Chapter 4
Reasons for Living

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Ada:
"What a death!
What a chance!
What a surprise!
My will has chosen life!
Still it has had me spooked and many others besides!"

(Campion, 1993)

Acronyms

ACT	Acceptance and Commitment Therapy
CAMS	Collaborative Assessment and Management of Suicidality
CB	Coping beliefs
CC	Child-related Concerns
CFC	College and Future-Related Concerns
CMLI	Chinese-language Motivations for Living Inventory
CS-RFLI	College Student Reasons for Living Inventory

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DBT	Dialectical Behavior Therapy
EMIL	Experienced Meaning in Life scale
FA	Family Alliance
FD	Fear of Death
FE	Future Expectations
FMS	Family Member Support
F/O	Family/Others
FO	Future Optimism
FR	Family Relations
FrS	Friend Support
FS	Fear of Suicide
FSD	Fear of Social Disapproval
HF	Hope for the Future
LS	Life Satisfaction
MBCT	Mindfulness Based Cognitive Therapies
MIL	Meaning in Life
MO	Moral Objections
MRO	Moral/Religious Objections
NIFM	Negative Impact on Family Members
NSSI	Non-Suicidal Self-Injury
PAS	Peer-Acceptance and Support
PASTOR	Positive Appraisal Style Theory of Resilience
PP	Positive Psychology
PR	Peer Relations
PRSI	Protective Reasons against Suicide Inventory
PSE	Positive Self-Evaluation
RB	Religious Beliefs
RF	Responsibility to Family
RFD	Reasons for Dying
RFF	Responsibility to Friends and Family
RFL	Reasons for Living
RFL-A	Reasons for Living Inventory for Adolescents
RFLI	Reasons for Living Inventory
RFL-OA	Reasons for Living for Older Adults scale
RFL-YA	Reasons for Living Inventory for Young Adults
SA	Suicide Attempt
SelfA	Self-Acceptance
SD	Suicide Death
SCB	Survival and Coping Beliefs
SI	Suicidal Ideation
SRC	Suicide-Related Concerns
TMBI	Teachable Moment Brief Intervention

Introduction

Reasons for Living (RFL) are reasons that persons can find for staying alive, things that matter most in their life, and those which may prevent them from dying by suicide. They are elements of life, including beliefs and values, interpersonal relationships, and socio-cultural and religious/spiritual concerns. Hence, they are specifically linked to the concept of resilience to suicidality, that is, the individual ability to buffer against the development of suicidality despite acute or chronic stressors or risk factors. Resilience variables have also been reviewed in their role as moderators of suicidal risk (buffering hypothesis; Johnson, Wood, Gooding, Taylor, & Tarrier, 2011). Two categories of variables have been identified: (1) cognitive abilities and processes (e.g., attributional style, coping and problem solving, personality, and emotional intelligence); and (2) beliefs and attitudes (e.g., self-related, other-related, and future-related beliefs). RFL have been conceptualized as a type of self-related belief, together with self-esteem, agency (e.g., sense of self-efficacy and internal locus of control), problem-solving confidence, and satisfactory life evaluations and purpose in life. In fact, RFL correspond to the *perception* of the patient, and they are a state-dependent phenomenon, which may not always be linked to external reality (for example, they are influenced by intrapersonal depressive states).

While previous research has mainly focused on the maladaptive characteristics of suicidal individuals (i.e., why individuals may want to end their life), Marsha Linehan and her team were the first to change the approach by providing an alternative perspective. Within a cognitive and cognitive-behavioral framework for suicidal behavior, hypothesizing that the cognitive pattern represents a substantial mediator of suicidal behavior, they focused on adaptive and life-maintaining beliefs and expectations and, consequently, developed the Reasons for Living Inventory (RFLI; Linehan, Goodstein, Nielsen, & Chiles, 1983). Our team of researchers recently performed a systematic review of the literature focused on the link between RFLI domains and suicidal thoughts and behaviors, in particular suicidal ideation (SI) and suicide attempt (SA), confirming the protective role of RFL (Bakhiyi, Calati, Guillaume, & Courtet, 2016).

However, RFL have been categorized in different ways after the introduction of the RFLI. Further, instruments differently categorizing RFL have been developed to be administered to adolescents, college students, and young adults, respectively: the Reasons for Living Inventory for Adolescents (RFL-A; Osman et al., 1998), the College Student Reasons for Living Inventory (CS-RFLI; Westefeld, Cardin, & Deaton, 1992), and the Reasons for Living Inventory for Young Adults (RFL-YA; Gutierrez et al., 2002). Furthermore, the Reasons for Living for Older Adults scale (RFL-OA; Edelstein et al., 2009) has been introduced, as well as two Chinese versions of the scale developed for the elderly, the Chinese-language Motivations for Living Inventory (CMLI; Wang, Tsai, Wong, & Ku, 2013) and the Protective Reasons against Suicide Inventory (PRSI; Wang, Tsai, Lee, Chen, & Chen, 2016). Furthermore, the Reasons for Living versus Reasons for Dying Assessment has been developed, in the context of the Collaborative Assessment and Management of

Suicidality (CAMS; Jobes & Mann, 1999). It has to be underlined that the involved teams of research derived the RFL from different populations (Bagge & Linehan, 2000), including: community (Linehan et al., 1983), college students (Westefeld et al., 1992), and low-lethality suicidal patients (Jobes & Mann, 1999).

The primary aim of this chapter is to provide the reader with a broad overview of the link between RFL and suicidal thoughts and behaviors, describing the main findings related to several scales developed for assessing RFL. We did not aim to perform a systematic review of the literature, but to include the main findings, leaving to the interested reader the task of extending and deepening the topic. Since our systematic review on the association between RFLI domains and suicidal thoughts and behaviors was recently published (Bakhiyi et al., 2016), in this chapter we wanted to extend the focus, including and comparing further assessment scales and critically evaluating this growing body of literature. We decided to consider here RFL scales that, to some extent, are different from one another (i.e., they have been specifically created for different populations or by different teams of researchers) in order to cover, as much as possible, all the different types of RFL. Our secondary aim was to describe specific therapeutic strategies for suicide prevention connected to RFL enhancement. In fact, the RFL assessment is relevant not only because it allows the distinction between individuals with and without suicide risk, but also because it could be useful in illuminating potential targets of therapeutic intervention.

Methods

A literature web search was performed to identify studies focusing on the link between RFL and suicidal thoughts and behaviors. PubMed database was used to search articles published from 1983 until June 2017 using the search terms "reason* for living" OR "RFL*" AND "suicid*". Only papers in English language were included. Additionally, the reference lists of the identified studies and reviews were checked for further relevant articles.

Concerning the primary aim of this chapter, studies were included if (1) they focused on the association between RFL, measured using different scales, and suicidal thoughts and/or behaviors; and (2) they focused not only on psychiatric patients but also on college students or the general population or any other group of any age. Studies were excluded if (1) they did not consider RFL but different, even if related, constructs (e.g., resilience); or (2) they did not consider suicidal thoughts and/or behaviors as an outcome. In the paragraph describing each RFLI-related scale, we focused on RFL scales with differences between them, rather than on those which mainly overlap. For example, we did not describe here the Brief Reasons for Living Inventory for Adolescents (Osman et al., 1996), because it is very similar to RFLI. Moreover, we did not include here the validation of the RFLI in other languages for the same reason, although the interested reader may find a number of versions: the Italian (Pompili, Girardi, Tatarelli, Lester, & Rogers, 2007),

in which only three factors were identified; the Spanish (Garza & Cramer, 2011), which yielded a seven factor structure; the Swedish (Dobrov & Thorell, 2004), in which two subscales formed one common factor; the Chinese (Chan, 1995); the Korean (Lee & Oh, 2012); and the Malaysian (Aishvarya et al., 2014). Concerning the secondary aim, studies were included if (1) they focused on any kind of therapeutic intervention; (2) they included RFL in the assessment or a related construct such as Meaning in Life (MIL); or (3) they included not only suicidal patients but also non-suicidal psychiatric patients, considering the paucity of studies focused on suicidal patients.

Further, studies have been included if interesting for both the primary and the secondary aims of this chapter (e.g., Kalisch, Muller, & Tuscher, 2015). Since this is not a systematic review of the literature, only the most representative studies have been included, and, given our recent review (see Bakhiyi et al., 2016), we did not report in detail already-discussed material from this paper (only referring to it as needed), but we reported any new studies since its publication. Moreover, in this chapter we did not focus on assessment scales of constructs deeply related to RFL, such as resilience (for a systematic review focused on the psychometric rigor of resilience scales, see Windle, Bennett, & Noyes, 2011). In addition, in some points of the text we considered the construct of MIL together with RFL, even though they only partially overlap.

Reasons for Living Assessment Scales

Reasons for Living Inventory

As noted above, the most well-known and used scale for the assessment of RFL is the RFLI, developed in 1983 by Marsha Linehan et al. (1983). It has been shown to have good internal consistency between items, as well as good test-retest reliability and convergent, discriminant, and factorial validity. Initially, 65 subjects from the community were asked to list (1) reasons for not killing themselves in a moment in their lives when they had the most serious suicidal thoughts, (2) reasons for not killing themselves at the current moment, and (3) reasons why other people do not kill themselves. In this manner, a total of 343 RFL were generated, then reduced to 72 statements and, finally, a 48-item questionnaire that focused on reasons for *not* dying by suicide was obtained, yielding six primary factors: Survival and Coping Beliefs (SCB), Responsibility to Family (RF), Child-Related Concerns (CC), Fear of Suicide (FS), Fear of Social Disapproval (FSD), and Moral Objections (MO; see Table 4.1 for examples of items for each factor, across different scales).

In the RFLI, subjects are asked to rate the importance, at the current moment, of each reason for not killing themselves on a 6-point Likert scale (1: Not at all important; 6: Extremely important). A minimum of 48 and a maximum of 288 could be obtained as a total score, with higher scores corresponding to greater RFL. However,

Table 4.1 Subscales and examples of items of the Reasons for Living Inventory (Linehan et al., 1983), Reasons for Living Inventory for Adolescents (Osman et al., 1998), College Student Reasons for Living Inventory (Westefeld et al., 1992), Reasons for Living Inventory for Young Adults (Gutierrez et al., 2002), Reasons for Living for Older Adults scale (Edelstein et al., 2009), Chinese-language Motivations for Living Inventory (Wang et al., 2013), Protective Reasons against Suicide Inventory (Wang et al., 2016), and Reasons For Living of Collaborative Assessment and Management of Suicidality (Jobes & Mann, 1999)

RFLI	RFL-A	CS-RFLI	RFL-YA	RFL-OA	CMLI	PRSI	RFL (CAMS)
48 items	32 items	46 items	32 items	69 items	15 items	20 items	No items
Survival and Coping Beliefs		*Survival and Coping Beliefs*	*Coping Beliefs*	*Survival and Coping Beliefs*		*Life Satisfaction*	*Enjoyable Things*
I believe I can learn to adjust or cope with my problems.		I have confidence in my ability to deal with problems.	When faced with a problem, I work hard to understand and avoid similar problem situations.	I have learned to laugh at my troubles and not take life too seriously.		My life is better than in the past.	Any mention of activities or objects that are enjoyed.
I believe I have control over my life and destiny.		I believe I can cope with my problems.	After an argument, I prefer to focus on dealing with the situation rather than attempt to kill myself.	I have coped before and I can do it again.		My life is very smooth.	
	Future Optimism		*Future Expectations*		*Hope for the Future*	*Hope for the Future*	*Hopefulness for the Future*
I have hope that things will improve and the future will be happier.	I expect many good things to happen to me in the future.	I am looking forward to the future.	My future looks quite hopeful and promising.	Tomorrow I may feel better.	Even though I am getting older, I still have hope for the future.	Even though I am getting older, I still have hope for the future.	Future-oriented statements that deal with vague abstract yearnings, expressing a hopeful attitude or a curiosity of how the future will be.

I am curious about what will happen in the future.	I am hopeful about my plans or goals for the future.		I look forward to many fun things in the future.	I am curious about what will happen in the future.	My future is full of expectations.	I still have many plans that I intend to complete.	
		College and Future-Related Concerns					*Plans and Goals*
I still have many things left to do.	I have a lot to look forward to as I grow older.	I want to put my college degree to good use.	I have many plans I am looking forward to carrying out in the future.	I want to see my grandchildren grow up.			Statements referring to future-oriented plans, expressing a desire to see something through or left to be completed.
I want to experience all that life has to offer and there are many experiences I haven't had yet which I want to have.	I would like to accomplish my plans or goals in the future.	I have my career to look forward to.	I would like to see my plans (have a job, career, or family) for the future come true.	I still have many things left to do.			
Responsibility to Family		*Responsibility to Friends and Family*		*Responsibility to Family/Others*		*Negative Impact on Family Members*	*Responsibility to Others*
It would hurt my family too much and I would not want them to suffer.		I have a responsibility and commitment to my family.		My spouse requires care.		Suicide causes distress for family members.	Any mention of responsibilities or obligations owed to others. These responses may also refer to protecting others.

(continued)

Table 4.1 (continued)

RFLI	RFL-A	CS-RFLI	RFL-YA	RFL-OA	CMLI	PRSI	RFL (CAMS)
48 items	32 items	46 items	32 items	69 items	15 items	20 items	No items
My family depends upon me and needs me.		It would cause a lot of guilt and pain for my friends.		It would hurt my family too much, I would not want them to suffer.			
Child-Related Concerns							
The effect on my children could be harmful.				I have a responsibility to my pet.		Suicide would lead to my children being blamed by others as unfilial.	
It would not be fair to leave the children for others to take care of.						Suicide makes children sad.	
							Burdening Others
							Any mention to not be a burden for others.
	Family Alliance		*Family Relations*		*Family Member Support*	*Family Member Support*	*Family*

	Whenever I have a problem, I can turn to my family for support and advice.		My family gives me the love I need.	I have a loving family who supports me through bad times.	When I feel distress, I can get support from my family.	When I feel distress, I can get support from my family.	Any references to family such as marriage or children.
	I enjoy being with my family.		I have a close relationship with my family.		My family spends time listening to my experiences.	I enjoy hanging around with my family.	
	Peer-Acceptance and Support		*Peer Relations*		*Friend Support*	*Friend Support*	*Friends*
	My friends stand by me whenever I have a problem.		I have close friends who are willing to help in times of need.		When I feel distress, I can get support from my friends.	When I feel distress, I can get support from my friends.	Any mention of friends, including specific names.
	I feel loved and accepted by my close friends.		I have close friends who really care a lot about me.		I can feel love and acceptance from my close friends.	I believe that my friends enjoy spending time with me.	
Fear of Suicide	*Suicide-Related Concerns*	*Fear of Suicide*		*Fear of Suicide*	*Fear of Death*	*Fear of Death*	
I am afraid of the actual "act" of killing myself (the pain, blood, violence).	It would be painful and frightening to take my own life.	I'd be afraid of trying it and failing.		I am afraid that my method of killing myself would fail.	I am afraid of death, so I don't consider killing myself.	I am afraid of suicide.	

(continued)

Table 4.1 (continued)

RFLI	RFL-A	CS-RFLI	RFL-YA	RFL-OA	CMLI	PRSI	RFL (CAMS)
48 items	32 items	46 items	32 items	69 items	15 items	20 items	No items
I am a coward and do not have the guts to do it.	I am afraid to die, so I would not consider killing myself.	I'm scared of the pain that I would experience.		I am afraid of death.	Suicidal ideas make me fearful.	Suicidal ideas make me fearful.	
Fear of Social Disapproval		*Fear of Social Disapproval*					
Other people would think I am weak and selfish.		I would be afraid of what others might think.		I am concerned about what others would think of me.			
I am concerned about what others would think of me.		Killing myself would show a lack of character.					
Moral Objections		*Moral Objections*		*Moral/Religious Objections*		*Religious Beliefs*	*Beliefs*
My religious beliefs forbid it.		It is against my religious beliefs to commit suicide.		I consider it morally wrong.		Suicide will be repeated and suffered in the next life.	Statements referring to religion.
I consider it morally wrong.		I believe that only God has the right to end life.		Committing suicide would prevent me from going to heaven.		My religious beliefs stop me from killing myself.	
	Self-Acceptance		*Positive Self-Evaluation*		*Self-Acceptance*		*Self*

	I accept myself for what I am.		I am happy to be the person I am.		I accept myself.		Specific references to self or feelings or qualities about the self.
	I am satisfied with myself.		I have a great deal of respect for myself.		I feel that my health condition is ok.		

RFLI Reasons for Living Inventory, *RFL-A* Reasons for Living Inventory for Adolescents, *CS-RFLI* College Student Reasons for Living Inventory, *RFL-YA* Reasons for Living Inventory for Young Adults, *RFL-OA* Reasons for Living for Older Adults scale, *CMLI* Chinese-language Motivations for Living Inventory, *PRSI* Protective Reasons against Suicide Inventory, *RFL* Reasons for Living, *CAMS* Collaborative Assessment and Management of Suicidality

from a clinical perspective, the most important aspects are scores for each subscale, because they allow a better understanding of the subject's specific protective factors and on which factor(s) therapy should center the attention.

Regarding subscale meaning, the Survival and Coping Beliefs subscale has two parts: the first is associated with confidence in the personal ability to adequately face challenges in life; the second contains general positive expectations for the future. SCB are closely positively related to an individual's self-efficacy, or one's personal conviction to be able to succeed in specific situations or accomplish a task (Bandura, 1977), and negatively related to hopelessness (Range & Penton, 1994). Responsibility to Family includes the commitment of the individual to her/his family (e.g., spouse, siblings, parents) and an evaluation of the amount of suffering that her/his death could cause to the family. Child-Related Concerns involve the individual's concerns about the impact of her/his death on her/his children. Fear of Suicide relates to the level of fear toward death and suicide. In this context, it is interesting to briefly mention the Interpersonal Theory of Suicide by Joiner et al. (Joiner, Brown, & Wingate, 2005; Van Orden et al., 2010), which suggests that suicide is related to (1) the desire to die by suicide and (2) the capability to die by suicide. The acquired capability of suicide arises from fearlessness in relation to death: when individuals repeatedly expose themselves to physical pain (e.g., tattoos, cutting) and fear-inducing events (e.g., combat experience, previous SA), they reduce their fear of death and increase their capability for suicide. As such, we can speculate that FS might be related to this concept. Fear of Social Disapproval reflects an individual's concern about others' judgment of her/his suicidal act. Finally, Moral Objections refer to religious or moral beliefs against suicidal acts; for individuals with strong religious or moral values, particularly those related to religions forbidding suicide, this RFL can be an important protective factor (Kralovec, Kunrath, Fartacek, Pichler, & Ploderl, 2017).

As stated above, recently we systematically reviewed the literature concerning RFLI and suicidal thoughts and behaviors (39 studies; Bakhiyi et al., 2016). Overall, a high total RFLI score was found to be potentially protective against both SI and SA in clinical and non-clinical samples. We should state "potentially protective" because, despite the negative association between RFL and suicidal thoughts and behaviors, other factors might moderate the RFL protective effect (e.g., cognitive abilities and processes, attributional style, coping and problem solving, and emotional intelligence; Johnson et al., 2011). Moreover, low RFL seemed to be associated with specific characteristics of suicidality, such as suicide intent, SA lethality (Oquendo et al., 2005), and the sum of the scores for hopelessness, subjective depression, and SI (a measure of "clinical suicidality"; Malone et al., 2000). Unfortunately, in this review we were unable to find any study focused on suicide death (SD). Moreover, non-suicidal self-injury (NSSI) has not been taken into account in the review but deserves future attention, considering its connection with SI, SA, and SD (Hamza, Stewart, & Willoughby, 2012). For example, in a recent study conducted with adolescents engaging in both NSSI and repeated fire-setting, the Brief Reasons for Living Inventory for Adolescents (14 items) was administered (Tanner, Hasking, & Martin, 2015). Specifically, adolescents who had attempted

suicide reported lower SCB scores than ones with SI and ones with no suicidality. No difference in SCB was observed between adolescents with SI and those with no suicidality.

When we focused on specific RFL, SCB and MO seemed to have a specific protective role against SI and SA. The perception of personal ability to cope with or generate solutions to problems (i.e., self-efficacy), together with general positive expectations for the future and religious or moral beliefs against suicide, could offer greater protection against suicidal thoughts and behaviors, as these are self-related qualities in comparison to, for example, RF, CC, or FSD, which are subscales focused on one's relation with others. Findings on CC are promising as well, even though only a few studies have investigated it (four studies were included in our past review, three of them with significant results): individuals with high CC scores were less likely to report SI or SA (Bakhiyi et al., 2016). Results on FS are inconsistent, since the majority of published studies did not report significant results on both SI and SA (Bakhiyi et al., 2016). This could be interpreted in the context of the Interpersonal Theory of Suicide (Joiner et al., 2005; Van Orden et al., 2010), in which fearlessness alone in relation to death is not sufficient for suicide to arise, but must be jointed to suicide desire, that is, linked to the perception of being alone (thwarted belongingness) and being a burden to others (perceived burdensomeness). Another explanation could be the presence of individual heterogeneity in terms of exposure to events that increase the capability to die by suicide: subjects who have never been exposed to such events (e.g., chronic pain conditions, self-cutting) are different from those who have been (Hooley, Franklin, & Nock, 2014). Hence, future studies may assess this heterogeneity.

Results on RF and FSD are inconsistent as well. Interestingly, depressed patients with high RF reported increased hopelessness and higher SI rate and severity (Britton et al., 2008), while among individuals with substance abuse or dependence (as assessed in outpatient setting and prison), high FSD was linked to higher suicide risk (Mohammadkhani, Khanipour, Azadmehr, Mobramm, & Naseri, 2015). Hence, on the one hand, others (e.g., family and society) could be perceived as a burden, and the suicidal act in this case could represent an aggressive act against the other in the attempt to eliminate the onerousness of relationships; whereas, on the other hand, such an action may also be linked to the perception of the self as a burden (i.e., perceived burdensomeness).

Cultural differences have been reported as well. In a United States study, compared to non-Latinos, Latinos reported significantly less SI, less lethal SA, and higher SCB, RF, and MO; however, multivariate analyses showed that, while lower SI was independently associated with being Latino, other suicidal behaviors (e.g., suicide intent and lethality of SA) were more strongly associated with SCB and MO in comparison to ethnicity (Oquendo et al., 2005).

After the publication of our review, further studies have been published, substantially confirming the protective role of RFL on SI and SA in patients with depression (Luo, Wang, Wang, & Cai, 2016), with co-morbid psychopathology (Tillman et al., 2017), and in nursing students (Leal & Santos, 2016). For instance, our team of researchers focused on the interaction between life events and RFL on current SI

in a sample of patients with past SA (Laglaoui Bakhiyi et al., 2017), confirming the negative association between RFL (total scores and all the subscales with the exception of FS) and SI. However, neither interaction nor additive effect between positive life events and RFLI total score were significant for SI.

A systematic review has been recently published on religion and suicide risk (89 included articles; Lawrence, Oquendo, & Stanley, 2016), with most research focusing on two primary aspects of religion: religious affiliation and attendance at religious services. Religious affiliation seems to be protective against SA and the severity of SA and SD, but not against SI. This is in line with clinical experience, reflecting the fact that individuals may think about suicide but would never attempt suicide because of their religion, but it is also in contrast with the finding of a negative correlation between MO and SI (Bakhiyi et al., 2016). This may be because religious affiliation, or simple belonging, represents a different construct in comparison to MO, which comprises religion-related prohibitions and moral objections to suicide. Hence, we can explain this conflicting result with the limitations linked to the religious affiliation variable, which is wide-ranging. Moreover, adhering to a minority religious affiliation might also increase suicide risk through increased feelings of isolation. As an example, according to the strain theory of suicide, which requires the presence of at least two pressures (e.g., differential values, discrepancy between aspiration and reality, relative deprivation, and lack of coping skills), religiosity in China could be related to suicide since China has a traditional polytheistic religion (e.g., for some, not exactly a religion but a combination of cultural practices), and so to follow a specific religion in China is often still considered deviant (Zhang, Wieczorek, Conwell, & Tu, 2011). The attendance at religious services seemed to be associated with lower suicide risk, but this finding could be related to the fact that service attendance might create opportunities for social support, rather than to religion itself. When social support was taken into account among covariates, service attendance was found to be protective only against SA but not SI (Lawrence, Brent, 2016); however, this dimension seems more distant from MO.

In the same year of the publication of this review on religion and suicide (Lawrence, Oquendo, & Stanley, 2016), an original study was performed by the same team of researchers (Lawrence, Brent, et al., 2016). Interestingly, different results have been reported. After adjusting for sex, ethnicity, age, number of biological children, and total RFLI scores, (1) depressed patients with a religious affiliation reported a higher rate of past SA, and (2) depressed patients who considered religion more important and who attended services more frequently reported higher SI.

So, in addition to the already reported issues in the assessment of the religion role, the authors suggested that a deep understanding of the link between religion and suicide risk requires both "a sensitivity to the individual's life narrative and how he/she experiences being a member of that religious group," and information on potential "negative religious coping" strategies (e.g., to defer all the responsibility to God, to feel abandoned by him or to wish to die to be with him; Lawrence, Brent, et al., 2016). This issue may need prospective studies to understand the direction of the association; for instance, religion may become a coping strategy for suffering patients, or it may complicate coping efforts.

Summarizing, we are able to confirm the conclusion of our previous review (Bakhiyi et al., 2016), reporting that a high total score on the RFLI seems to be potentially protective against both SI and SA, and SCB and MO seem to be predominantly involved. In the future, SCB should be disentangled from further self-related beliefs (e.g., self-esteem, self-efficacy, internal locus of control, and problem-solving confidence). MO seems to be an efficacious construct for the identification of protective factors against not only SA but also SI. However, the importance of an appropriate integration between nomothetic and idiographic approaches (i.e., the study of inter-individual variations to find generalization laws versus the study of intra-individual variations that render each individual unique) should always be emphasized (Lyon et al., 2017).

Review of Additional Scales Developed from the RFLI

Numerous other instruments assessing RFL have been developed, originating from the RFLI but with different subscales: the Reasons for Living Inventory for Adolescents (RFL-A; Osman et al., 1998), the College Student Reasons for Living Inventory (CS-RFLI; Westefeld et al., 1992), the Reasons for Living Inventory for Young Adults (RFL-YA; Gutierrez et al., 2002), and the Reasons for Living for Older Adults scale (RFL-OA; Edelstein et al., 2009; see Table 4.1).

The 32-item RFL-A was developed by Osman et al. (Osman et al., 1998) by assessing a sample aged 14–18 years. It was introduced because of the problem of using an adult measure with adolescents. The scale showed convergent, discriminant, and construct validities and a high Cronbach's α coefficient (internal consistency). It is consistently different from the RFLI. Five factors were identified, only two of which were already present in the RFLI: Suicide-Related Concerns (SRC), which corresponds to FS, and Future Optimism (FO), which matches with a portion of SCB, specifically the items related to hope for the future, and plans and goals. Three factors were different: Family Alliance (FA) and Peer-Acceptance and Support (PAS), which focused on the consideration of family and friends as sources of support, and Self-Acceptance (SelfA), which is linked to acceptance and positive feelings related to the self. No further findings were reported on this scale after the publication of our review (Bakhiyi et al., 2016).

A college student version of the RFLI was developed by Westefeld et al. (1992) to investigate whether students would generate different RFL from adults. The hypothesis was that college students could have partially different RFL, considering the delicate developmental phase they are facing. A pool of 271 RFL (reasons why students would *not* die by suicide) was generated by 125 college students and then reduced to 84 items, which were subsequently administered to 384 college students; at the end, a final inventory of 46 items was created, the CS-RFLI. Four factors present in the RFLI were found in college students as well (SCB, FS, FSD, and MO) and a fifth, RF, was slightly changed into Responsibility to Friends and Family (RFF). RFF includes the commitment of the student to the family, and the evaluation of

pain caused not only to family members but also to friends. CC were not included in the measure; whereas, the College and Future-Related Concerns (CFC), a college-specific subscale, was added, which corresponds to plans and hopes for the future.

The RFL-YA is a 32-item inventory developed to be administered to young adults aged 17–30 years (Gutierrez et al., 2002). To motivate the validation of this scale, the authors mentioned two major limitations of the CS-RFL: the extensive overlap between it and the RFLI, with the consequent limit in the exploration of other dimensions, and the CS-RFL's length. Cronbach's α estimates for the subscales ranged from 0.89 to 0.94. Concurrent, convergent-discriminant, and criterion validity were obtained. The RFL-YA is similar, in some ways, to the RFL-A, including the identification of five factors: Coping Beliefs (CB), Future Expectations (FE), Family Relations (FR), Peer Relations (PR), and Positive Self-Evaluation (PSE). CB partially correspond to SRC in the other scales. FE correspond to FO, FR to FA, PR to PAS, and PSE to SelfA, in the RFL-A.

The 69-item Reasons for Living for Older Adults scale (RFL-OA) comprises four subscales, all similar to the ones in the RFLI: SCB, RF, FS, and Moral/Religious Objections (MRO; Edelstein et al., 2009). Forty-one of the 69 items differed from those in the original RFLI, with differences in items intended to reflect age-related changes (e.g., "I want to see my grandchildren grow up"). The RFL-OA was administered in a recent study on older adults (Heisel, Neufeld, & Flett, 2016). Heisel et al. (2016) reported an association between RFL-OA scores and SI, which was mediated by MIL, assessed with the 40-item Experienced Meaning In Life scale (EMIL; Heisel, 2009). EMIL consisted of four subscales: Creative (e.g., "I enjoy participating in recreational activities"); Experiential (e.g., "The beauty of nature is uplifting to me"); Attitudinal (e.g., "I try to find meaning in life even when I am suffering or in pain"); and Ultimate Meaning (e.g., "My spirituality helps me feel connected with something greater than myself").

Review of Chinese RFL Scales

Two scales have been validated independently from the Chinese version of the RFLI, the dimensions of which closely corresponded to the original RFLI dimensions (Chan, 1995), and they could be of interest for the purpose of this chapter.

A Chinese version of the scale, the Chinese-language Motivations for Living Inventory (CMLI), has been developed by Yi-Wen Wang and colleagues for older male residents of veterans' homes (Wang et al., 2013); Motivations for Living has been used by the authors, as a synonym of RFL. It includes five clusters of three items each (15 items in total): Family Member Support (FMS), Friend Support (FrS), Hope for the Future (HF), Fear of Death (FD), and Self-Acceptance (SelfA; Table 4.1). FMS corresponds to receipt of support from family and the enjoyment of being with family, so it is not linked to a sense of responsibility toward the family. Similarly, FrS is related to the perception of support, love, and acceptance from friends and, in this case, to the belief that friends enjoy staying with the subject. HF

is related to hope, plans, and expectations for the future. FD corresponds to fear of death and suicide. SelfA relates to satisfaction about the self; moreover, it evaluates, through one item ("I feel that my health condition is ok"), the satisfaction on the subject's healthiness, evidencing its important impact among older people. In fact, the link between suicidal behavior and functional disability and specific physical conditions has been quite established among older adults (Fassberg et al., 2016), as well as the relation between suicidal thoughts and behaviors and physical pain (Calati, Laglaoui Bakhiyi, Artero, Ilgen, & Courtet, 2015). In the validation study, subjects with no SA had higher CMLI scores than subjects who had attempted suicide in the previous 3 months (global score and all subscales scores), revealing good criterion validity (Wang et al., 2013). Moreover, the scale had good content validity, and both inventory reliability and intraclass correlation coefficient were satisfactory.

To overcome limitations of the previous scale (CMLI), since its validation was conducted in institutions, and considering the paucity of similar scales to assess older Chinese-speaking people, the same team of researchers developed a new scale for assessing suicidality in older people who live in the community, the 20-item Protective Reasons against Suicide Inventory (PRSI; Wang et al., 2016). Seven factors have been identified (Table 4.1): four were already present in the CMLI (FMS, FrS, HF, and FD), and an additional three factors include Life Satisfaction (LS), Negative Impact on Family Members (NIFM), and Religious Beliefs (RB; Table 4.1). In the validation study, in primary care settings, outpatients without SI had higher scores than outpatients with SI (also in this case, both total score and subscales scores), indicating good criterion validity (Wang et al., 2016). Furthermore, the scale had excellent content validity and face validity, while inventory reliability and intraclass correlation coefficient were satisfactory.

Reasons for Living Versus Reasons for Dying Assessment

The Reasons for Living (RFL) versus Reasons for Dying (RFD) Assessment has been developed by David A. Jobes and Rachel E. Mann (Jobes & Mann, 1999) in the context of the Collaborative Assessment and Management of Suicidality (CAMS) protocol (Jobes, 2012), an evidence-based clinical intervention for suicidal risk patients. CAMS relies on the use of the Suicide Status Form (SSF), which is a seven-page clinical assessment, treatment planning, tracking, and outcome tool, comprising both quantitative rating scales and qualitative open-ended items.

Embedded within the SSF qualitative assessment, there is the RFL versus RFD Assessment. The patient is required to list up to five RFL and five RFD, and to then rank them in order of importance (from 1 to 5). In their development of the instrument, Jobes and Mann organized the patient-generated RFL and RFD (from 49 low-lethality suicidal patients, mostly suicidal ideators) into categories (Jobes & Mann, 1999), including 173 responses for the RFL and 145 responses for the RFD. Nine different RFL clusters were identified (Jobes, 2012): Family, Friends,

Responsibility to Others, Burdening Others, Plans and Goals, Hopefulness for the Future, Enjoyable Things, Beliefs, and Self (Table 4.1). Similarly, nine RFD clusters were recognized: Relationships, Unburdening Others, Loneliness, Hopelessness, General Descriptors of Self, Escape in General, Escape the Past, Escape the Pain, and Escape Responsibilities.

The authors recognized that the RFL/RFD assessment reveals the "internal struggle hypothesis" of suicidal behavior as proposed by Maria Kovacs and Aaron T. Beck; that is, suicide attempters are a heterogeneous group, many of whom manifest an internal struggle and may not have a unidirectional motivation to die (Kovacs & Beck, 1977). This hypothesis has its origin in one of the basic concepts of psychoanalysis—the constant conflict during life, between death and life drives: the Freudian metaphor of the struggle between Eros (Ἔρως, the drive toward life) and Thanatos (Θάνατος, the drive toward self-destruction; Freud, 1920).

Comparison Between Different RFL Scales

In this section, and in Table 4.1, we integrate and juxtapose the factors identified in each mentioned scale. In the first version of the scale (RFLI), as well as in RFL-OA, SCB seemed to have a specific protective role against SI and SA, as we have seen. There are a number of items related to hope for the future that, in other scales (RFL-A, RFL-YA, CMLI, PRSI, and RFL of CAMS), is a separate factor. Although, in these five scales, a separate factor related to hope for the future is present: future-related plans, which are more specific than general hope, represent a separate factor in two scales only (CS-RFLI and RFL of CAMS); however, plan-related items are present in the other scales as well, except for the Chinese ones. This difference could be culturally mediated or related to the fact that the Chinese scales are for the elderly, so future planning specifically related to career or family, for instance, could be absent based on one's older age. However, although future plans are not necessarily present in the scales for the elderly, focusing on future medium- and short-term plans should still be an emphasis of treatment in older adults.

Responsibility to family and friends is not present in both versions for adolescents and young adults (RFL-A and RFL-YA); however, in the context of therapy with adolescents, it could be useful to inquire as to how family and friends might feel when facing their death. Surprisingly, in the RFLI, family and friends were only considered in terms of responsibility, whereas in all the other scales, except the CS-RFLI, family and friends were considered in terms of support, care, and feelings of acceptance.

Another difference found among the scales was the lack of fear of death/suicide in the RFL-YA and in the RFL of CAMS (Bagge & Linehan, 2000). FSD was only present in RFLI and CS-RFLI. Moral objections/religious beliefs were not present in both RFL-A and RFL-YA and in the CMLI. Concerning the Chinese scale, Wang and colleagues provided an interpretation concerning the lack of religious beliefs subscale (Wang et al., 2013): the Chinese traditional polytheistic religion could ren-

der difficult the conceptualization of religion's impact on an individual's life. The subscale related to positive feelings or qualities about the self and self-acceptance was not present in RFLI, CS-RFLI, RFL-OA, and PRSI. In this case, we believe that this factor should be better analyzed, and differentiated from the self-esteem variable: in fact, the association between low self-esteem and suicidal behaviors has been reported (Mann, Hosman, Schaalma, & de Vries, 2004) and the concepts of self-acceptance and self-esteem were found to be similar, even if they are not synonymous (MacInnes, 2006).

In contrast to Linehan et al. (1983) asking participants reasons for *not wanting to kill themselves*, Jobes and Mann asked subjects their reasons for *wanting to live* (Jobes & Mann, 1999). However, remarkably, the different questions generated similar responses, so we can speculate that reasons to not kill themselves and reasons for living could overlap.

Importantly, Jobes and Mann underlined that their combined assessment is different from the assessment of either RFL or RFD separately (Jobes & Mann, 2000). As previously stated, they grounded their measure using the "internal struggle hypothesis" (Kovacs & Beck, 1977), and argued that the focus of suicidology should not be on only what makes life worth living, but on death drives as well, to provide to the patients tools to identify, manage, and cope with death drives, beginning with recognizing them together with the patient during the sessions, and proposing to the patient alternative coping strategies.

Overview of Qualitative Research with RFL

In the field of suicide prevention, qualitative research represents a precious instrument for both researchers and clinicians to gain better access to patients' feelings and thoughts, and to better understand the meaning patients ascribe to their experiences. From a systematic review and thematic content analysis on how individuals live with suicidality or recover from it, which included 12 studies, the connection with others (i.e., having direct interpersonal relationships and sharing the same cultural and/or religious background) was associated with MIL (Lakeman & FitzGerald, 2008). We may hypothesize that this connection with others, given its ubiquity, could be linked to the recognition of them as a RFL. The reconnection with others, culture, or God was associated with recovery or resolution of crisis among suicidal individuals. In particular, in one of the analyzed studies, the relationship with caring nurses appeared to be substantially different from relationships with others (Cutcliffe, Stevenson, Jackson, & Smith, 2006). For example, in the early recovery stages, caring nurses rendered possible the reconnection of the suicidal person with humanity, in a moment in which the relations with others were otherwise too difficult. The authors described three stages in this process of reconnection, including reflecting an image of humanity, guiding the individual back to humanity, and learning to live.

In another systematic review and content analysis examining reasons why elderly have self-harmed (eight included studies), themes related to sense of alienation from others (family and society), disconnectedness from family and health care providers, and sense of invisibility and meaningless ("the perception of being no longer able to give to others or to achieve anything more in life, and a desire to feel useful and needed") emerged (Wand, Peisah, Draper, & Brodaty, 2017). In this case, the focus was more on RFD, inversely related to RFL domains such as support from others and SCB.

Furthermore, in an original qualitative study on Taiwanese elderly outpatients with SI, three themes were identified from interviews (Huang, Tsai, Liu, & Chen, 2017): SI triggers (e.g., physical discomfort, loss of respect and/or support from family, impulsive emotions due to conflicts with others, and painful memories), psychological changes contributing to SI (e.g., feelings of loneliness, a sense of helplessness, or lack of self-worth), and factors of adaptive response (e.g., support from family and friends, control of emotions, establishing a support network, comfort from religion, medication, and focusing on the family). In this case, thematic results that could be associated with RFL include connection with others and religious beliefs.

From these qualitative contributions, relations with others, receiving support from others, and sharing a common background with others emerged as fundamental RFL that can contribute to meaning in life. From clinical experience, however, we know that, in some moments of life, everyday relationships may not be sufficient and may even represent a burden, and some individuals could manifest the need to receive support from a mental health specialist. In this case, the most meaningful relation could be between patient and clinician; therefore, clinicians should be equipped to literally embody the RFL of the patient, just for a transient phase for most cases, and for extremely long periods for some others (e.g., chronically, mentally ill persons).

Concerning the sense of meaningless, we would like to briefly describe an experience with a psychotic patient who was institutionalized in a therapeutic community. Since he had motivational difficulty getting out of bed, the director of the community decided to assign him an extremely important task: every morning the patient would deliver an important document to the director, without which the director could not have started the activities of the day. The entire therapeutic staff promoted this assignment. This strategy instilled in the patient the feeling of being useful and helped him to rediscover an everyday meaning. The document was only a pretext in this case, but this was not incompatible with the Bionian[1] "truth instinctual drive" postulated by Grotstein (i.e., a need of truth, which has the quality and the power of an instinctual drive; Grotstein, 2004), because the document was truly special for the clinician, having the role of activating in the patient a daily meaning and the perception of being helpful. We recognize that this is an extreme example,

[1] Wilfred R. Bion (1897–1979) was a British psychoanalyst. According to him, truth is essential for the existence and growth of the mind and for psychic health (Bion, 1984).

but the promotion of meaning in life should always be among therapeutic targets in suicidal patients, no matter the diagnosis or the severity of symptoms.

Preventive and Therapeutic Interventions

Therapeutic strategies for suicide prevention should promote the individual discovery of RFL or MIL and increase patients' contact with them. RFL are often considered in therapeutic interventions (e.g., encouraging familial connections, teaching coping strategies) but are not always evaluated by means of specific assessment. Even if we know that a number of psychotherapies are generally efficacious in the reduction of both SA and non-suicidal self-injury and risk factors for subsequent SA (Calati & Courtet, 2016), knowledge on RFL enhancement is limited to a few types of psychotherapies.

First, Dialectical Behavior Therapy (DBT), in all its different components, was found to globally enhance RFL (according to RFLI) and decrease SA frequency and severity, SI, and use of crisis services because of suicidality (Linehan et al., 2015). Skills training (i.e., mindfulness-based emotion regulation, distress tolerance, relationship management) appears as the most effective component in DBT for suicide prevention (Linehan et al., 2015). Considering suicidal behavior as a dysfunctional experiential avoidance behavior aimed to escape suffering, the increasing of skills in psychological pain management allows the patient to connect to what is meaningful in life. Furthermore, mindfulness is a way to identify what is important in one's life by differentiating what appears as urgent from what is important, and therefore creating more space in one's life for what really matters. Finally, mindfulness redirects the search for happiness from external goals we do not have control over, leading to psychological dependence on the way the reality appears to us, to internal values that attribute more importance on the way we want to behave in the world, and less importance on external results or the way we believe reality should be.

From this perspective, Mindfulness Based Cognitive Therapies (MBCT) have shown effectiveness to reduce SI (Serpa, Taylor, & Tillisch, 2014). Being mindful means to pay attention in a specific manner, that is, in the present moment, and non-judgmentally. Mindfulness improves effective management of unpleasant psychological events (e.g., negative cognitions and emotions; Chiesa, Anselmi, & Serretti, 2014; Chiesa, Calati, & Serretti, 2011) and hedonic capacities (Thomas & Garland, 2017), aspects that could be linked to an augmented capacity to recognize RFL. A short-term intervention based on kindness mindfulness (i.e., one form of mindfulness practice) significantly improves positive mental health, perceived connection with others, and perceived MIL, even up to 6 months follow-up (Ozawa-de Silva, 2015).

In addition to mindfulness, gratitude involves the ability to appreciate little things already present in our environment and our lives. Gratitude is a social emotion that is often directed toward a person, and it is conceptualized as a virtue, a moral sentiment, a motive, a coping response, a skill, and an attitude. Minimally, gratitude

is an emotional response to a gift, or the appreciation felt after one has been the beneficiary of an altruistic act (Emmons & Crumpler, 2000). Recently, Huffman and colleagues found that practicing exercises of Positive Psychology (PP), including gratitude, was associated with increased optimism and decreased hopelessness in suicidal patients (Huffman et al., 2014). Furthermore, grateful adolescents (Li, Zhang, Li, Li, & Ye, 2012) and young adults (Kleiman & Beaver, 2013) are less likely to be suicidal. Gratitude increases affiliation feeling (Fredrickson, 2001), or connectedness to others, which is an RFL essential for human surviving. In sum, being grateful is comprised of being aware of, and satisfied for, what is already part of our life, increasing RFL in the here-and-now. As an example of a gratitude exercise, patients are asked to write, each evening, a journal in which they indicate three things having occurred in the day for which they feel grateful. Patients are encouraged to connect with all the reasons why they are grateful for these events. For example, one could write he/she is grateful for having received a text message from a friend, describing the importance of this relationship and the feeling of belongingness. Another aspect of gratitude is the social connection feeling and interdependence, which can be developed with higher attention to all the people who have contributed to the experience the subject is currently living; for example, eating something is dependent on the dealer having sold the product, which is dependent on those who have contributed to packaging the product, which is dependent on those who have cultivated the components of this product, and so on. Therefore, gratitude helps people to attribute value to what already exists in one's reality, and to connect them to human interdependence.

Acceptance and Commitment Therapy (ACT) integrates mindfulness, motivational interviewing, and existential therapy (i.e., logotherapeutic treatment). ACT helps patients to learn how (1) to accept unavoidable innate/private events, just noticing them as transient mental events different from *self*; and (2) to identify and focus on valued actions. Values represent what is important in one's life, and the way one wants to act in the meaningful areas of his/her life. Values are important to anchor patients to life, and to increase intrinsic motivation to engage in meaningful actions (Niemiec, Ryan, & Deci, 2009). It is all the more interesting as suicidal patients show decreased hedonic capacities and MIL (Heisel & Flett, 2004; Xie et al., 2014). Additionally, values may act as a buffer between stressful life events and suicidal vulnerability, being a source of resilience against hopelessness (Marco, Guillen, & Botella, 2017). Through several samples, findings support a significant negative correlation between MIL and suicidal tendency (Wilchek-Aviad & Malka, 2016). Thus, logotherapeutic strategies (including ACT) may focus on searching for meaning in one's life and, therefore, help to promote the ability to make one's life worth living despite the suffering entailed. Finally, an ACT program (7 weekly sessions) has shown effectiveness in (1) reduction of severity of SI; (2) reduction of psychological pain, hopelessness, anger, and suicidal risk factors; and (3) improvement in global functioning in patients having attempted suicide in the last year (Ducasse et al., 2014). ACT may reduce SI intensity through several factors: an increase in acceptance skills, and in MIL, through personal engagement toward value-oriented actions and a modulation of suicidal risk factors.

Moreover, the CAMS has been shown to be effective in reducing SI, increasing hope (Ellis, Rufino, & Allen, 2017), and increasing RFL even after 12 months (Comtois et al., 2011). Notably, CAMS is a structured, collaborative framework for alliance-building, risk assessment, case formulation, treatment planning, and risk reduction with suicidal patients. Interestingly, principles of the CAMS framework are used in ACT therapy, such as: (1) developing a shared understanding of the suicidal process (i.e., experiential avoidance function) and planning for stabilization between patient and therapist; (2) conceptualizing suicidality as a primary problem and treatment focus, regardless of clinical diagnosis; and (3) addressing psychological vulnerabilities to suicidality and increasing RFL. A brief intervention, the Teachable Moment Brief Intervention (TMBI), was similarly found to enhance RFL in suicide attempters in 1 month (O'Connor et al., 2015). The TMBI was based on elements of both CAMS and DBT. Specifically, it is comprised of rapport building, identification of factors related to the SA through functional assessment, short-term crisis planning, and discussion of connection to outpatient mental health services.

Furthermore, as we already underlined, the focus on future short-term plans should be present in the treatment of suicidal patients, including of the elderly. A few therapies include this aspect, such as problem-solving therapies, recently found to be effective for the decrease of depressive symptoms in elderly (Kirkham, Choi, & Seitz, 2016).

Finally, concerning antidepressant treatments, duloxetine was found to enhance RFL, in 8 weeks, in hospitalized patients with severe depression (Demyttenaere, Desaiah, Raskin, Cairns, & Brecht, 2014). This result is connected to the fact that RFL are, at least partially, state-dependent: in fact, RFL scores, low at baseline, increased during the treatment of this severely depressed sample, in parallel with symptomatology amelioration. In summary, helping individuals to find RFL and meaning in their lives shows beneficial outcomes when integrated in therapeutic intervention aiming at suicide prevention.

Discussion

The broad conceptual framework of RFL is mental health *resilience*, which characterizes a person who, despite acute or chronic social or physical stressors, would resist against or recover from mental health problems. Following the definitions used by Kalisch et al. (2015), resilience could be considered as an *outcome* (if mental health is measured one time) or a *process* (if mental health is measured more than one time), while *resilience factors* are variables (such as social support, social status, personality, coping style, genetic background, and, as we have posited, RFL) predicting a resilient outcome. So, an individual reporting a high number of RFL could be more likely to have a resilient outcome in terms of mental health. A further concept is represented by *resilience mechanisms*: a limited set of shared psychological or biological mechanisms that mediate the link between *resilience factors* and *resilience outcome/process*.

In their study, Kalisch and colleagues hypothesized the existence of a single mediating mechanism, the positive appraisal style, formulating the Positive Appraisal Style Theory of Resilience (PASTOR; Kalisch et al., 2015). According to this theory, a positive appraisal style, defined as "a generalized tendency to appraise potentially aversive stimuli or situations in a non-negative/non-averse ('positive') fashion," is the crucial protective mechanism mediating the effects of other resilience factors and producing resilience to stressors. In the words of the authors: "A positive appraisal style is the common resilience mechanism onto which all resilience factors converge and through which they exert their protective effects on mental health." Consequently, we can hypothesize that RFL could exert their protective effect, converging in this positive appraisal style. In other words, a subject may have this positive style due to several factors, among which RFL play a consistent role: the higher the number of RFL, and/or the individual capacity to recognize them, the more the subject will be able to positively appraise her/his environment and to have corresponding positive emotional responses.

It would be interesting, in the future, to better understand the unique contributions and the potential bidirectional interrelations between (1) presence and frequency of RFL, and (2) capacity to recognize them. Moreover, two main interpretations of the overall findings reported in this chapter could be traced (Mammen, George, & Tharyan, 2001) and should be deepened in the future: on the one hand, non-suicidal patients could have a more optimistic approach because they perceive, or they have, more reasons to live or because of inner restraints to suicide; whereas, on the other hand, suicidal patients could perceive less RFL because of the higher depressive symptomatology and hopelessness, so they are simply not able to perceive RFL. Longitudinal studies are necessary to substantiate these patterns of association.

Interestingly, in connection to the PASTOR model, Peter Fonagy and colleagues linked a general psychopathology factor (p factor), an underlying vulnerability for psychopathology, to the lack of resilience, resulting in the impairment of three central mechanisms of resilience: immediate positive situation appraisal, retrospective reappraisal of a traumatic event, and inhibition of re-traumatizing triggers (Fonagy, Luyten, Allison, & Campbell, 2017). Moreover, they considered personality disorders and, particularly, borderline personality disorder, as characterized by the lack of resilience, so defined. We can hypothesize that this p factor could be connected to the lack of RFL or the capacity to recognize them as well; future research is needed to test this hypothesis.

Beyond the association between RFL and the concept of resilience to suicidality and psychopathology in general, it is well established that RFL are potentially protective against both SI and SA in clinical and non-clinical samples, and, more specifically, the RFLI SCB and MO subscales. Future perspectives to be investigated include: (1) a further investigation of RFL differences among different cultures and ages; (2) further additions to the RFL list, based on societal changes since the original development of the scale, for instance a career/vocation subscale may be added; and (3) a consideration of the importance of intimate supportive relationships as RFL among adults (RFLI), including, as we mentioned above, therapeutic relationships,

as some severe patients could be able to cling to a unique relation, including the one with the therapist.

Overall, our findings support the perspective of Malone and colleagues, who encouraged researchers to develop clinical treatments enhancing RFL during depression, and then to test them on the emergence of suicidal behavior (Malone, Oquendo, Haas, Ellis, & Mann, 2001). Promising treatments specifically focusing on RFL enhancement are DBT and CAMS, but evidence concerning MBCT, PP, ACT, and problem-solving therapies are also present. Our suggestion is that it may be possible to include a focus on RFL within every therapeutic intervention aiming at suicide prevention.

Notation: The mentioned scene from "The Piano" movie (Campion, 1993) is representative of the constant conflict during everyone's life between life and death drives, the inescapable oscillation between Reasons for Living and Reasons for Dying, and patients should be made aware of and ready to face this alternation.

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