrics, 17*(7S), S108–S114. https://doi.org/10.1016/j.acap.2017.01.008

Stice, E., Ragan, J., & Randall, P. (2004). Prospective relations between social support and depression: Differential direction of effects for parent and peer support? *Journal of Abnormal Psychology, 113*, 155–159.

Suls, J., & Rothman, A. (2004). Evolution of the biopsychosocial model: Prospects and challenges for Health Psychology. *Health Psychology, 23*(2), 119–125. https://doi.org/10.1037/0278-6133.23.2.119

Taillefer, M. C., Dupuis, G., Roberge, M. A., & LeMay, S. (2003). Health-related quality of life models: Systematic review of the literature. *Social Indicators Research, 64*(2), 293–323.

Townsend, E., Hawton, K., Altman, D. G., Arensman, E., Gunnell, D., Hazell, P., … Van Heeringen, K. (2001). The efficacy of problem-solving treatments after deliberate self-harm: Meta-analysis of randomized controlled trials with respect to depression, hopelessness and improvement in problems. *Psychological Medicine, 31*(6), 979–988.

Utsey, S. O., Bolden, M. A., Lanier, Y., & Williams, O. (2007). Examining the role of culture-specific coping as a predictor of resilient outcomes in African Americans from high-risk urban communities. *Journal of Black Psychology, 33*(1), 75–93. https://doi.org/10.1177/0095798406295094

Van Orden, K. A., Witte, T. K., Cukrowicz, K. C., Braithwaite, S. R., Selby, E. A., & Joiner, T. E., Jr. (2010). The interpersonal theory of suicide. *Psychological Review, 117*(2), 575.

Varia, S. G., Ebin, J., & Stout, E. R. (2014). Suicide prevention in rural communities: Perspectives from a community of practice. *Journal of Rural Mental Health, 38*(2), 109–115. https://doi.org/10.1037/rmh0000019

Walsh, R., & Shapiro, S. L. (2006). The meeting of meditative disciplines and western psychology: A mutually enriching dialogue. *American Psychologist, 61*(3), 227–239. https://doi.org/10.1037/0003-066X.61.3.227

Webb, J. R., Hirsch, J. K., & Toussaint, L. (2015). Forgiveness as a positive psychotherapy for addiction and suicide: Theory, research, and practice. *Spirituality in Clinical Practice, 2*(1), 48–60.

Weinstein, N. D. (1987). Unrealistic optimism about susceptibility to health problems: Conclusions from a community-wide sample. *Journal of Behavioral Medicine, 10*(5), 481–500. https://doi.org/10.1007/BF00846146

West, L. M., Davis, T. A., Thompson, M. P., & Kaslow, N. J. (2011). "Let me count the ways:" Fostering reasons for living among low-income, suicidal, African American women. *Suicide and Life-Threatening Behavior, 41*(5), 491–500.

Wilson, T., Milosevic, A., Carroll, M., Hart, K., & Hibbard, S. (2008). Physical health status in relation to self-forgiveness and other-forgiveness in healthy college students. *Journal of Health Psychology, 13*(6), 798–803. Retrieved from http://hpq.sagepub.com/content/13/6/798.abstract

Witvliet, C. v. O., Ludwig, T. E., & Vander Laan, K. L. (2001). Granting forgiveness or harboring grudges: Implications for emotion, physiology, and health. *Psychological Science, 12*(2), 117–123. Retrieved from http://pss.sagepub.com/content/12/2/117.abstract

Wood, A. M., Froh, J. J., & Geraghty, A. W. A. (2010). Gratitude and well-being: A review and theoretical integration. *Clinical Psychology Review, 30*(7), 890–905. https://doi.org/10.1016/J.CPR.2010.03.005