



# *Assessment and Treatment of Youth*

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# **Our Approach to Suicide and Self-Destructive Behavior**

- Each person is divided: One part wants to live and is goal directed and life affirming and one part is self-critical, self-hating and at its ultimate end, self-destructive. The nature and degree of this division varies for each individual.



# **Our Approach to Suicide and Self-Destructive Behavior**

- Negative thoughts exist on a continuum, from mild self-critical thoughts to extreme self-hatred to thoughts about suicide



# **Our Approach to Suicide and Self-Destructive Behavior**

- Self-destructive behaviors exist on a continuum from self-denial to substance abuse to actual suicide



# Our Approach to Suicide and Self-Destructive Behavior

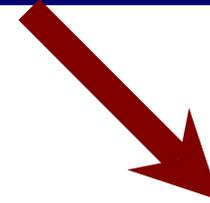
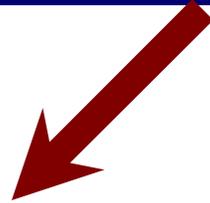
- There is a relationship between these two continuums. How a person is thinking is predictive of how he or she is likely to behave.



# DIVISION OF THE MIND

## Parental Ambivalence

Parents both love and hate themselves and extend both reactions to their productions, i.e., their children



- Parental Nurturance

- Parental Rejection, Neglect, Hostility
- Other Factors (accidents, illnesses, death anxiety)



# SELF SYSTEM - ANTISELF SYSTEM

## Self System Characteristics

Unique makeup of the individual -- physical, temperamental, genetic structure; harmonious identification and incorporation of parents' positive attitudes and traits; and the effect of experience and education on the maturing self system.

## Anti-self System Characteristics

The Fantasy Bond (core defense) is a self-parenting process made up of two elements: the helpless, needy child, and the self-punishing, nurturing parent. Either aspect may be extended to relationships. The degree of defense is proportional to the amount of damage sustained while growing up.



# ANTI-SELF SYSTEM

*The anti-ego is composed of three primary factors or stages of self-attack*

## Voice Process

1. Critical thoughts toward self.
2. Microsuicidal injunctions.
3. Suicidal injunctions suicidal ideation.

## Behaviors

Verbal self-attacks-generally negative attitude toward self and others predisposing alienation.

Addictive patterns. Self-defeating and self-limiting behaviors.

Actions that jeopardize, such as carelessness with one's body, physical attacks on the self, and actual suicide.

## Source

Critical parental attitudes, projections, and unreasonable expectations.

Identification with and imitation of parents' defenses.

Parents' covert and overt aggression (identification with the aggressor).



# Continuum of Negative Thought Patterns

Thoughts that lead to low-self-esteem or inwardness (self-defeating thoughts):

## Levels of Increasing Suicidal Intention

1. Self-depreciating thoughts of everyday life
2. Thoughts rationalizing self-denial; thoughts discouraging the person from engaging in pleasurable activities
- 3 Cynical attitudes towards others, leading to alienation and distancing

## Content of Voice Statements

- ← You're incompetent, stupid. You're not very attractive. You're going to make a fool of yourself.
- ← You're too young (old) and inexperienced to apply for this job. You're too shy to make any new friends. Why go on this trip? It'll be such a hassle. You'll save money by staying home.
- ← Why go out with her/him? She's cold, unreliable; she'll reject you. She wouldn't go out with you anyway. You can't trust men/women.



# Continuum of Negative Thought Patterns

Thoughts that lead to low-self-esteem or inwardness (self-defeating thoughts):

## Levels of Increasing Suicidal Intention

4. Thoughts influencing isolation; rationalizations for time alone, but using time to become more negative toward oneself ↔
5. Self-contempt; vicious self-abusive thoughts and accusations (accompanied by intense angry affect) ↔

## Content of Voice Statements

*Just be by yourself. You're miserable company anyway; who'd want to be with you? Just stay in the background, out of view.*

*You idiot! You bitch! You creep! You stupid shit! You don't deserve anything; you're worthless.*



# Continuum of Negative Thought Patterns

Thoughts that support the cycle of addiction (addictions):

**Levels of Increasing Suicidal Intention**



**Content of Voice Statements**

**6. Thoughts urging use of substances or food followed by self-criticisms (weakens inhibitions against self-destructive actions, while increasing guilt and self-recrimination following acting out).**

*It's okay to do drugs, you'll be more relaxed. Go ahead and have a drink, you deserve it. (Later) You weak-willed jerk! You're nothing but a drugged-out drunken freak.*



# Continuum of Negative Thought Patterns

Thoughts that lead to suicide (self-annihilating thoughts):

## Levels of Increasing Suicidal Intention

7. Thoughts contributing to a sense of hopelessness urging withdrawal or removal of oneself completely from the lives of people closest.
8. Thoughts influencing a person to give up priorities and favored activities (points of identity).
9. Injunctions to inflict self-harm at an action level; intense rage against self.

## Content of Voice Statements

See how bad you make your family (friends) feel. They'd be better off without you. It's the only decent thing to do; just stay away and stop bothering them.

What's the use? Your work doesn't matter any more. Why bother even trying? Nothing matters anyway.

Why don't you just drive across the center divider? Just shove your hand under that power saw!



# Continuum of Negative Thought Patterns

Thoughts that lead to suicide (self-annihilating thoughts):

## Levels of Increasing Suicidal Intention

## Content of Voice Statements

10. Thoughts planning details of suicide (calm, rational, often obsessive, indicating complete loss of feeling for the self).



*You have to get hold of some pills, then go to a hotel, etc.*

11. Injunctions to carry out suicide plans; thoughts baiting the person to commit suicide (extreme thought constriction).



*You've thought about this long enough. Just get it over with. It's the only way out.*



# Thoughts About My Life

Name \_\_\_\_\_ Date \_\_\_\_\_

Sex \_\_\_\_\_ Race \_\_\_\_\_ Age \_\_\_\_\_ Education \_\_\_\_\_

Occupation \_\_\_\_\_

by William M. Reynolds, Ph.D.

## Directions

Listed below are sentences which describe thoughts that people sometimes have. Read each sentence carefully and decide which of these thoughts you have had in the past month. Circle the letter beneath the answer that best describes your own thoughts. If you make a mistake or change your mind, make an "X" through the incorrect response and then circle the correct response. **DO NOT ERASE!** There are no right or wrong answers so answer each sentence as openly and honestly as possible. Be sure to answer each sentence. Do NOT leave any sentences blank.

This thought was in my mind:	Almost every day	Couple of times a week	About once a week	Couple of times a month	About once a month	I had this thought before but not in the past month	I never had this thought
1. I thought it would be better if I was not alive.....	A	B	C	D	E	F	G
2. I thought about killing myself.....	A	B	C	D	E	F	G
3. I thought about how I would kill myself.....	A	B	C	D	E	F	G
4. I thought about when I would kill myself.....	A	B	C	D	E	F	G
5. I thought about what to write in a suicide note.....	A	B	C	D	E	F	G
6. I thought about telling people I plan to kill myself.....	A	B	C	D	E	F	G
7. I thought that people would be happier if I was not around.....	A	B	C	D	E	F	G
8. I thought about how people would feel if I killed myself.....	A	B	C	D	E	F	G
9. I wished I were dead.....	A	B	C	D	E	F	G
10. I thought about how easy it would be to end it all.....	A	B	C	D	E	F	G



# The Suicidal Child

by Cynthia R. Pfeffer, MD  
The Guilford University Press

## Spectrum of Suicidal Behavior

1. ***Nonsuicidal***- No evidence of any self-destructive or suicidal thoughts or actions.
  
2. ***Suicidal Ideation***- Thoughts or verbalization of suicidal intention.  
Examples: a. “I want to kill myself”  
b. Auditory hallucination to commit suicide
  
3. ***Suicidal Threat***- Verbalization of impending suicidal action and/or a precursor action which. If fully carried out, could have led to harm.  
Examples: a. “I am going to run in front of a car”  
b. Child puts a knife under his or her pillow  
c. Child stands near an open window and threatens to jump



# Firestone Assessment of Self-Destructive Thoughts

	Never	Rarely	Once In A While	Frequently	Most Of The Time
1. <b>Just stay in the background.</b>	0	1	2	3	4
2. <b>Get them to leave you alone. You don't need them.</b>	0	1	2	3	4
3. <b>You'll save money by staying home. Why do you need to go out anyway?</b>	0	1	2	3	4
4. <b>You better take something so you can relax with those people tonight.</b>	0	1	2	3	4
5. <b>Don't buy that new outfit. Look at all the money you are saving.</b>	0	1	2	3	4



# Firestone Assessment of Suicide Intent Record Form

Name: \_\_\_\_\_ Sex: Male Female  
Age: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Examiner: \_\_\_\_\_

## ■ Instructions

This form contains a number of statements. I want you to read each statement carefully and indicate how often you have each thought by filling in the appropriate box to the right. For example, consider the thought, “You are going to make a fool of yourself.” Do you experience this thought never, rarely, once in a while, frequently, or most of the time? **Please indicate the frequency with which you experience the following thoughts toward yourself.** If you wish to change your answer, put an X through it and fill in your new choice. If you have questions, be sure to let me know.

Never Rarely Once in Awhile Frequently Most of the Time

1. Life would be so much easier if you just killed yourself.
2. Life would be simple; there would be no life and you wouldn't have to torture yourself any longer.
3. You coward, just do it already. Kill yourself.
4. It's too bad you have to kill yourself to show people how much you're hurting.



# **Suicide Risk Factors Checklist**

## **■ Psychiatric**

- Major Depression-particularly endogenous**
- Alcohol dependence-rate 50x the general population, 25% of all suicides**
- Drug addiction- 10% die by suicide**
- Personality Disorders- especially borderline or compulsive**
- Schizophrenia-frequently with command hallucinations**
- Organic psychoses**



# **Suicide Risk Factors Checklist**

## **■ Psychiatric**

- Past history- especially if attempts were serious**
- Family History-increased risk in twin and adoption studies**
- Possible biologic markers: Decreased CSF 5-HIAA, increased CSF MHPG, nonsuppressing DST, low platelet MAO, low platelet serotonin, high platelet serotonin-2 receptor responsibility**
- Poor physical health- renal dialysis patients have a suicide rate 400X higher than the general population**



# **Suicide Risk Factors Checklist**

## **■ Psychological**

- History of Recent Loss**
- History of parental Loss During Childhood**
- Important Days-anniversaries, holidays, etc.**
- Family instability**
- Social Isolation-loss of social supports**



# Suicide Risk Factors Checklist

## ■ Social

### Sex-

**Male 3X female**

### Race-

**Whites 2x nonwhites, except urban areas where rate is the same: Native Americans have higher rates**

### Age-

**in men rates rise with age above age 45; in women the peak risk is about age 55, then the rate declines**

### Religion-

**Protestants and atheists have higher rates than Jews and Catholics**



# Suicide Risk Factors Checklist

## ■ Social

- Geography-**  
urban rates higher
- Marital Status-**  
divorced > single > widowed > married
- Socioeconomic-**  
high rates at both spectrums, retired and  
unemployed at higher risk



# Standard Suicide Risk Assessment Form

## Appendix A

A comprehensive suicidality assessment was conducted due to (check one about the nature of the referral):

- Referral source identified suicidal symptoms or risk factors
- Patient reported suicidal thoughts/feelings on intake paperwork/assessment tools
- Recent event already occurred (suicide attempt/suicide threat)



# Standard Suicide Risk Assessment Form

## Appendix A

Describe the therapeutic alliance/ relationship at the end of the initial session

Poor

Routine

Good

### **Precipitants to Consider:**

Y N Significant Loss (Describe)

Y N Interpersonal Isolation (Describe)

Y N Relationship Problems (Describe)



# Standard Suicide Risk Assessment Form

## Appendix A

Nature of Suicidal Thinking:

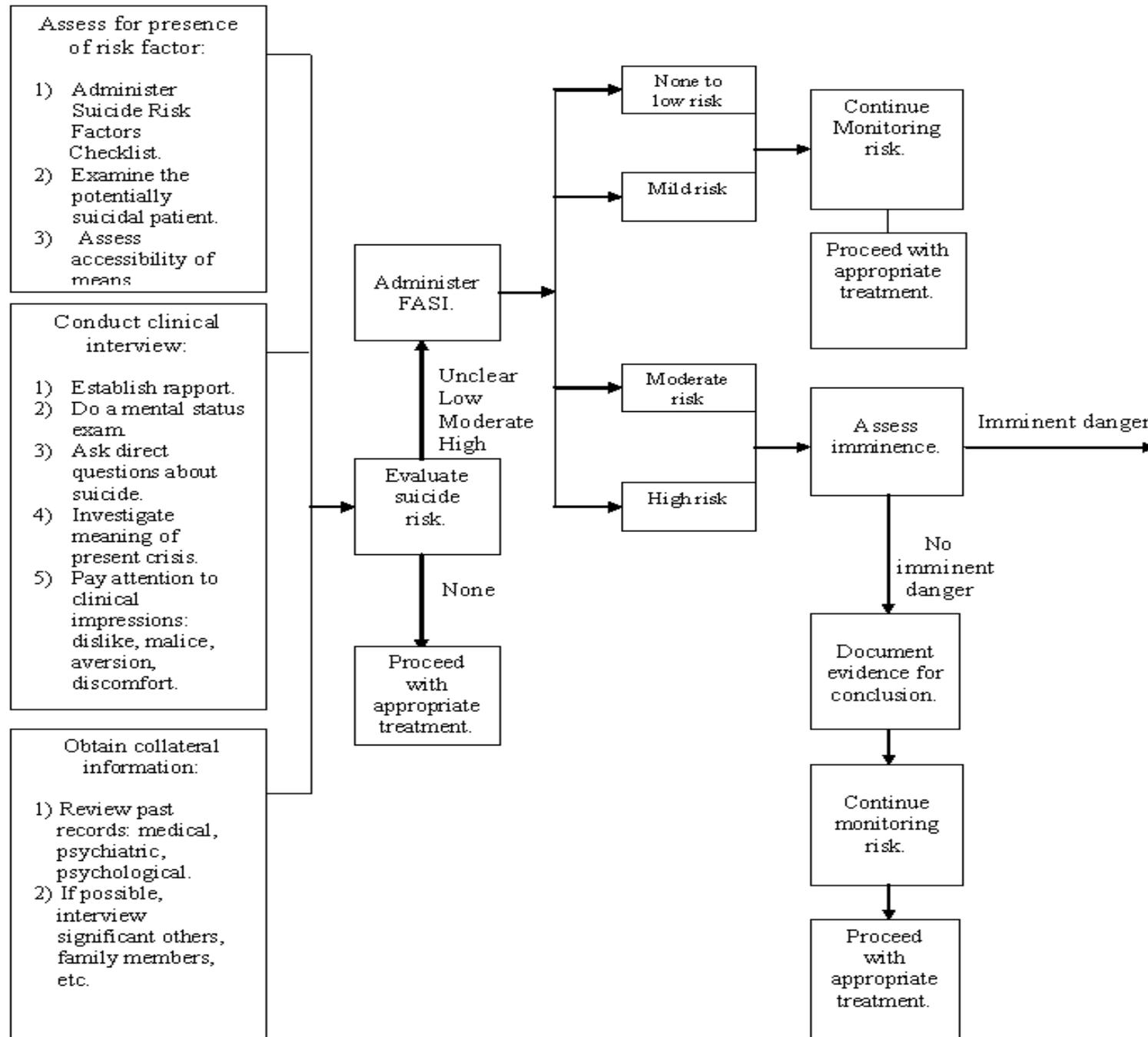
Y    N    Suicidal Ideation

Frequency:

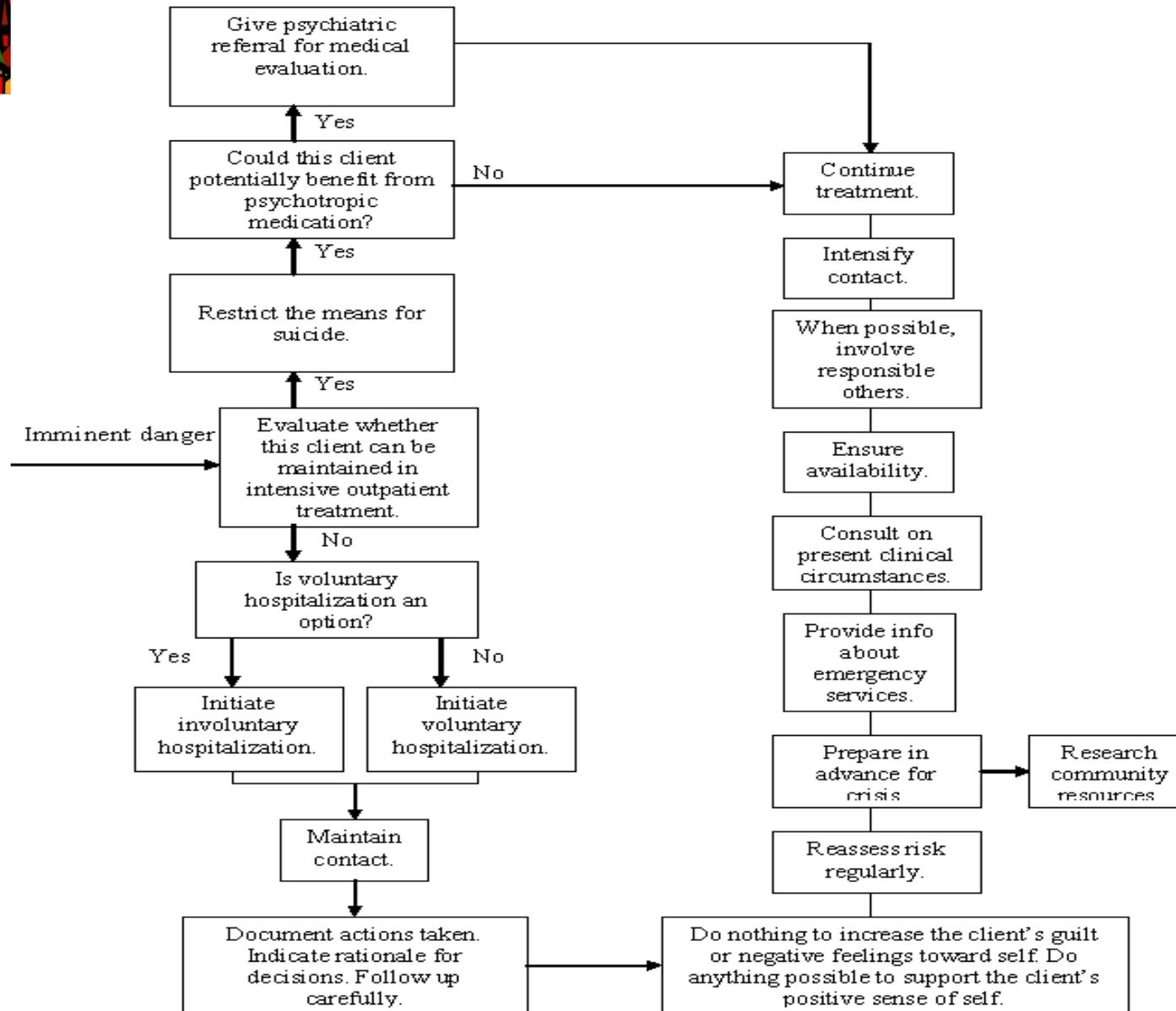
Never   Rarely   Sometimes   Frequently   Daily

Intensity:

(Mild)   1   2   3   4   5   6   7   8   9   10   (Severe)



**Figure 5.1. Assessment and Management of the Suicidal Patient**



**Figure 5.1. Assessment and Management of the Suicidal Patient**



# Crisis Response Plan

When I'm acting on my suicidal thoughts by trying to find a gun (or another method to kill myself), I agree to take the following steps:

- Step 1. I will try to identify specifically what's upsetting me.
- Step 2. Write out and review more reasonable responses to my suicidal thoughts, including thoughts about myself, others, and the future.
- Step 3. Review all the conclusions I've come to about these thoughts in the past in my treatment log. For example, that the sexual abuse wasn't my fault and I don't have anything to feel ashamed of.
- Step 4. Try and do the things that help me feel better for at least 30 minutes (listening to music, going to work, calling my best friend)
- Step 5. Repeat all of the above at least one more time.
- Step 6. If the thoughts continue, get specific, and I find myself preparing to do something, I'll call the emergency call person at (phone number: XXXXXXXX).
- Step 7. If I still feel suicidal and don't feel like I can control my behavior, I'll go to the emergency room located at XXXXXXXX, phone number XXXXXXXX.



# Commitment to Treatment Statement in Practice

We recommend that the CTS always be handwritten and individualized by the clinician; avoid using a standard preprinted form. The CTS should always include a crisis response plan, that is, the specific steps the patient should take during a crisis. Some manner of agreement should be accomplished in the first session. The implicit, and potentially problematic, messages are likely profound with use of a preprinted form. In addition to the central elements noted, it is important to identify any time restrictions imposed by the patient: What is the duration of the agreement – 1 week, 1 month, 1 year?

Here is an example of a CTS from our practice (Rudd, Joiner, & Rajab, 2004):

I, \_\_\_\_\_, agree to make a commitment to the treatment process. I understand that this means that I have agreed to be actively involved in all aspects of treatment including:



# Commitment to Treatment Statement in Practice

1. Attending sessions (or letting my therapist know when I can't make it),
2. Setting goals,
3. Voicing my opinions, thoughts, and feelings honestly and openly with my therapist (whether they are negative or positive, but most importantly my negative feelings),
4. Being actively involved *during* sessions,
5. Completing homework assignments,
6. Taking my medications as prescribed,
7. Experimenting with new ways of doing things,
8. And implementing my crisis response plan when needed (see attached crisis response plan card for details).



# Commitment to Treatment Statement in Practice

I understand and acknowledge that, to a large degree, a successful treatment outcome depends on the amount energy and effort I make. If I feel like treatment is not working, I agree to discuss it with my therapist and attempt to come to a common understanding as to what the problems are and identify potential solutions. In short, I agree to make a commitment to living. This agreement will apply for the next three months, at which time it will be reviewed and modified.

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_



# ***What to do to Help Save a Life...***

## ***Helper Tasks***

- Engage
- Identify
- Inquire
- Assess
- Develop an Action Plan



# Recommendations From The Aeschi Group

## Goals of the Interview With the Suicidal Patient:

1. To reach a shared understanding of the patient's suicidality, based on the patient's narrative.
2. To restore the patient's sense of mastery.
3. To re-establish life-oriented goals.



# Practice Recommendations

1. When imminent risk does not dictate hospitalization, the intensity of outpatient treatment should vary in accordance with risk indicators for those identified as high risk.



# Practice Recommendations

2. If the target goal is a reduction in suicide attempts and related behaviors, treatment should be conceptualized as long-term and target identified skills deficits (e.g., emotion regulation, distress tolerance, impulsivity, problem-solving, interpersonal assertiveness, anger management), in addition to other salient treatment issues.



# Practice Recommendations

3. If therapy is brief and the target variable is suicidal ideation, or related symptomatology such as depression, hopelessness, or loneliness, a problem-solving component should be used in some form or fashion as a core intervention.



# Practice Recommendations

4. Regardless of therapeutic orientation, an explanatory model should be detailed identifying treatment targets, both direct (i.e., suicidal ideation, attempts, related self-destructive and self-mutilating behaviors) and indirect (depression, hopelessness, anxiety, and anger; interpersonal relationship dysfunction; low self-esteem and poor self-image; day-to-day functioning at work and home).



# Practice Recommendations

5. Use of standardized follow-up and referral procedure (e.g., letters or phone calls) is recommended for those dropping out of treatment prematurely in an effort to enhance compliance and reduce risk for subsequent attempts.



# Practice Recommendations

6. The lack of definitive data regarding the efficacy of one approach over another should be reviewed with the patient as a component of informed consent.



# The Therapeutic Process in Voice Therapy

## ■ Step I

Identify the content of the client's negative thought process. The client is encouraged to say the attack as he or she experiences it. If the client is holding back feelings, he or she is encouraged to express them.



# The Therapeutic Process in Voice Therapy

- Step II

The client discusses insights and reactions to verbalizing the voice. The client attempts to understand the relationship between voice attacks and early life experience.



# The Therapeutic Process in Voice Therapy

## ■ Step III

The client answers back to the voice attacks, which is often a cathartic experience. Afterwards, it is important for the client to make a rational statement about how he or she really is, how other people really are, what is true about his or her social world.



# The Therapeutic Process in Voice Therapy

## ■ Step IV

The client develops insight about how the voice attacks are influencing his or her present-day behaviors.



# The Therapeutic Process in Voice Therapy

- Step V

The client then collaborates with the therapist to plan changes in these behaviors. The client is encouraged to not engage in self-destructive behavior dictated by his or her negative thoughts and to also increase the positive behaviors these negative thoughts discourage.



# Poem

- “I Am” by Dean Wood



# 2009 Voice Therapy Training



## Level I – February 2009

Los Angeles, CA ~ February 6-8

San Francisco, CA ~ February 20-22

Vancouver, BC, Canada ~ February 27-28

## Level II- Spring 2009

Santa Barbara, CA ~ April 3-5

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