

# Cognition and Suicide: Theory, Research, and Therapy

**Edited by Thomas E. Ellis**

*Cognition and suicide: Theory, research and practice*

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## Chapter 6

### Suicide and the Inner Voice

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George began “hearing” a voice inside, a male voice, not unlike his father’s, saying emphatically, “Die, boy, die.” He heard this voice as he increasingly felt tempted to jump in front of a train or truck or out of a window. He spent considerable time...working on his intense depressive feelings; his self-destructive impulses and behavior; his wish to die and rejoin his parents; his negative introjects, such as the voice. (Blatt, 2004, p. 19)

In this chapter, I first discuss Separation Theory, developed by Robert Firestone, with specific emphasis on how the theory explains cognitions and suicide. I describe how Separation Theory defines the self and antiself systems and explains the concept of the “voice” (Firestone, 1988, 1997a; Firestone, Firestone, & Catlett, 2002; Firestone, Firestone, & Catlett, 2003). I delineate the research, both clinical and empirical, that validated this theoretical perspective. My colleagues and I conducted this research while developing the *Firestone Assessment of Self-Destructive Thoughts* (FAST) (Firestone & Firestone, 1996), an instrument to assess suicide risk (Firestone, 1991; Firestone & Firestone, 1998). I then discuss implications of this theoretical approach for clinical practice, including a treatment approach called Voice Therapy (Firestone, 1988, 1997a), to address this negative thought process. Finally, I provide a case example to illustrate these concepts and methods.

Voice Therapy is similar in certain respects to Cognitive Therapy; however, there are a number of basic differences. The major differences between Rational Emotive Therapy, Cognitive Therapy, and Voice Therapy can be found in (a) the importance each system places on investigating the etiology of the client's disturbance; (b) the theory of personality upon which the therapeutic methodology is based; (c) the techniques used to identify and correct dysfunctional thinking; and (d) the emphasis on emotion or affect. The therapist practicing Voice Therapy is concerned with the dynamic origins of the voice. Separation Theory and Voice Therapy procedures are more deeply rooted in an integrated psychoanalytic/existential approach than in a cognitive/behavioral model. The theoretical focus is on understanding the psychodynamics of the client's functional disturbance in the present, and the methods are based on an underlying theory of personality that emphasizes a primary defensive process. R. Firestone (1988, 1997a) conceived of self-destructive or neurotic tendencies as the perpetuation of psychological defenses that originally had survival value but later predispose maladaptive responses and increase personal distress. The "voice" represents the end process of incorporating destructive attitudes into oneself; as such, it refers to an alien viewpoint which is an overlay on the personality that functions as a negative force in the direction of self-hatred and self-attacks.

Unlike Cognitive Therapy, Voice Therapy expressly discourages therapists from replacing self-critical thoughts with more realistic ones, focusing rather on the historic origins of the disturbance. Suicidal patients are helped to see that their self-destructive impulses stem from critical or hostile messages that were adopted from the parents and that the voice is in fact "alien" to their real self. (Ellis, 2001, p. 137)The specialized techniques of Voice Therapy can be used as

an adjunct to other approaches, including cognitive/behavioral therapy. The methods of Voice Therapy bring to the surface not only negative or dysfunctional cognitions but also the feelings associated with them. Identifying “automatic thoughts” in the presence of strong affect can provide the “hot emotional climate” necessary for changing core schemas.

### **THEORY**

Separation Theory (Firestone, 1997a) provides a framework for understanding the suicidal process. The theoretical approach, as it relates to suicide, focuses on internalized negative thought processes. There are three premises underlying this approach to suicide and self-destructive behavior (Firestone, 1997b). The first premise states that a division exists within each individual between the self system, which is life-affirming and goal-directed, and the antiself system, which is self-critical, self-hating, and, ultimately, suicidal. The second premise states that self-destructive thoughts exist on a continuum from mildly self-critical to suicidal. The third premise states that there is a corresponding continuum of self-destructive behaviors that are strongly influenced or controlled by these destructive thoughts, or “voices.” The voice is defined as “an integrated system of negative thoughts and feelings, antithetical to the self and cynical toward others, that is at the core of maladaptive behavior (R. Firestone, 1997b, p. 16). At its extreme, the voice encourages and triggers self-harm and suicidal behavior.

#### **The Self and the Antiself Systems**

Robert Firestone’s concept of the “division of the mind” (Figure 1) is derived from the observation that people are divided between the self and the forces within them that oppose or attempt to destroy the self. Both the self system and the antiself system exist within the individual and develop independently; both are dynamic and continually evolving.

The self system is the innate personality of the individual, including the biological,

temperamental, and genetic traits, along with the harmonious identification with early caretakers. Positive nurturing experiences with caretakers and other significant figures in the person's early life have a significant impact on the development of the self system. The positive traits and values of parents and other caretakers are easily assimilated into the personality through identification and imitation.

The antiself system can be conceptualized as the defensive element of the personality. The child develops defenses to deal with a multitude of interpersonal experiences that cause emotional pain and frustration, ranging from neglect, intrusiveness, and rejection, to actual parental aggression. Even parents who have a great deal of love and concern for their offspring will cause them some degree of pain and frustration. Parents' ability to adequately meet their children's needs will be influenced by their own life experiences, the parenting they received, and the degree to which they have resolved these issues for themselves (Baumeister, Bratslavsky, Finkenauer, & Vohs, 2001; Fonagy, et al., 1995; Main & Hesse, 1990; Main & Solomon, 1986; Sanders & Giolas, 1991; Siegel, 2001).

### **The Fantasy Bond**

The fantasy bond (Firestone, 1985) is an imaginary connection with the primary caregiver that acts as the core defense against interpersonal pain and frustration, deprivation, rejection, and aggression. This defense is a process of parenting oneself internally in fantasy and externally by using objects and persons in the environment. This process of parenting oneself is made up of both the self-nourishing and the self-punishing components. Both of these take on a unique character, resulting from the incorporation and internalization of parental attitudes and responses in the process of growing up in a particular interpersonal environment (Firestone, 1997a). The

self-nourishing component continues into adult life in the form of praising and coddling oneself, vanity, eating disorders, addiction to cigarettes, alcohol, and other drugs, compulsive masturbation, and an inward, self-feeding habitual style of sexual relating. The self-punishing component includes self-critical thoughts, guilt reactions, warnings, prohibitions and attacks on self, which are all examples of the punitive aspect of parental introjects.

This conceptualization parallels that of Berne's (1961) Transactional Analysis (TA). The TA approach sees the person as being in either the child or parent state (similar to the self-parenting process described here) or the adult state (corresponding to the self system). In their relationships, many people act out either the childlike or parental aspects of the self-parenting process. Unlike Berne, Robert Firestone believes that people's tendencies to reenact these childish/parental elements in their current relationships are *not* manifestations of their attempts to achieve the gratification that was missing from the early environment. Rather, he believes that the person repeats the past and the self-parenting process in order to protect his or her defense system and psychological equilibrium.

Robert Firestone has observed that defenses that were originally formed to cope with interpersonal pain in the early environment become much more ingrained in the personality with the realization of death. Between the ages of 3 and 7, children begin to develop a concept of death and attempt to cope with the existential anxiety and dread through the defenses they developed early in life. Unfortunately, defenses cannot selectively cut off emotional pain without cutting off other feelings, leading to emotional deadness and serious deterioration in the quality of life. Being cut off from feeling for oneself and for one's life can contribute to suicidal behavior. The fantasy of suicide can provide a sense of triumph over death, that is, of taking control over one's destiny (Kaiser in Fierman, 1965; Maltzberger, 1999; Orbach, 2002).

## The Voice

The voices or destructive thoughts act as a secondary line of defense protecting the core defense. As mentioned earlier, the “voice” can be defined as an integrated system of negative thoughts and attitudes, antithetical toward the self and suspicious and hostile toward others, that is at the core of maladaptive behavior. Voice attacks are sometimes experienced consciously, but more often than not are only partially conscious or even totally unconscious. These thoughts reach their most dangerous and life-threatening expression in suicidal behavior. Suicide can be conceptualized as a triumph of the antiself--the self-destructive aspect of the personality. The following is an excerpt from an interview with a woman who made a serious suicide attempt:

Actually, I wanted to flee from these thoughts, not from the too heavy demands but from the many thoughts because they made me do what they wanted. I couldn't live with them any longer. I wanted to kind of kill them.

Our research (Firestone, 1991; Firestone, 1997a; Firestone, 1997b) has described three levels or stages of self-destructiveness that people experience, each of which is associated with different behaviors and has different sources. The first level includes thoughts that lead to low self-esteem and inwardness. These thoughts run the person down, are cynical toward others, contribute to a self-denying posture, support tendencies to isolate oneself, and promote distrust of others and extreme self-hatred. These thoughts are important in relation to suicide because they contribute to several behaviors and lifestyles that have been shown by research to have a strong association with suicide risk. Self-denial and cynicism toward others lead to a lack of investment in life. It is easier for a person to kill himself or herself if he or she is less invested in life. Isolation is also a risk factor for suicide. The voices encouraging isolation are particularly

dangerous, because our research has shown that isolation provides the environment where these negative thoughts take more hold over the individual (Firestone, Firestone, & Catlett, 2003). Isolation prohibits the person from opening up to others and gaining a more rational evaluation of himself or herself and his or her circumstances. An isolated lifestyle also deprives people of the compassion and caring they might receive from family or friends. Finally, this level includes extreme self-hating thoughts that cause a great deal of psychological distress and emotional pain, similar to Shneidman's (1993) concept of "psychache" and Baumeister, Bratslavsky, Finkenauer, & Vohs' (2001) descriptions of self-hate.

The second level of self-attacks includes thoughts that contribute to the cycle of addictions. These thoughts take two forms. First, they encourage, almost seduce, the person into engaging in the behavior. After the person has indulged, he or she berates himself or herself for having given in to the addiction. Often these self-attacks include vicious diatribes in which the person is beating him/herself up internally. However, these self-criticisms do not result in changing the addictive behavior. Instead, they lead to considerable pain and distress. In seeking relief, the person often engages again in the addictive behavior, thereby completing the cycle.

The source of these microsuicidal behaviors (Firestone & Seiden, 1987) that truncate or shorten a person's life seems to be in an identification with early caretakers. People imitate the defensive behavior of their parents, which includes the ways they soothed themselves. Considering the fact that there is a significant correlation between substance abuse and suicide (Lester, 2000), the processes of identification and imitation can be seen to play an important role in suicide risk.

The third level or stage of self-attack is the most serious and most relevant in relation to suicide. This level includes the following.

*Thoughts of Being a Burden to Friends and Family.*

This feeling of being a burden is common in suicidal individuals and contributes to a sense of hopelessness, an affect that is an established risk factor for suicide (Beck, Steer, Beck, & Newman, 1993). The following excerpt is from an interview with a woman who made a serious suicide attempt.

I then said to myself that I didn't want my children to end up with a disturbed mother and that they would have to come to see me in a psychiatric hospital, but that they should rather have no mother at all, then. I didn't want that my children or my relatives would have to suffer because I was nuts.

*Feeling That Nothing Matters Anymore.*

Disconnecting from points of identity, not caring, or being unable to enjoy activities as one did in the past are important risk factors for suicide. It is easier to kill a self that one no longer feels identified with. This type of disconnect, known as anhedonia, is also associated with suicide risk (Fawcett, et al., 1990; Loas, Perot, Chignague, Trespalacios, & Delahousse, 2000; Oei, et al., 1990; Orbach, 2003).

*Thoughts Urging Self-Harm and Extreme Risk-Taking Behavior.*

These thoughts have an extremely agitated quality that is temporarily relieved when the person acts on them. This often develops into a cyclical pattern in which the agitated thoughts escalate, the person acts on injunctions to injure him/herself and subsequently experiences feelings of relief when the thoughts temporarily diminish or disappear.



*Actual Thoughts About the Details of Suicide.*

Having a detailed plan increases risk, especially if the method planned is highly lethal and the time frame is short.

*Thoughts Baiting the Person to Take His or Her Own Life.*

At this level, there is extreme thought constriction: “Do it or you are a coward.” “It’s the only thing you can do.”

Richard Heckler’s (1994) interviews with 50 people who made serious suicidal attempts led him to conceptualize a “suicidal trance,” in which those thoughts take more and more control over a person’s behavior. He described these baiting thoughts as those the person experiences just before he/she takes his/her own life. For example:

The reality for myself is almost constant pain and torment. The voices and visions, which are so commonly experienced, intrude and so disturb my everyday life. The voices are predominantly destructive, either rambling in alien tongues or screaming orders to carry out violent acts. They also persecute me by way of unwavering commentary and ridicule to deceive, derange, and force me into a world of crippling paranoia. Their commands are abrasive and all-encompassing and have resulted in periods of suicidal behavior and self-mutilation. I have run in front of speeding cars and severed arteries while feeling this compulsion to destroy my own life. (A patient with a history of suicide attempts, as reported by Jamison, 1999, pp. 119-120)

The thoughts at the third level drive behaviors that are highly self-destructive. The source of these thoughts seems to be identification with the aggressor, both the overt and covert

aggression of the parent or primary caretakers. At times of stress when a parent “loses it” with the child, the child protects himself or herself by identifying with the powerful aggressor instead of with himself or herself as the helpless child. The child incorporates the parent’s hostility toward him or her being expressed at that moment (Fairbairn, 1952; Ferenczi, 1933/1955). This incorporation represents an internalization of the parent at his or her worst, not as he or she was on average. The person may later unleash that anger against him/herself. For example, an excerpt from the diary of a young woman who committed suicide included these thoughts:

I sit here with my untamed piano, untamed mind, untamed heart, with the music I only know, within myself. My mother is alive! Screaming viciously, laughing viciously, Jekyll and Hyde. Mommy Dearest (Firestone, 2004).

### **A Developmental Perspective**

Unfortunately, children have a stronger memory trace for negative events than for positive ones (Armony & LeDoux, 1997; Buchanan & Lovallo, 2001; Cahill, Roozendaal, & McGaugh, 1997). This propensity may stem from the fact that these experiences seem life-threatening to them and therefore the intensity of focus is a survival mechanism. Also, many situations that may not seem significant to the adult may be very frightening to the child.

Under conditions of physical, emotional, or sexual abuse on the part of a primary caretaker or caretakers, the person to whom the child naturally turns for care also becomes the frightening or punishing agent, and the child typically fails to develop a secure attachment (Main & Solomon, 1986). Research has also found that parents who have unresolved trauma, even when they are not abusive, are prone to display frightened/frightening behavior with their children. This often results in the formation of an insecure/disorganized attachment with their

infants (Hesse, Main, Abrams, & Rifkin, 2003). This is especially important during the first few years of life when the ability to regulate emotions is limited, and children are dependent on caretakers to provide this function for them. The lack of ability or skill to regulate affect is strongly associated with suicide risk (Linehan, 1993; Rudd, Joiner, & Rajab, 2001). Fear states aroused by these interactions can cause the brain to release certain toxins that actually change the structure of the brain and central nervous system, destroying cells and synapses that are responsible for the regulation of emotions and the development of compassion and empathy (Lyons-Ruth & Jacobvitz, 1999; Perry, 1997; Schore, 1994; Siegel, 1999; van der Kolk, McFarlane, & Weisaeth, 1996).

### **Dissociation**

At these times of stress, children learn to depersonalize in an attempt to cope with the overwhelming emotions of fear, anxiety, and anger. The split within the personality develops when the child depersonalizes under the circumstances that threaten his or her “going on being” (Winnicott, 1958). Ironically, the child’s desperate struggle to preserve intactness and wholeness produces fragmentation and disintegration.

This ability to dissociate is initially a survival mechanism but later leads to serious problems and can contribute to suicide risk (Briere & Runtz, 1987; Brown, Cohen, Johnson, & Smailes, 1999; Chu & Dill, 1990). Recent research with suicide attempters indicates that this type of dissociation may play a key role in the person acting on a suicidal impulse (Maltzberger, 2002; Orbach, 2002).

One has to be removed from oneself to kill oneself. Suicide is diametrically opposed to our animal instinct to survive at all costs. This excerpt from an interview with a woman who

made a serious suicide attempt illustrates this point:

*Patient:* And then I cut myself in the strategic places (wrist) and put the arm into water and watched the rings, which was pretty. I was more or less simply watching myself. In the previous months when I was feeling so low after the breakdown of the relationship with my boyfriend, I had often looked at myself from outside, like now while I was cutting myself.

*Interviewer:* The way you tell it, it sounds, as if you were separated from your feelings.

*Patient:* Yes, completely.

Anna Freud (1966) contended that the mechanism of identification or introjection combines with imitation:

To form one of the ego's most potent weapons in its dealings with external objects which arouse anxiety. (p. 110) By impersonating the aggressor, assuming his attributes or imitating his aggression, the child transforms himself from the person threatened into the person who makes the threat. (p. 113)

It is painful for clients to realize how divided they are and to recognize that it may not be safe to trust their own thoughts. In essence, rather than facing the destructive enemy within, the client begins to believe that the antiself actually represents his or her own point of view.

### **Case Example**

The following is an excerpt from an interview of a man in a Swiss psychiatric hospital three days after he made a serious suicide attempt:

As time went past I became more and more isolated. In early summer I found that it got worse and worse. I began to forget things. In discussions with colleagues I had problems

following the conversation. I have also a young girlfriend. And in addition I had become impotent. Of course, this led to additional worries. I started to think about my life. I simply had to say to myself that if now my colleagues and my girlfriend left me, then I had nothing left.

Then I developed problems with sleep. Last Monday I had an appointment with a physician. And last Monday I simply said to myself “No.” I was afraid that now everything would come out into the open. I was afraid that people would say that I had always lived on the expenses of my friends and my girlfriend, and that in fact I had nothing of my own. I would then be called a scoundrel.

The patient states that after having the thought, “I should just go,” he began his suicide attempt.

So I fetched a knife and cut my blood vessels in the wrist. But I had to realize that this didn’t work. So I got my axe out and chopped my hand off. I simply wanted to go. So I was lying there for several hours. I was slightly unconscious when the phone rang. I said to myself that I won’t answer. After the fourth ring I still picked up the receiver.

In an earlier portion of this interview, the patient describes aspects of the self system, i.e., he reveals the fact that he loves skiing and hiking, activities he expected to be able to engage in more often when he retired. Instead, he found himself dominated by aspects of the antiself system, thoughts influencing him to increasingly isolate himself, and ruminations about his perceived deterioration in functioning. In this interview, the patient reported experiencing negative thoughts at the extreme end of the continuum: “I simply had to say to myself, ‘if my colleagues and girlfriend leave me, I will have nothing, I would be called a scoundrel. I should just go.’”

Suicidal crises are fraught with ambivalence, an ambivalence that Separation Theory

addresses directly: whether to live life as a fully vital human being who is feeling and experiencing life, or whether to deaden oneself, resort to addictive behaviors to cut off feeling, and in essence, live a life that never reaches its full human potential. This ambivalence is clearly demonstrated in a later part of the patient's interview in which he describes ignoring the first three rings of the phone, but then, as he feels life returning, answering the phone--an act that saved his life.

### RESEARCH

On the basis of Robert Firestone's theoretical approach, my colleagues and I felt it was logical that an assessment of individuals' self-destructive thoughts could be used to predict the likelihood of their engaging in self-destructive behavior. We also felt that an instrument of this type could aid a clinician in understanding his or her client, developing case conceptualization, and planning effective treatment. We developed the *Firestone Assessment of Self-Destructive Thoughts* (FAST) (Firestone & Firestone, 1996) (Firestone, 1991; Firestone & Firestone, 1998), a scale that is derived from 20 years of clinical experience and research into the self-attacking attitudes and negative parental introjects that drive self-destructive behavior. Items on the scale were drawn from clinical material obtained from Robert Firestone's 22-year longitudinal study of the "voice" (Firestone, 1986, 1997b). The items represented all 11 levels of the Continuum of Self-Destructive Thoughts (Exhibit 6.1 – Continuum of Negative Thought Patterns).

The relationship between the voice process and self-destructive behaviors, including suicide, was empirically established by our research on the FAST. The original subject pool included 500 persons in outpatient psychotherapy. The criterion variable in the study, past suicide attempts, was established through both patient and therapist reports. A second study was undertaken with inpatient populations, drawn from the diagnostic categories found to have the

highest risk of suicide: Major Depression, Bipolar Disorder, Substance Abuse, Schizophrenia, Personality Disorder, and Anxiety Disorder. Participants were asked to endorse how frequently they experienced negative thoughts toward themselves (or “voices”) on a 5-point Likert-type scale from (1) Never to (5) Almost Always. In addition, participants completed a battery of additional instruments covering diverse areas of self-destructiveness to provide construct validity for the 11 levels of the FAST.

Internal reliability consistency for the FAST was established using Cronbach’s alpha (Cronbach, 1951). The internal consistency coefficients for the 11 levels of the FAST ranged from .76 to .91, with a median of .84. All exceeded acceptable measurement standards. The test/retest reliability for the FAST total score was .94.

The validity of the FAST was examined through content-related, construct-related, and criterion-related methods (Firestone, 1991; Firestone & Firestone, 1996). Content-related validity was established through three methods: (1) The statements were taken directly from self-destructive thoughts that people revealed, with the suicidal items coming from people with a past history of suicide attempts; (2) experts were used to identify the level the items best represented; and (3) the assumption that self-destructive thoughts exist on a continuum ranging from self-depreciation through suicidal injunctions was supported by a Guttman Scalogram Analysis (Gilpin & Hays, 1990). The hypothesized hierarchy of self-destructiveness was confirmed (Figure 6.2).

Construct validity of the 84 FAST items was examined using factor analysis. A three-factor solution was identified (Firestone and Firestone, 1996). Composite Factor 1 was labeled “Self-Defeating Composite” and consisted of Levels 1-5 on the continuum. Level 6 is Composite Factor 2, and was labeled the “Addictions Composite.” Composite Factor 3 is made up of Levels

7-11 and was labeled the “Self-Annihilating Composite.” These are the thoughts that represent the full spectrum of self-annihilation, from psychological suicide (Levels 7 and 8) to actual physical suicide (Levels 10 and 11).

A final composite, made up of 27 items, was empirically derived by summing those items that were found to have the most significant discriminatory power in distinguishing patients with current suicidal intent, and was labeled the “Suicide Intent Composite.” (This composite has been developed into a brief screener for suicide risk, the Firestone Assessment of Suicide Intent (FASI; Firestone & Firestone, in press).

Convergent and divergent validity methods supported the construct validity of the FAST. The highest correlations with the FAST were other measures of similar constructs, and there were highly negative correlations with tests of opposing constructs, such as positive self-regard. Criterion validity for the FAST was evaluated by comparing scores with the criterion variable (previous suicide attempts and current suicidal ideation). The FAST had higher correlations with this criterion variable than any of the preexisting suicide measures.

Incremental validity was established using logistic regression analysis, confirming that the FAST adds significantly to our ability to discriminate those individuals who are at highest risk for suicide. Sensitivity and specificity were demonstrated, correctly classifying 95.8% of ideators and 89.2% of nonideators.

One interesting finding was how easily participants identified with the self-statements written in the second person, as though someone else were addressing the attack to them, rather than as “I” statements. On a number of occasions, subjects reported recognizing their own styles of self-attack as they were filling out the test. Many participants had a physical reaction when they read statements with which they closely identified. Those reactions strengthened our



hypothesis that items on the scale are related to internalized thought patterns that are only partly conscious. Moreover, therapists reported that in the weeks following the testing, clients brought up topics related to self-destructive thoughts and behavior that they had never previously discussed.

Sample items from the FAST can be seen in Exhibit 6.2

The FAST has been translated into several languages, and ongoing research in other countries is in progress. Dr. Yasmin Farooqi in Pakistan translated the FAST into Urdu. She found that the FAST was able to distinguish between suicidal and nonsuicidal individuals in Pakistan (Farooqi, 2004). This finding suggests that self-destructive thought processes or voices may play a role in suicide across cultures.

The studies described above suggest a connection between negative thought processes (voices) and self-destructive behavior and suicide. Participants in early clinical studies (Firestone, 1988) identified their voices as parental statements or as representative of overall attitudes they perceived as directed toward them in their early years. The items for the scale were selected directly from this clinical material. The fact that these statements were then able to distinguish those at risk for suicide more accurately than other instruments lends support to the hypothesis that destructive voices associated with self-destructive acts may well represent introjected parental attitudes (Firestone, 1986; Firestone & Firestone, 1998).

## **PRACTICE**

Administering the FAST at the beginning of therapy allows therapists to assess where their clients fall on the continuum of self-destructive thoughts. It alerts the therapist to the negative thoughts clients are experiencing with the greatest degree of intensity, allowing the

therapist to plan appropriate interventions. In addition, taking the FAST increases clients' awareness of their previously subconscious thoughts.

### **Voice Therapy**

Identifying the contents of the client's negative thought process is the first step in a three-step procedure in which the client and therapist collaborate in understanding the client's destructive ways of thinking. The process of verbalizing the voices can be approached in an intellectual manner, focusing on the cognitions, or in a more dramatic, cathartic method. In both methods, clients learn to expose their self-criticisms in the second person as "you" statements, as though they were another person verbalizing the thoughts about the client. This helps the client to begin to separate their own point of view from the hostile, alien point of view of the antiself. Prior to articulating voices, clients generally accept these negative thoughts as being true evaluations of themselves.

In the more abreactive approach, clients are encouraged to express the emotion behind the thoughts, to say the voices louder, or to say them in the tone they experienced them and to express the emotions behind them (which often are strong anger and sadness). The therapist might encourage the client to "say it louder," "really feel that," or "let go and blurt out anything that comes to mind." In early studies of the voice process, clients and subjects frequently adopted this style of expression of their own volition. Putting their thoughts in the second person often led, in and of itself, to saying them with more intensity of feeling. Clients would start off with the thoughts they were aware of on the surface, but got to much deeper material, core beliefs about self. Frequently they adopted the mannerisms or speech patterns of their parents, again supporting the contention that these thoughts are incorporated from early experiences within the

family.

This emotional expression in many instances leads spontaneously to the second step in the Voice Therapy process, which involves developing insights into the sources of these negative thoughts. Statements such as “that’s what my father used to say to me,” or “that is the feeling I got from my mother,” or “that was the atmosphere in our home,” are often made by a subject or client after verbalizing the voice. The therapist can encourage this process by asking “Where do you think those thoughts came from?” “Where have you heard those before?” In Voice Therapy, the therapist refrains from interpreting to the client, but instead helps elicit insight from the person. Insights are most powerful when they come from the client and when they are coupled with a full expression of feelings. When clients develop insight, they experience a sense of compassion for themselves and have a clearer sense of their true identities.

Another aspect of this step involves clients making connections between their voices and their current self-destructive behavior patterns. They explore what behaviors they are engaging in based on these ways of thinking. This process leads naturally to the third step.

The third step involves changing behaviors that are based on these self-destructive ways of thinking, thereby altering one’s basic self-concept and core defenses. The corrective suggestions for behavioral change are arrived at through a collaboration between therapist and client, and are designed to challenge the client’s misconceptions about himself or herself. Collaborative interventions that effect changes in an individual’s behavior are a necessary part of an effective therapeutic procedure. These suggestions are in line with the client’s personal goals and ambitions. However, it is important to remember that acting on corrective suggestions always involves personal risk and feelings of increased vulnerability in clients, since they are breaking with psychological defenses that were originally necessary and that warded off painful

emotions. It is important to prepare clients for the anxiety they are likely to experience when they implement suggestions that are counter to the dictates of the voice.

As a client acts against his or her voices, these destructive thoughts may become more intense, almost like a parent yelling at him or her to get back in line. However, if they can endure the anxiety and maintain the behavior change, the voice attacks become less intense and eventually fade into the background, almost like a parent who becomes tired of nagging. This does not imply that these voice attacks may not resurface, but, if they do, they will not have as much influence over the person's behavior.

Corrective suggestions may include the client engaging in positive goal-directed behaviors that his or her voice has been discouraging, such as asking someone out for a date or applying for a desired job. Other suggestions might include refraining from self-destructive behaviors the voice is encouraging, such as substance abuse or risk-taking behavior. In either case, the goal is for the client to follow the suggestion, resist the voice attacks, go through the anxiety, expand his or her boundaries and positive sense of self.

### **Application to Suicidal Clients**

The most important first step in the therapy of an individual in suicidal crisis is to establish a strong therapeutic relationship, which includes trust. The therapist must be able to communicate empathy and non-judgment (Ellis, 2001). Establishing an effective therapeutic alliance may prove difficult and requires strong relational skills on the part of the therapist. Suicidal clients tend to evoke negative countertransference reactions in their therapists. They often make the therapist feel like getting rid of them, much as they want to get rid of themselves. Obviously, the therapist must be aware of this reaction and try to see the client as he/she would

be without the defended behaviors. A compassionate, caring stance toward suicidal clients is essential, because breakdowns in the treatment alliance can lead to disastrous outcomes. Research into clients' suicides during treatment indicate that the suicide often followed a break in the rapport (Maltzberger, Hendin, Haas, & Lipschitz, 2003).

It is important that therapists help clients identify their self-destructive thinking, especially as it applies to suicide. Often they have shared these thoughts with no one and were afraid they would be seen in a negative light if they did. The therapist can use his/her understanding of these thoughts to build rapport with the client. It is essential to help the client separate the thoughts or voices driving his/her hopelessness and desperation from a more realistic evaluation of him/herself and his/her circumstances. This separation will lessen the probability that the client will act on these thoughts.

The therapist needs to support and strengthen aspects of the client's self system. With suicidal individuals in particular, the therapist needs to be finely attuned to any indication of activities or relationships that are meaningful to the client or offer a sense of relief or hope. The therapist can then encourage the client and support engagement in these activities or relationships. Corrective suggestions need to be focused on keeping the client alive. Therefore, the focus is toward reducing the level of self-destructive behavior the client is engaging in.

Suggestions might include encouraging the client to spend time around caring others; supporting the pursuit of any activities that give the client energy or excitement; and encouraging the client to engage in acts of generosity, to spend time thinking of what he/she can do for others, thus helping him or her to develop a sense of meaning in his or her life. At the same time, there should be a focus on discouraging time spent alone, as well as substance use or other addictive behaviors. Helping clients recognize when they are attacking themselves is important in and of

itself. It is also important to help them recognize their anger in situations rather than turning that anger against themselves. Therapists' statements, techniques, or suggestions that support the self system and the client's desire to live are potentially life-saving.

Clinicians may be concerned that if a client recognizes hostile or suicidal thoughts toward self, he or she will be more likely to act them out. Actually, the opposite seems to be true: becoming aware of partially conscious or even unconscious negative attitudes toward self and others allows greater mastery over one's behavior. Through the use of Voice Therapy techniques, these destructive introjects are brought to the surface and the person is able to see the various dimensions of the "enemy within." This allows the client to better identify alien aspects of self and to understand their sources. Voice Therapy empowers clients, helps them gain a degree of control over behaviors regulated by the antiself system, and increases their ability to resist acting out self-destructive tendencies. Depressed and suicidal clients in particular often become exhausted struggling against self-destructive thoughts. They often lack the means of developing an accurate view of themselves and their lives. Voice Therapy can help them to make the important distinction between their current negative view of self and an objective, compassionate point of view. Clients regain feeling for themselves and reconnect with themselves as a person, making suicide a less likely outcome.

### **Case Description and Analysis**

"Fred" entered psychotherapy seeking marriage counseling for himself and his new wife, Mary. Although they had been married for almost a year, they had only recently begun living in the same city. They met when he was consulting with the company she worked for. They continued their contact through e-mails, occasional phone calls, and an the occasional

rendezvous that typically lasted for only a weekend.

Previously married for 15 years, Fred had an amicable divorce with the mother of his 20-year-old daughter. Mary had also been married previously and had a son prior to her first marriage, who was now 18. Their difficulties began when they started to live together for the first time. It seemed that they argued over practical matters such as who did the dishes and how, and their fights were escalating.

### *Family Dynamics*

Fred described a childhood filled with betrayal and abuse. He revealed that his mother would take the other children for an outing while leaving him at home where he was invariably beaten by his father. He felt that his abusive childhood left him distrustful of women. Fred also described joining the Marines, partially to escape his family. He was assigned to a unit in Vietnam, which proved to be a second source of trauma. Trained to conduct covert operations, he admitted committing many atrocities, for which he felt considerable guilt.

In discussing his relationship with women, he expressed ambivalence, on the one hand desiring love and closeness, yet on the other, feeling manipulated and controlled by women. He felt that women generally used sex to control men, and that men would be stronger if they “boycotted” all women. Fred described his prior marriage as friendly but asexual and distant.

Mary had a difficult childhood as well. She had been abandoned by her father early on, and her mother remarried when she was 16. At that point, her mother moved to another city with her new husband and leaving Mary behind. It was soon after this abandonment that Mary became pregnant with her son.

Fred stated that he wanted to get over his professed mistrust of women, to improve his

increasingly depressed mood, and to process memories and feelings from his painful past, both as a child and in Vietnam. Fred denied any current suicidal ideation; however, he did admit that the thought occasionally crossed his mind. His overall demeanor was characterized by a self-effacing manner, and he often made negative comments about himself. Mary seemed to be uncomfortable with these remarks, but at times her manner toward Fred appeared to be quite critical in a way that fit in with his own self-attacks. Fred also disclosed that he felt intruded on by his wife's habit of "taking over their home" and her apparent need for control--to have everything "her way." Another strong feeling he experienced was a sense of claustrophobia, a feeling of being smothered by her desire to constantly be with him.

Memories began to emerge into Fred's conscious awareness, which often focused on gory situations in which he had participated in violent acts or inflicted bodily harm on another person. He expressed a great deal of remorse and pain about these violent behaviors. His guilt reactions were accompanied by self-recriminations. "Why should I be alive when I have done things like that?" He reported that he had been increasingly plagued by these feelings in recent weeks. He also was experiencing outbursts where he acted out aggressive behaviors followed by extreme remorse. Fred admitted that his rage reactions tended to fluctuate between self-hatred and fury at Mary. Recently he had broken objects in their home during fights and on one occasion he bit Mary's ear.

Fred's scores on the FAST can be seen in Figure 6.3

#### *Individual Voice Therapy Session with Fred*

(Note: The following hypothetical session is an abridged version of what would likely take place over the course of 3 or 4 sessions. It has been condensed in order to better illustrate the



steps in the therapeutic process.)

*Therapist:* Fred, you have said that you attack yourself a lot, and on the FAST you indicated some extremely self-hating thoughts and even thoughts of suicide. I was wondering if we could talk about that.

*Fred:* Yeah, filling out that test, I realized how familiar those thoughts are to me. I wouldn't have said I was suicidal, but I have a lot of thoughts like that. Like I would be better off dead, that nothing is going to work out for me, not now, not ever. That I am useless to other people, that people close to me would be better off without me.

*Therapist:* Fred, I want to try something with you. I want you to say those thoughts again, the ones you just told me. But instead of saying "I am useless," say it as though someone else were saying it to you, like "you're useless."

*Fred:* Okay. *You're no good. You fail at everything you try. Stay away from people, leave them alone. No one wants you around. You're no good for anything. Do everyone a favor and die!* (Angrier and angrier, and then sadness)

*Therapist:* It makes you sad.

*Fred:* I can't believe the amount of anger behind those thoughts. I sounded like my father to myself as I said those things. He had that harsh tone in his voice toward me almost all the time. He was a very unhappy guy and he saw me as the source of all of his problems. I was the target of his pain and misery. And my mother would leave me alone with him, just to let it happen. I was like the sacrificial lamb in our family. I absorbed his anger. Yet now I can see I unleash that same aggression toward myself. I don't need him to do it to me, I do it to myself. (Sobs and cries) I can't believe how much I do this to myself.

*Therapist:* Like your father.

*Fred:* It is like my worst nightmare to be like him. I hated him. And now when I see myself like him, when I act in ways that remind me of him, then I have the goods on myself. Then I really am bad, evil, dangerous to others. That's when I start thinking things like "You should get away from other people, go off by yourself. You're unfit to be around other people." (pause)

*Therapist:* Just let the thoughts go.

*Fred:* *You can't love anyone else. No one loves you. You're just filled with violence. No one is safe around you. (angrier) You don't deserve to live. Everyone would be better off if you just died. Kill yourself, get yourself off of this earth. (Louder and louder, crying painfully) (pause)*

*Therapist:* That seems to be the final attack, that you should just get rid of yourself.

*Fred:* Yeah, I can feel that really strong sometimes. But I had never realized that these were his feelings toward me. He wanted to get rid of me, first because I was what he saw as causing the problems and then because I think he was ashamed of beating me. Almost like he wanted to destroy the evidence of his crime.

*Therapist:* Yes, it's almost like you are acting out his death wish for you.

*Fred:* Yeah, it makes me angry. I don't want to do this to myself. I don't want to destroy myself every time I get angry. I need to get a handle on my anger because when I act it out, then I am being him. That's my proof to myself that I am as bad as he is, that I deserve to die, because I am as evil as he was.

*Therapist:* You and I need to work together on strategies for dealing with your anger more effectively. We all get angry, anger is a natural reaction to frustration. But the power is in being able to control your anger, to let yourself feel it, accept the feeling, but then decide

on what your behavior is going to be, behaving in a manner to accomplish what you want, to behave in accordance with your own morals.

*Fred:* Yeah, I would like to work on that. I try to suppress my rage, and then it builds up to a point where I explode. I want to learn to identify it and express it so I am not overwhelmed with it.

*Therapist:* So you try to hold back your anger, suppress it, and then it comes bursting out of you.

*Fred:* Yeah, and it's been getting worse since Mary has moved in. It has made me feel so pent up. Everything she does around the house makes me feel intruded on, messed with. So I feel the anger building, but I try to not feel it until the point where I feel like I am about to explode. Then the self-recriminations start. I think I am such a volatile guy.

*Therapist:* Could you say those thoughts as voices, as though someone else were saying them to you?

*Fred:* *Can't you feel it building? You're going to hurt someone. You can't love anyone. You're just going to explode and hurt someone. You're a dangerous guy. People should get away from you. You're just like your father, That's why he punished you, you were a bad kid and now you're just like him. You think you can be any different, well you're not, you're just like me.* (angrier and angrier, sadness and deep sobbing) (pause)

It makes me so angry. I feel like yelling back "I'm not like you. I would never lay a hand on a helpless child. I loved my daughter. I was good to her. I didn't hurt her like you hurt me." I'm not like him. But when I get out of control with my anger, I have the goods on myself. I am like him at those moments and then I hate myself, just like I hated him.

Sometimes his feelings are in me. I know I have to stop acting this way because then I

really do hate myself.

*Therapist:* Breaking the identification with him is very important. You have to see his point of view as outside of you, not in you. Let's think about what you could do differently in your behavior that would help you break this connection. What are the voices you have before you have these outbursts? What's going on in your mind?

*Fred:* Well, usually something happens with Mary where I feel provoked. Like I'll come home and she has rearranged the furniture or she lets me know "our" plans for the weekend. Then I think to myself, *You weak piece of shit, you let her run the show, don't you? You can't let her treat you this way. You'd better put her in her place. This bitch is ruining your whole life. Are you going to let her get away with that, let her make a fool of you? You'd better make her listen. You'd better make her do things your way or you're nothing.*

Then I lash out and she starts to fight back, and it escalates. Finally I am so outraged that I can't even think. I just explode verbally and sometimes even physically. Then afterward it's like I annihilate myself. I tear myself apart and feel like I am the most poisonous, dangerous person and that I should just get out of here, that everyone would be better off if I were just dead.

*Therapist:* Where do you think those attacks come from?

*Fred:* That was my father's point of view, my mother's as well. You weren't really a man if you couldn't make your woman listen to you, if you were not in control. So now I act just like he did when I hear those voices.

*Therapist:* What could you do differently in the situation when you come home and Mary does something that annoys you? How could you handle it differently to go against these

voices, to achieve your goal of being a nonviolent, nonthreatening guy, different from your father?

*Fred:* Well, I could just be aware that I'm provoked and maybe say it to her before the anger builds up.

*Therapist:* So when you start hearing the attacks on yourself and on Mary about the situation, you could recognize that you are attacking yourself, that these thoughts are not your point of view about the situation. Then you could just calmly tell her what you really feel about the situation.

*Fred:* Yeah, it sounds simple, but I know it would be a struggle to do that.

*Therapist:* If you stick to this plan and not let the thoughts get you enraged, then you will probably feel anxious, and initially the thoughts might get louder or more extreme. But if you go through the anxiety, the thoughts will fade into the background and you won't feel so compelled to act on them. Initially if you stay calm rather than yelling at her, the thoughts may get louder, call you a coward, or comment on how weak you are being. But if you stick with your calm mood, they will pass.

It would be hard, and it would make you anxious to act against those voices. The trick is to stick it out, not to give in to the voices, to starve the monster inside of you by not feeding it, not giving in to what it says. If you do this, not act out your aggression at those times when you are provoked, you will begin to feel stronger and develop more of a sense of yourself. You also might want to take some time to write down the thoughts if you have any during or after the situation in the second person, the way you have expressed them in the session today. On the other side of the page, write down a more realistic evaluation of yourself or Mary, a more compassionate view.

*Fred:* So I write down the thoughts rather than act on them.

*Therapist:* Exactly. Then bring them to our session next week and we can talk about them.

*Fred:* Okay, I'll try that. It would feel a lot better to me to get a handle on this anger.

*Therapist:* Next week let's talk about how this plan goes.

*Fred:* Sounds good. I know it will be hard and that sometimes Mary doesn't make it easy when she acts in certain ways. But for me the real strength would be in changing myself. This out of control, angry part of me definitely comes from my father. This has never been more clear to me than today. When I act like him I hate myself and I end up feeling suicidal. If I can break this connection to him, I think I could get some respect for myself and not feel like I need to kill myself to spare everyone from me.

*Therapist:* It's very important to separate yourself from this overlay of him on your personality and to start to get a real sense of your own identity.

### **Voice Therapy Research**

Outcome research examining the efficacy of Voice Therapy is essential. Initial naturalistic studies are planned with therapists who have been trained in Voice Therapy methods. Randomized clinical trials of Voice Therapy also will be essential. The primary goal is to reduce the intensity and severity of negative thoughts the client is experiencing and reduce the self-destructive behaviors that result. A secondary goal is an increase in clients' sense of self and ability to make use of healthy coping strategies. Additional studies on the efficacy of Voice Therapy techniques as an adjunct to other treatment modalities also should be conducted.

### **CONCLUSION**

In order to understand human behavior, we must explore the ways in which a fundamental ambivalence toward self compromises the desire to live, to act according to one's goals, wants, and priorities, to individuate, and to find personal meaning in life. In essence, people are torn between motives to actualize themselves and to destroy themselves. Therefore, negative reactions against the self are an integral part of each person's psyche, ranging from critical attitudes and mild self-attacks to severe assaults on the self. These assaults include feelings and attitudes that predispose physical injury to the self and even complete obliteration of the self. Understanding this fundamental ambivalence toward self and the associated destructive thought processes can help us to conceptualize our suicidal clients, assess their risk, and intervene effectively to help resolve suicidal crises.

We believe that every person suffers some degree of pain growing up and has therefore internalized negative voices and possesses some potential for suicide. There are a multitude of factors that influence whether an individual ever reaches a suicidal crisis or actually takes suicidal actions; however, incorporated parental hostility seems to play a crucial role. We conceptualize suicide as representing the extreme end of a continuum of destructive mental processes that results in the ultimate annihilation of self. Clients who view suicide as the best solution are not basing their perceptions on rational thinking but on irrational, malevolent cognitive processes.

The ability of a scale made up of self-destructive thoughts or voices to assess suicide risk supports the contention that these thoughts are driving the suicidal process. The FAST provides a means for clinicians to better understand what is going on in the minds of their self-destructive clients. By identifying the areas where the client is experiencing the most intense destructive thoughts, clinicians can target their intervention more effectively to reduce the pain and

desperation the client is experiencing. Clinicians can use the results of the FAST to facilitate the discussion of these thoughts in therapy, subject the thoughts to reality testing, and reduce the risk of the client acting on them.

Robert Firestone developed Voice Therapy as a cognitive/affective/behavioral therapeutic methodology that brings introjected hostile thoughts, with the accompanying negative affect, to consciousness, rendering them accessible for treatment. This technique facilitates the identification of the negative cognitions driving suicidal actions, which in turn helps clients to gain a measure of control over all aspects of their self-destructive or suicidal behaviors. Clients become aware that their distortions or negative perceptions of events, and not the events themselves, are the principal cause of their depression, perturbation, and hopelessness. They develop a greater understanding of themselves and how these self-destructive voices adversely affect their lives. Their sense of self is also strengthened, giving them a more realistic perspective on themselves and their circumstances, so that they can more effectively cope with adverse life events. This process helps clients expand their personal boundaries, develop a sense of meaning in life, and reduce the risk of self-destructive behavior, including suicide.



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