CHAPTER 11

Voice Therapy: A Treatment for Depression and Suicide

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> *I could not sleep, although tired, and lay feeling my nerves shaved to pain & the groaning inner voice: oh, you can't teach, can't do anything. Can't write, can't think. . . . I cannot ignore this murderous self: it is there. I smell it and feel it, but I will not give it my name. . . .*
>
> *I have a good self, that loves skies, hills, ideas, tasty meals, bright colors. My demon would murder this self by demanding that it be a paragon, and saying it should run away if it is anything less.*
>
> From "Letter to a Demon" by Sylvia Plath
> (Hughes & McCullough, 1982, pp. 176–177)

Sylvia Plath's quote illustrates the three premises underlying the approach to understanding suicide and self-destructive behavior developed by Robert Firestone, clinical psychologist and theorist (R. Firestone, 1986, 1997a, 1997b; R. Firestone & Firestone, 1998). The first premise states that a division exists within all of us, as Plath so clearly expressed. There is a "good self" that is life-affirming, goal-directed, with specific desires and wants and priorities; and there is an inner demon, an antiself that is self-critical, self-destructive, and, at its ultimate extreme, suicidal. As Plath described it, her "demon" demanded perfection of her, and when she fell short, she thought she deserved to die for this failure.

The second premise of Firestone's approach, as reflected in the quote, involves the concept of the inner voice, or the language of the defensive process. His early investigations into the voice process demonstrated that self-destructive thoughts exist on a continuum, from mild self-critical

thoughts, to thoughts of extreme self-hatred, and finally to actively suicidal thoughts. "You can't teach, you can't do anything. Can't write, can't think." These self-destructive thoughts lead to emotional pain, perturbation, and a desperation to escape, driving the suicidal process.

The third premise of his approach proposes that there exists a corresponding continuum of self-destructive behaviors that people engage in, directed by the voice process. In Plath's case, she isolated herself, alienated the people closest to her, and ultimately took her own life.

It was found that by accessing the negative thoughts that people are experiencing toward themselves, we can predict the self-destructive behaviors they are likely to engage in (R. Firestone & Firestone, 1996, 1998). In addition, R. Firestone has developed a treatment technique, voice therapy, for giving voice to this self-destructive process (R. Firestone, 1988, 1997a). The technique allows clients to identify the enemy within, understand its sources, recognize the impact it is having on their lives today, and learn to resist carrying out its dictates and act instead in their own self-interest.

In this chapter, I first discuss the basic tenets of R. Firestone's overall theoretical approach of *separation theory,* including the *fantasy bond,* or self-parenting process, and the voice process. Second, I describe the steps in voice therapy, a cognitive/affective/behavioral treatment approach. Finally, I present a hypothetical session to illustrate this methodology as applied in the treatment of an individual at risk for suicide.

THEORETICAL APPROACH

Separation theory represents a broadly based system of concepts and hypotheses that integrate psychoanalytic and existential views (R. Firestone, 1997a; R. Firestone, Firestone, & Catlett, 2003). The theory explains how emotional pain and frustration in the child's earliest relationships lead to defense formation and how these original defenses are reinforced as the developing child gradually becomes aware of his or her own mortality. In this approach, there is an emphasis on the exposure of destructive fantasy bonds (imagined connections with another person) as externalized in personal relationships or as internalized in the form of negative parental introjects (destructive thought processes or *voices*). According to R. Firestone (1997b):

> Dissolution of these bonds and movement toward separation and individuation is essential for the realization of one's destiny as a fully autonomous human being. . . . A merged identity or diminished sense of self is a microsuicidal[1] or even suicidal manifestation, as one no longer lives a committed, feelingful existence. (p. 182)

Separation as described here is very different from isolation, defense, or retreat; rather, it involves the maintenance of a strong identity at close quarters with others. Without a well-developed self system, people find it necessary to distort, lash out at, or withdraw from intimacy in interpersonal relationships. A defended life characterized by imagined fusion with another person or other people acts to limit a person's capacity for self-expression and self-fulfillment. Without a strong sense of self, life seems empty, meaningless, and without direction.

Inwardness[2] is a necessary ingredient for suicidal ideation to take control over an individual's behavior. The syndrome of inwardness is made up of the following dimensions: a tendency toward isolation, self-denial and withholding, withdrawal from favored activities and relationships, reliance on addictive substances or routines to relieve emotional pain, preference for seeking gratification in fantasy rather than in the real world, increased attitudes of self-hatred and cynicism toward others, and a lack of direction in life.

The dissolution of a fantasy bond or imagined connection with another person often leaves the inward, self-protective person feeling overwhelming psychological pain. This pain is not a response to the loss of the relationship, which may or may not have been close or fulfilling, but to the loss of the imagined fusion, the feeling of being whole by being merged with another person. Repressed pain from childhood and existential fears of aloneness and death are aroused. For example, the

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[1] *Microsuicide* is a term that refers to behaviors, communications, attitudes, or lifestyles that are self-induced and threatening to an individual's physical health, emotional well-being, or personal goals (Firestone & Seiden, 1987).

[2] The term *inwardness* refers to a syndrome of specific personality traits and behavioral patterns that play a crucial part in all forms of psychopathology and that are especially evident in suicidal individuals. It is important to distinguish this syndrome from self-reflection, introspection, time spent alone for creative work or planning, meditation, and other forms of spiritual or intellectual pursuits (R. Firestone & Catlett, 1999; R. Firestone et al., 2003).

following statements were excerpted from the diary of a young woman who committed suicide. Here she reflects on her ambivalence about intimacy after feeling rejected by her boyfriend when he flirted with another girl:

> I have such a problem with loss. Fear of losing someone. Fear of loving someone. Fear of trusting someone. I feel so abandoned and unconnected with everyone, everyone. I feel like I'm going to die. . . . I did try reaching out again for the last time. People are so mean and selfish. I want to kill myself on my birthday. I have to.

What are the sources of pain and anxiety that disturb the individuation process, interfere with people's developing a strong sense of identity, and contribute to an inward, defended orientation toward life?

Origins of Psychological Pain

According to R. Firestone (1997a), there are two major sources of psychological pain and anxiety: (1) deprivation, rejection, and overt or covert aggression on the part of parents, family members, and significant others; and (2) basic existential problems of aloneness, aging, illness, death, and other facts of existence that have a negative effect on a person's life experience, such as social pressure, crime, economic fluctuations, political tyranny, and the threat of nuclear holocaust. *Interpersonal pain* refers to the frustration, aggression, and abuse an individual experiences in relationships, whereas issues of being, aloneness, and the fact of death fall into the category of existential pain. Firestone feels that it is important to integrate both psychoanalytic and existential systems of thought to achieve a better understanding of the conflict between life-affirming propensities and self-destructive tendencies operating within each individual.

Early Trauma

Each person experiences varying degrees of emotional pain in growing up. Even in ideal families, there is inevitable frustration, and most family constellations are less than ideal. Experiences of emotional deprivation, rejection, parental aggression, and intrusiveness necessitate the development of childhood defenses in order to cope with the interpersonal environment. The more that parents were deprived or rejected when they were children, the greater the impairment of their parenting

functions, regardless of their love and concern for their offspring (Baumeister, Bratslavsky, Finkenauer, & Vohs, 2001; Fonagy et al., 1995; Main & Hesse, 1990; Main & Solomon, 1986; Sanders & Giolas, 1991; Siegel, 2001).

Felitti (2002) has called attention to the prevalence of emotional, physical, and sexual abuse in our society. Some of the most compelling evidence of the prevalence of abusive or dysfunctional child-rearing practices and their effects were reported by the Kaiser Foundation Health Plan investigation into adverse childhood experiences (ACE; Felitti et al., 1998). Questionnaires filled out by more than 17,000 patient members revealed "a powerful relation between our emotional experiences as children and our adult emotional health, physical health, and major causes of mortality in the United States" (Felitti, 2002, p. 44). Felitti et al. (1998) also reported that "23.5% of participants reported having grown up with an alcohol abuser . . . contact sexual abuse was reported by 22% of respondents" (p. 252), and "more than half of respondents (52%) experienced ≥ 1 category of adverse childhood exposure" (p. 249).

Under conditions of physical, emotional, or sexual abuse, the person to whom the child naturally turns to for care also becomes the frightening or punishing agent, and the child typically fails to develop a secure attachment (Main & Solomon, 1986). Witnessing violence between parents and/or being the victim of these abuses are perhaps the most serious forms of trauma that can occur in the life of a young child. Fear states aroused by these events can cause the brain to release certain toxins that 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).

Psychological defenses formed as a reaction to interpersonal pain precede the child's growing awareness of death. They represent an adaptation to the parental climate and act as a psychological survival mechanism to maintain equilibrium. One defense mechanism or coping strategy that seems to be linked directly to suicide is dissociation (Briere & Runtz, 1987; Brown, Cohen, Johnson, & Smailes, 1999; Chu & Dill, 1990). *Dissociation* is a person's ability to detach from his or her body, to

watch things happen to the self, rather than the experience of being the one perpetrated on. Early abuse, particularly sexual abuse, appears to facilitate the development of this defensive maneuver. Unfortunately, this may pave the way for later self-destructive behavior and higher suicide risk (van der Kolk, 1996).

The Impact of the Evolving Knowledge of Death on the Child's Defenses

The point in the developmental sequence when the child first discovers death is the critical juncture where his or her defense system, developed to cope with interpersonal pain, crystallizes and shapes his or her future (R. Firestone et al., 2003). Thereafter, most people accommodate to the fear of death through the withdrawal of energy and emotional investment in life-affirming activity and close, personal relationships. In renouncing real satisfaction, they rely increasingly on internal gratification, fantasies of fusion, and painkillers. The fantasy of suicide can provide a sense of triumph over death, that is, of taking control over your destiny (Fierman, 1965; Maltsberger, 1999; Orbach, 2002).

Defenses provide a method of escaping psychological pain at the expense of varying degrees of obliteration of personality and personal experience. Unfortunately, defenses cannot selectively cut out emotional pain without seriously interfering with other functions. They act to dull awareness, distort perceptions, deaden emotional responses, and eventually lead to an overall deterioration in the quality of life. These distorted perceptions often result in persons seeing themselves and the world through a negative filter, which contributes to suicide risk. Moreover, detaching from themselves and their life sets the stage for suicidal behavior.

The Basic Defense System

R. Firestone asserts that the basic defense is the fantasy bond, originally an imagined connection with the mother or primary caregiver that the infant develops to protect itself against pain, anxiety, and frustration (R. Firestone, 1984). This illusion of fusion provides partial gratification of the infant's basic needs and reduces painful tension states. Infants have a natural ability to comfort or soothe themselves by using images and memories of past feeding experiences to ward off the anxiety of being temporarily separated from their mother and to help diminish feelings of hunger and frustration (R. Firestone, Firestone, & Catlett, 2002). The

fantasy bond is created to deal with the intolerable pain and anxiety that arise when the infant is faced with excessive frustration. This anxiety can be far more devastating to the infant than the frustration itself and at times may be experienced as a *threat of annihilation,* a very primitive anxiety that was described by Winnicott (1958). An illusion of being connected to the primary parenting figure thus becomes a substitute or compensation for the love and care that may be missing in the infant's environment. The degree to which the child, and later the adult, comes to rely on fantasies of fusion largely depends on the degree of deprivation and trauma he or she suffered early in life.

People have a natural tendency to resort to psychological defenses to reduce or eliminate primitive pain and anxiety states. Ironically, core defenses or imagined connections with other people that are erected by children early in life to protect themselves from a toxic environment and from painful aspects of the human condition can eventually become more damaging than the original trauma (R. Firestone, 1997b). In other words, defenses that initially function as a survival mechanism later act to limit their life.

The Self-Parenting Process

The fantasy bond is a manifestation of a process of parenting self both internally in fantasy and externally by using objects and persons in the environment. The result is a pseudo-independent posture of self-sufficiency—a fantasy that the individual can take care of himself or herself without needing others. The child experiences a false sense of self-sufficiency or omnipotence because he or she has introjected an image of the "good and powerful" mother or primary caretaker. Unfortunately, at the same time, the child must also necessarily incorporate the corresponding self-image of the "bad and helpless" child. This introjected parental image takes on the significance of a survival mechanism in the child's mind. The process of parenting oneself is made up of two components, each of which takes on its unique character from the introjection and internalization of parental attitudes and responses in the process of growing up in a specific interpersonal environment (R. Firestone, 1984, 1985, 1997a).

The self-nourishing or self-soothing component is made up of behaviors that dull or numb painful feelings: originally thumb-sucking, stroking a blanket, nail-biting, and later elaborated in adult life to eating

disorders; addiction to cigarettes, alcohol, and other drugs; compulsive masturbation; praising and coddling oneself; vanity; and an impersonal, self-feeding, habitual style of sexual relating. The self-nurturing component includes any behavior that is engaged in for the purpose of cutting off feelings. Even constructive behaviors, such as exercise, can be used in this way. 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 excerpt from the diary of the same young woman who committed suicide illustrates the internalization of the abusive parenting she experienced at the hands of a schizophrenic mother and an alcoholic father:

> I've got to make it end tonight!! I HATE MYSELF SO MUCH. I'VE TRIED to learn how to love myself . . . but I can't because people always want more than me. God, I wish I could torture myself—not subtly but viciously. I feel so sick. I CAN'T TAKE ANYMORE!! Please God Help Me!

Fantasies of fusion and self-parenting systems act as painkillers to cut off feeling responses and impede the development of a true sense of self. The end product of this progressive dependence on self-nourishing patterns is a form of psychological equilibrium achieved at the expense of genuine object relationships. Defended individuals seek equilibrium over actualization; that is, they are willing to give up positive, goal-directed activity to maintain internal sources of gratification.

The Voice Process

The voice process can be thought of as a secondary defense. The voice is defined as a well-integrated, discrete antiself system—an alien point of view that is an overlay on the personality at the core of an individual's maladaptive behavior. Our research (L. Firestone, 1991; R. Firestone & Firestone, 1998) has demonstrated that people are able to readily identify the content of their self-critical, self-destructive thoughts or voices when they verbalize them in the second person, that is, as though another person were addressing them (in the form of statements *toward* themselves rather than statements *about* themselves). They often get to deeper core beliefs about themselves that they were not fully aware of, but which govern a great deal of their behavior. Suicidal individuals have awareness of the voices they are experiencing, as evidenced by those

who have conducted interviews with suicide attempters (Heckler, 1994; Michel & Valach, 2001). For example, this excerpt is drawn from Michel and Valach's work:

> It was so that there were so many thoughts and they had such a power over me that I developed the feeling that I would really go mad. 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. This was very strong, rather something else, dead or unconscious or I don't know what. I also thought that I would tell my sister that if I ended up as a vegetable they should switch off the machines, because I didn't want that my children or my relatives would have to suffer because I was nuts. This, too, I felt very strongly. It was so that there were so many thoughts and they had such a power over me that I developed the feeling that I would really go mad.
>
> Actually, I wanted to flee from these thoughts, not from the too heavy demands but from the many thoughts because they made what they wanted. I couldn't live with them any longer. I wanted to kind of kill them.
>
> In the evening I was very agitated. My sister had a terrace to which the door was open, and I thought that the door should be closed, because I had the feeling that I was like being pushed out through this door. And always this thought—you can't live with the children if you end up in a psychiatric hospital. It seems that I also spoke to my mother on the phone and she said something about suicide and that I shouldn't harm myself, but somehow it didn't reach me. And my daughter said something but I couldn't concentrate and I thought it would be best if nobody said anything because I couldn't follow any more.
>
> And then—I can't remember what happened after that. They said that I got up and walked straight out to the terrace and jumped over it as if this had always been clear to me. My sister saw me in the last moment and asked what I was doing and in that moment I jumped.

The voice alternately builds up and tears down the self and provides ostensibly rational reasons for self-denial, isolation, and avoidance of others. It functions as an antifeeling, antibody process, wherein people live primarily in their heads, cut off from their emotions and bodily sensations. Even so-called positive voices of approval and self-affirmation are indications that people are removed from themselves and treating themselves as objects. This emotional distance from the self is a key element in the suicidal process. You have to be removed from yourself to kill yourself. Suicide is diametrically opposed to our animal instinct to

survive at all costs. The following excerpt from an interview with a woman who made a serious suicide attempt illustrates this point:

Client: I know it doesn't look appetizing, but it works well, and then I tried at first here (upper lower arm) and it did not hurt. Then I watched how it was bleeding, and it was nothing particular. 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.

Client: Yes, completely. I was watching myself even then. I know it sounds schizophrenic, but it was like that, "it's simply bleeding now." And then I cut again. I cut three times and then once more . . . and then, suddenly, I was not outside of myself any more.

Interviewer: Then you were what?

Client: Not outside of myself any more. It was this last deep cut and it really did not look nice any more and I knew that if I did not do anything, I would die. As stupid as it sounds.

In summary, psychological defenses are subject to malfunction in a manner that is analogous to the body's physical reaction to pneumonia. The presence of organisms in the lungs evokes cellular and humoral responses that meet the invasion, yet the magnitude of the defensive reaction leads to congestion that is potentially dangerous to the person. In this disease, the body's defensive reaction is more destructive than the original assault. Similarly, defenses that were erected by the vulnerable child to protect himself or herself against a toxic environment eventually become more detrimental than the original trauma. In this sense, people's psychological defenses formed under conditions of stress become the core of their self-destructive propensities and impact their risk of committing suicide.

The Core Conflict

As a result of forming defenses early in life, all people exist in conflict between an active pursuit of goals in the real world and a defensive reliance on self-gratification. An individual who chooses to cultivate life and lead an honest and undefended lifestyle will experience both the joy and pain of his or her existence. In contrast, the defended person's attempt to block out pain neutralizes the life experience and deprives the individual of life's enrichment. To the extent that individuals succumb to a defensive posture, form addictive attachments and habit patterns, and choose an inward self-protective life, their adjustment will suffer, and it is unlikely that they will approach their potential. Retreat to an increasingly inward posture represents, in effect, a form of controlled destruction of the self. Anything that threatens to disturb an individual's solution to the core conflict arouses fear. Descending into this process more and more and withdrawing investment from real life often creates the necessary conditions for suicide.

Movement in any direction, either a retreat further into fantasy and self-parenting or movement toward external goal-directed behavior, is accompanied by anxiety. The rise in anxiety results in both aggressive and regressive reactions. An individual's defensive reaction to the basic conflict is determined, to a considerable degree, by the amount of pain experienced early in life and the type of defense mechanism he or she adopted to deal with it. Overwhelming experiences from the perspective of the helpless child lead to an inability to tolerate and deal effectively with pain. Suicidal people, while heterogeneous in many ways, have in common a lack of pain tolerance and a lack of effective (non-self-destructive) coping strategies to deal with pain. In essence, they cannot tolerate psychological pain and are desperate to get out of it, and, because they lack healthy strategies for alleviating pain, they often resort to self-destructive actions.

The Self and Antiself Systems

Destructive parental introjects that are represented by the voice lead to an essential dualism within the personality. This "division of the mind" reflects a primary split between forces that represent the self and those

that oppose or attempt to destroy the self. These propensities can be conceptualized as the *self system* and the *antiself system.* The two systems develop independently; both are dynamic and continually evolve and change over time (see Figure 11.1).

The *self system* consists of the unique characteristics of the individual including his or her biological, temperament, and genetic traits; the harmonious identification with parents' positive qualities and strivings; and the ongoing effects of experience and education. Parents' genuine selves, as demonstrated in lively attitudes, positive values, and an active

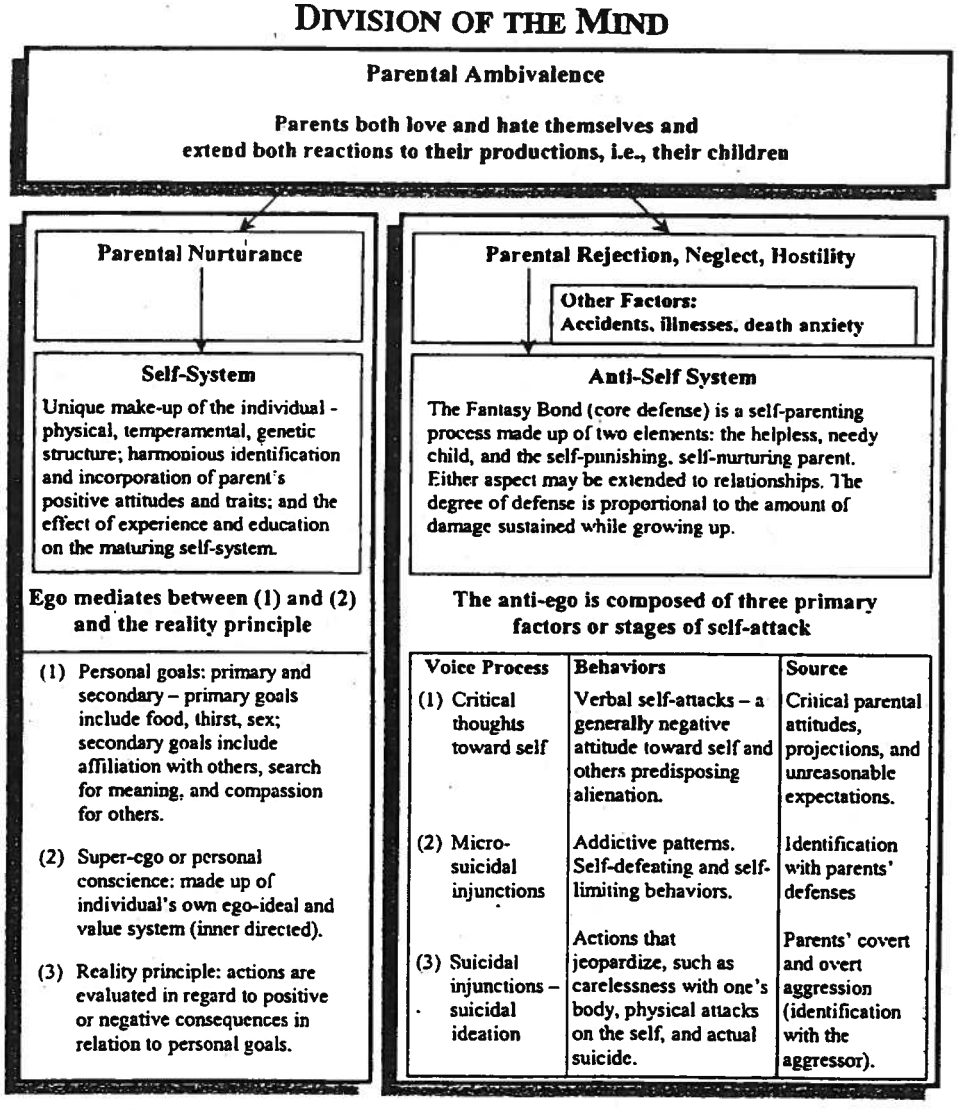

Figure 11.1 Divisions of the mind. Copyright © 2004 by the Glendon Association.

pursuit of life, are easily assimilated into the self system through the process of identification and imitation and become part of the child's developing personality.

The *antiself system* refers to the accumulation of destructive internalized cynical or hostile voices that represent the defensive aspect of the personality. These negative parental attitudes cannot be assimilated because they are against the self. Therefore, they exist as an alien point of view. As stated previously, the defensive process is influenced primarily by interpersonal pain reinforced and compounded by the suffering inherent in the human condition. People tend to protect the defensive apparatus at the expense of limiting their real lives and goal-directed activities. They tend to exist in a state of defensive equilibrium.

The antiself system has three primary factors or levels of self-attack. The first level consists of critical thoughts leading to inwardness and low self-esteem, thoughts promoting self-denial and isolation as well as cynical, hostile attitudes toward others. The second level of self-attacks consists of thoughts that encourage indulgence in addictive behaviors followed by thoughts of self-recrimination. The third level includes thoughts that represent the full spectrum of self-annihilation, from psychological suicide (hopelessness, thoughts urging the removal of self from significant others), thoughts associated with giving up priorities and favored activities, injunctions leading to self-mutilation, and actual physical suicide including suicide plans and suicide injunctions.

The thoughts at level three seem to stem from parents' covert or overt aggression (in other words, the anger the parents covered over or acted out). At this serious level, the person has become identified with the punishing parent and has taken on that anger toward himself or herself. In the process, the child idealizes the parent, seeing the parent as good or powerful; in internalizing the parent's anger, the child perceives himself or herself as bad and weak. Identifying with the powerful parent functions to partially relieve the child's terror in relation to being at the mercy of an out-of-control parent (Ferenczi, 1929). As Fairbairn (1952) commented in writing about the defense of identifying with the aggressor: "It is better to be a sinner in a world ruled by God than to live in a world ruled by the Devil" (pp. 66–67). This level represents an internalization of the parent at the parent's worst—not the parent as he or she was every day, but the angry parent at those times of extreme stress

when the parent "lost it." The child now unleashes that anger toward himself or herself.

For example, the following are excerpts from the diary of a young woman who committed suicide:

> 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.

Individuals are reluctant to recognize the essential division within their personalities because they are afraid to realize how distorted their thinking is or feel that they cannot trust their own thoughts. They attempt to deny this fracture by identifying negative traits predisposed by the antiself system as their own. As a result, they tend to compromise their essential point of view, their aliveness, spontaneity, and individuality and move in the direction of the prescriptions of the voice, as noted in this excerpt from the same young woman's diary:

> I see how my interests & drives as a child have honestly disappeared. It all makes me very angry. There are a lot of things & people to blame for this. I never picked my circumstances. . . . Besides, who in their right mind would actually choose to live where I did—honestly now—come on. Anyway, it is all taking so long. I've changed things on a bit—let them dangle—or better yet myself in limbo. It's not very healthy.
>
> But then, what is always going on inside me? I can feel so damn restless and irritable talking about it. Obsessing aimlessly. It's ridiculous. But mainly I have inner fears and abuses. Things I do to myself. I act out horrible ways with myself. I act very unconstructive. Whether it's lying to people, or stealing, or being cruel by hurting my body. Whether it's all the helplessness I had to accept—lack of control which both of these were imperative factors.

People worry that if they recognize hostile or suicidal inclinations in themselves, they will be more likely to act them out. The reverse is true: Becoming aware of unconscious negative attitudes toward self and others allows greater mastery of your life. In voice therapy sessions, the destructive introjects surface and the full profile or the various dimensions of the enemy within can be identified and understood. This enables clients to resist defensive behavior patterns and self-destructive tendencies and helps

them to take control over destructive behavioral manifestations of the antiself system.

The Continuum of Negative Thought Patterns

The extent to which people act out self-limiting, self-destructive behaviors is related to the intensity of and frequency with which they experience negative thoughts. As noted earlier, self-attacks or voices vary along a continuum from mild self-critical thoughts to vicious self-attacks and thoughts urging self-harm. Severely depressed or suicidal clients characteristically become exhausted and listless in struggling against self-destructive urges and self-abusive thoughts. Furthermore, they often lack the means of determining an accurate view of self and cannot differentiate an objective assessment from the current negative view of themselves. The specialized techniques of voice therapy help depressed clients learn to make this important distinction. They provide the opportunity for individuals to identify and separate from negative views of themselves and to strengthen their own point of view, thereby regaining feeling for themselves and a more positive, realistic view of self.

Excerpts from this same diary:

> This life is so empty—didn't even get a quick fix this time—just uneasiness and emotional eruption. I felt like I died—all my dreams died—felt like a different person—completely isolated from other selves in other parts of my life—still feel that way now—feel dirty now—not only because I was abused when I was young, but because I abuse myself now—mutilate, destroy, manipulate, lie, control (sickens).

As described at the beginning of this chapter, three hypotheses about self-destructive behavior were derived from data gathered in R. Firestone's early investigations into the voice process:

1. A conflict exists within each individual between life-affirming tendencies to actively pursue goals in the real world and self-limiting, self-protective, and self-destructive propensities that are related to seeking gratification primarily through fantasy processes.
2. Thoughts opposed to the self vary along a continuum of intensity from mild self-reproach to strong self-accusations and suicidal ideation.

3. Self-destructive behavior exists on a parallel continuum ranging from self-denial; self defeating behaviors, that is, behavior contrary to the individual's goals; accident-proneness; substance abuse; and eventually to direct actions that cause bodily harm, with suicide representing an acting out of the extreme end of the continuum (R. Firestone, 1988, 1997a, 1997b).

Based on these premises, it was logical to conclude that an assessment of an individual's self-destructive thoughts could be utilized to predict future self-destructive behavior. This led to the development of the *Firestone Assessment of Self-Destructive Thoughts* (FAST: R. Firestone & Firestone, 1996) to provide an accurate estimation of an individual's self-destructive and suicide potential.

VOICE THERAPY METHODOLOGY

Voice therapy is a method developed by R. Firestone for uncovering core defenses that directly affect the acting out of self-destructive behavior patterns. It was found in early investigations that by exposing negative thoughts and their antecedents, individuals were able to alter their self-concept in a positive direction, experience relief of symptoms, and feel more in control of their behavior (R. Firestone, 1988).

The ultimate goal of therapy is to help clients move away from compulsive, self-limiting lifestyles so that they can expand their lives and tolerate more gratification in reality. The hope is to help clients achieve a free and independent existence, remain open to experience and feelings, and maintain the ability to respond appropriately to both positive and negative events in their lives. To this end, the process of identifying the voice and the associated feelings of hatred toward self, combined with corrective strategies of behavioral change, significantly expand the client's boundaries and bring about a more positive sense of self.

Overview of the Three Components of Voice Therapy

Voice therapy consists of three components:

I. The process of eliciting and identifying negative thought patterns and releasing the associated affect.

II. Discussing insights and reactions to verbalizing the voice.

III. Changing self-destructive behaviors regulated by the voice through the collaborative planning and application of appropriate corrective experiences.

Voice therapy is not interpretive or analytical in the sense that clients form their own conclusions as to the sources of their destructive thinking.

The first step of voice therapy involves identifying the contents of the client's negative thought process and facilitating the release of the associated affect. Articulating the self-attacks in the second person facilitates the process of separating the client's own point of view from the hostile thought patterns that make up an alien point of view toward self. Before articulating the voice, most clients generally accept their negative thoughts as true evaluations of themselves and implicitly believe them. In addition, these thoughts dictate much of their behavior in a manner that undermines their true goals in life.

The process of identifying the voice can be approached intellectually as a primarily cognitive technique or approached more dramatically using cathartic methods. In both procedures, the client attempts to identify self-criticisms and self-attacks and learns to restate negative thought patterns in the second person as voices experienced from the outside. In the latter technique, there is an emphasis on the release of the affect accompanying the voice attacks on the self. In this abreactive method, the client is asked to amplify his or her self-attacks and express them more emotionally, with instructions to, "Say it louder," "Really feel that," or "Let go and say it the way you really hear it."

In our early studies, clients and subjects frequently adopted this style of expression of their own volition. When asked to formulate their negative thoughts in the second person, they spontaneously began to speak louder and with more intensity of feeling. With this release of emotions, valuable material was revealed. Often, clients would pause for a few seconds after saying their initial self-attacks and then go to a much deeper level and bring out core negative beliefs about themselves.

In the second step, clients discuss their spontaneous insights and their reactions to verbalizing the voice. They then attempt to understand the relationship between their voice attacks and their self-destructive behavior patterns. They subsequently develop insight into the limitations

that they impose on themselves in everyday life functions. The insights also give clients an understanding of where their thoughts originated so that they can develop compassion for themselves. This step is important in that it helps clients account for their limitations and self-defeating behaviors. The approach does not attribute blame to parents or other family members. Parents are not malicious people; they generally wish the best for their children. But they, too, suffered varying degrees of emotional pain and frustration in *their* formative years. To the extent that they remain unaware of the ways they may have been mistreated, they tend to unintentionally reenact this form of maltreatment in interactions with their children. This step in the therapeutic process helps clients recognize that events in their childhood contributed to the formation of their distorted beliefs and other forms of destructive thinking.

The third step involves the process of initiating behavioral changes that expand individuals' boundaries and expose misconceptions about themselves. Since the procedures of voice therapy challenge core defenses and an individual's basic self-concept, collaborative interventions that effect changes in an individual's behavior are a necessary part of any effective therapeutic procedure. The potential for therapeutic progress is not merely a function of identifying negative thought patterns and uncovering repressed material; indeed, personal growth ultimately must involve constructive behavioral changes that oppose self-limiting or self-destructive patterns and lifestyles.

Corrective experiences bear a direct relationship to the maladaptive behavior patterns that are influenced and controlled by the client's negative cognitive processes. The therapist and client identify the specific behaviors regulated by the voice that are self-destructive and constricting, and both participate in formulating ideas about altering routine responses and habitual patterns of behavior. Corrective suggestions are arrived at through a collaborative effort and are in accord with clients' personal goals and ambitions. Taking the action always represents personal risk in the sense of increased vulnerability, breaking with psychological defenses that protected the individual from experiencing painful emotions. Altering negative self-image and core defenses invariably arouses an individual's anxiety and generates a temporary intensification of self attacks. Clients need to be educated that initially acting against the voice will arouse voice attacks, trying to get the person back

in line. If they can tolerate the anxiety and stick with the behavior, these attacks will subside and the person will have less compulsion to act on these voices.

Applying the Techniques of Voice Therapy

The therapist's first task is to establish a therapeutic relationship that is conducive to working together. The therapeutic alliance or relationship provides empathic support and establishes an expectation of collaboration. This sets the stage for the application of voice therapy techniques in clinical practice.

Step I: Introducing Voice Therapy to the Client

The principal technique of voice therapy is the verbalizing of the individual's negative thoughts in the second person format. This methodology is important for two reasons:

1. This is the form in which most people think critically about themselves or experience internal dialogue (the voice is a kind of intrapsychic communication wherein people carry on internal conversations or dialogues with themselves as though another person were talking to them, advising, accusing, and enticing them in ways that are self-defeating and often self-destructive).
2. This technique usually brings out considerable affect, leading to important emotional and intellectual insight. The release of feelings provides the "hot emotional environment" needed for changing core beliefs (Samoilov & Goldfried, 2000; Westen, 2000).

Assessment and Development of a Focused Treatment Strategy

The *Firestone Assessment of Self-Destructive Thoughts* (FAST) can be used to establish a therapeutic focus. The FAST is a self-report questionnaire consisting of 84 items drawn equally from 11 levels of self-destructiveness (see Table 11.1). The FAST asks clients to endorse how frequently they experience negative thoughts on a five-point Likert-type scale. Using information about the specific items and levels that clients endorse as being experienced, the therapist can direct his or her interventions toward those areas in which clients are experiencing the most distress.

Table 11.1 Continuum of Negative Thought Patterns

Levels of Increasing Suicidal Intention	Content of Voice Statements
Thoughts that lead to low self-esteem or inwardness (self-defeating thoughts):	
1. Self-depreciating thoughts of everyday life	*You're incompetent, stupid. You're not very attractive.* *You're going to make a fool of yourself.*
2. Thoughts rationalizing self-denial; thoughts discouraging the person from engaging in pleasurable activities	*You're too young (old) and inexperienced to apply for this job. You're too shy to make any new friends, or* *Why go on this trip? It'll be such a hassle. You'll save money by staying home.*
3. Cynical attitudes toward others, leading to alienation and distancing	*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).*
4. Thoughts influencing isolation; rationalizations for time alone, but using time to become more negative toward oneself	*Just be by yourself. You're miserable company anyway; who'd want to be with you? Just stay in the background, out of view.*
5. Self-contempt; vicious self-abusive thoughts and accusations (accompanied by intense angry affect)	*You idiot! You bitch! You creep! You stupid shit! You don't deserve anything; you're worthless.*
Thoughts that support the cycle of addiction (addictions):	
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.*
Thoughts that lead to suicide (self-annihilating thoughts):	
7. Thoughts contributing to a sense of hopelessness, urging withdrawal or removal of oneself completely from the lives of people closest	*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.*
8. Thoughts influencing a person to give up priorities and favored activities (points of identity)	*What's the use? Your work doesn't matter any more. Why bother even trying? Nothing matters anyway.*
9. Injunctions to inflict self-harm at an action level; intense rage against self	*Why don't you just drive across the center divider? Just shove your hand under that power saw!*
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!*

Any combination of the voice attacks listed above can lead to serious suicidal intent. Thoughts leading to isolation, ideation about removing oneself from people's lives, beliefs that one is a bad influence or has a destructive effect on others, voices urging one to give up special activities, vicious self-abusive thoughts accompanied by strong anger, voices urging self-injury and a suicide attempt are all indications of high suicide potential or risk.

Administering the FAST can be beneficial as a first step in voice therapy for two reasons. First, it allows the clinician to gain direct access to voices that are governing clients' self-destructive actions. The FAST thereby provides direction for interventions. Second, the FAST alerts clients to the presence of specific negative cognitions and brings those cognitions more fully into clients' conscious awareness so that they can work on them in therapy.

The Intake Interview As in most therapy approaches, in the intake interview or first session, the therapist explores with the client the specific problem or problems that brought him or her to treatment. Often, this exploration provides an opportunity for the therapist to inquire about the methods the client has traditionally used in coping with problems. This line of inquiry also helps to build rapport and establish the therapeutic alliance. An informal review of personal history and recent events can increase the therapist's awareness of clients' overall feeling state and typical ways of thinking about themselves, others, and events in life.

In general, when a client begins the session with a complaint related to his or her presenting problem, the therapist would ask, "When did you start feeling this way?" The client might describe an event that he or she believes signaled the onset of the problem. The therapist would then inquire: "What do you think you were telling yourself about this event?" The client would go on to discuss his or her thoughts related to the event.

For example, a client reveals: "I feel terrible. I'm out of work and I can't find a job. I feel like I can't do anything right. I feel like such a failure."

The therapist would respond: "Try to say that as though you were talking to yourself."

The client might respond: "What do you mean?"

The therapist would then say: "Like, '*You can't do anything right. You're such a failure.*' "

Another client relates how he asked a woman for a date and was turned down. The therapist would ask: "What were you telling yourself about being turned down?" The client at this point might say, "I was telling myself that I'm not very attractive. I'm not very interesting. Women don't like me very much." The therapist would suggest that the client

say the same statements as though he were talking to himself, for example, "*You're* not attractive. *You're* not interesting. No woman would ever like *you.*"

In another example, a client discloses that she was hurt by a criticism from someone. The therapist would ask, "What really bothered you about the criticism? What really got to you? Was there a certain part of it? A certain word?" In cases where people respond to criticism in a dramatically negative manner, it is not the content that causes the pain but the fact that the negative feedback happens to correspond to specific self-critical, self-attacking thoughts already existing within the person. The therapist then says, "What did it make you think to yourself?" After the client relates the thoughts, the therapist says, "Now try to put these thoughts in the second person—as though someone were talking to you."

When clients put their thoughts in this form, strong feelings often emerge in which the tone is transformed from flat, matter-of-fact statements to a more expressive, emotional verbalization. It has been found that, as clients express the voice in this format, they usually have their own momentum and keep the words and feelings going on their own initiative. The therapist simply offers encouragement with statements such as, "Say it louder." "Don't hold back." "Let go." "Say it how you're really hearing it."

Many clients come by this method naturally, on their own, without needing much encouragement from the therapist. They sense the emotion behind specific thoughts and spontaneously express it along with the content. Others who are more inhibited in expressing themselves need support and permission to not hold back their feelings while revealing their voices. Verbalizing the voice dramatically and releasing the associated feelings often uncover core beliefs previously unknown to the client. The voice is made up of conscious and partially unconscious thought processes that emerge during the feeling release segment of the session. As noted previously, clients sometimes become silent after verbalizing their initial self-attacks, the thoughts that are in their conscious awareness. This pause may last for several seconds. The therapist needs to remain quiet and listen patiently as other, partly conscious thoughts emerge. These thoughts often represent the client's basic negative beliefs or core schema.

With the release of deep emotion, the client often experiences a sense of relief on a physical level. The pent-up aggression toward self is

relieved, along with a great deal of body tension. This can relieve some of the perturbation and psychic pain the suicidal person is experiencing.

In clinical studies, it was observed that assuming an angry, attacking posture in relation to parental attitudes and prohibitions was less effective than initiating behavioral change and was frequently counterproductive.

Therapist's Responses to Client's Expression of Feeling There are a number of responses that therapists should both use and avoid:

- Therapists should not attempt to interrupt or stop a client's expression of feeling or show by their responses that they believe that strong emotions are somehow dangerous. If the therapist shows alarm or tries to reassure or quiet the client, the client will feel more tentative in relation to expressing strong feelings in the future. Clients will get the message that their feelings are bad, dangerous, or overwhelming. Therapists must have a tolerance for their own emotions to effectively use techniques that access strong emotions.
- Therapists should not become unduly alarmed if clients express suicidal ideation or injunctions to mutilate themselves while in the process of saying their voice. After clients say their voice and discuss their insights and feelings, the therapist should then inquire about the seriousness and possible intent of carrying out such actions. When clients are able to talk openly about these feelings, it is less likely that they will act on them.
- Therapists should indicate that they believe the expression of feeling can be beneficial in reducing symptoms, in clients recovering feeling for themselves, and in helping clients gain insight into the connection between self-attacks and destructive behaviors that they are acting out in their lives.
- Therapists should encourage clients to express feelings more freely if they perceive the client is holding back. For example: "Try just letting go." "Let it all out," and so on.
- Many therapists tend to intervene with comments, questions, or interpretations prematurely, thereby interrupting the client's flow of free associations, feelings, or insight development. In voice therapy sessions, especially when strong feelings are being expressed, it is important to permit clients to remain silent if they want, to close their

eyes and contemplate thoughts and feelings that are emerging into consciousness, to gather courage for the full expression of feelings perhaps never before expressed out loud to anyone. Therapists need to be comfortable with strong emotions and trust that they are not inadvertently communicating to clients a fear that their emotions can get out of control.

Step II: Discussing Insights and Reactions to Verbalizing the Voice

Following the verbalization of the voice and the expression of the accompanying affect, the therapist can help clients identify their dysfunctional core beliefs that govern their lives and provide the basic rationale for self-defeating and self-destructive behavior. Often, these beliefs emerge as clients express the anger and sadness associated with the verbalization of the voice.

Following the emotional release, often clients spontaneously develop insight into the origin of their negative thought processes. Clients can be encouraged to identify the connection between their destructive thoughts and important events in their everyday lives. This connection between past and present needs to be clearly made because it allows clients to develop compassion for themselves. Clients also examine the relationship between their self-attacks and the types of behaviors they engage in that are self-limiting or self-destructive. Questions designed to draw out the client are kept to a minimum because clients are generally eager to communicate their newly formed insights to the therapist. However, in some cases, the therapist may need to make inquiries about clients' feelings and thoughts after they have finished verbalizing the contents of their voices.

Questions such as the following can be posed: "What were you feeling just then?" "When did you start having thoughts like that about yourself?" Or, questions can be asked that challenge negative views that are clearly uncharacteristic of the client: "Where do you think you got an idea like that?" "Why do you think you feel like that about yourself?" "Where do thoughts like that come from?"

Inquiries that focus clients' attention on the connection between their thoughts and behaviors are also appropriate during the discussion phase of the session. Questions leading to this type of insight can be stated,

including: "Looking back over the past week, what would you say you typically do when you're listening to a voice like that one?"

The few statements that the therapist does make need not be interpretative. For example, instead of the therapist saying, "That sounds just like your father, the way you described your father" (a psychoanalytic interpretation), he or she might say, "Who does that remind you of when you're saying these negative thoughts that way?"

One man summed up his insights after a powerful session where previously unconscious material became available to him: "These voices sound just like my father. He always told me that I'd never amount to anything, that I was going to grow up to be a ditch-digger. Now here I am, 35 years old, failing at one job after another because I've listened to that voice—his predictions. It's like the voice is a self-fulfilling prophecy to prove that my father was right about me."

Step III: Corrective Suggestions

The techniques described in Steps I and II challenge clients' major character defenses, their self-concept, and their core beliefs. The next step consists of initiating behavioral changes that expand clients' sense of self, the real self. This step allows clients to overcome imagined limitations based on their misconceptions about themselves. Many clients come to therapy with a confused sense of their own identity. These clients are frightened of challenging these labels and definitions even though they reflect an unrealistic and often unfavorable self-image. They must learn to cope with the fear and the disorientation that comes with the exploration of a more positive identity. The process of accepting a changing identity rather than a fixed one disrupts an individual's psychological equilibrium. For this reason, corrective suggestions that challenge a client's rigid self-concept and open up new experiences play an important part in personal growth.

In the process of helping clients discover their unique points of identity and increase their sense of self (that is, allowing the self system to emerge and take precedence over the antiself system), the therapist needs to be alert to body language and other behavioral cues (increased rate of speaking, eye contact, a fleeting smile, or light in their eyes) indicative of any person or anything that might have special meaning for them. Subsequently, by their responses, they can encourage clients to

increase their participation in such activities, projects, or friendships and in the process take chances, reach out to others, or be more open to new experiences.

Corrective suggestions for behavioral change derive from the types of negative prescriptions clients have discovered for themselves. The ideas are not directives or strategies imposed by the therapist, but are usually initiated by clients based on their identification of specific destructive thoughts that control specific behaviors that they desire to change. The motivation for attempting to alter self-defeating behaviors comes from the client, who envisions new or different behaviors and activities as an "answer" to the dictates of his or her voice.

In using this approach, therapists encourage clients to explore alternatives and possibilities as equals; both client and therapist contribute corrective ideas that apply to the unique circumstances of each case. The therapist should approach the collaborative effort with compassion and a nonjudgmental attitude when clients indicate that they are afraid to undertake basic changes.

Although initially collaborating on the suggestion as an equal partner with the therapist, clients may subsequently deny their point of view and project the desire to change onto the therapist and perceive the therapist as having a stake in their progress. For example, clients may come to believe that the therapist is telling them how to run their lives or accuse the therapist of making decisions for them.

It is important for the therapist to avoid becoming overly invested in clients' acting on the corrective suggestions in order to preclude clients from polarizing against the suggestion; for example, playing out one side of themselves (the antiself) while the therapist is taking on the other side (the self). Therapists need to accept clients as they are, without having a stake in "changing them" in the disrespectful or prescriptive sense of the word. This will reduce clients' opportunities to polarize in this manner. Instead, the therapist can investigate with clients voices that arise and interfere with carrying out the corrective suggestions. Failures become opportunities to learn more about clients' voices and how they operate.

Collaboration to Change Specific Behaviors Perhaps the most simple and straightforward examples of the use of corrective suggestions are those that relate to substance abuse. Implementing a suggestion that

breaks a self-nourishing habit pattern is often a first step toward change on a deep character level. Although it is difficult for alcoholics, heavy drug users, or clients with eating disorders to maintain the resolution to alter their addictive patterns throughout the course of treatment, it is necessary for a successful prognosis.

In spite of this dilemma, a therapist of strong character, concerned and sensitive, can establish a preliminary contract with the client on this issue and act as a transitional object to alleviate the anxiety aroused by giving up the addiction. Early on, the therapist points out, in nonevaluative terms, the serious consequences of the client's addiction. It is important that clients *not* relate to their behavior as a moral issue, but that they become aware, on a feeling level, of the harm they are inflicting on themselves through the continued use of substances. The therapist's warmth, independence, and maturity are essential in gaining and holding clients' respect and trust so that they will continue to be motivated to give up the addiction. Controlling addictive behavior leaves clients vulnerable to the painful feelings they have been suppressing yet opens the way for potential cure.

Most clients find it difficult to give up symbolic substitutes for the love and care they felt they missed as children. They are reluctant to break into the self-parenting process in which they have been symbolically feeding and caring for themselves to preserve a sense of security and self-sufficiency. Many clients have revealed voices that tell them to isolate themselves. In such cases, the corrective suggestion would be to discourage time spent alone, encourage communication with a friend, and help the client schedule activities in a social context. The therapist can suggest to clients that they change seemingly simple actions such as eating lunch alone at the office, shopping alone, or avoiding socializing on the weekends.

When treating a suicidal client, the therapist should be especially alert to any tendencies toward isolation. Isolation provides the space for self-destructive voices to increase and gain control. Individuals' self-attacks decrease when they are in the company of friends or family, people more congenial toward them than they are toward themselves. Many suicidal individuals report that when they sought out isolation, their self-destructive voices increased, specifically suicidal ideation. In general, clients report a decline in voice attacks when in the company of other people.

Clients also report voices that cause them to hold back or withdraw emotional and behavioral responses from others (withholding) and pleasure and enjoyment from themselves (self-denial). This behavior is often held back because of clients' critical attacks on themselves. Having been thwarted as children in their attempts to express love, they now tell themselves when they feel generous, "They don't want (need) anything from you!" "He won't like your gift," or "What did she ever do for you, so why should you do anything for her?" Having been taught as children that it is selfish to want things, they now tell themselves: "You don't deserve anything. You're greedy, always thinking of yourself. You always want things your own way." Some make a virtue of self-denial and see it as constructive: "You don't really need to go on that trip. Think how much money you'll save by staying home and working!" In listening to the voice and following its injunctions, people deny themselves the excitement and enjoyment they could feel in their work and personal lives.

Corrective suggestions in voice therapy can be applied to a wide range of fears, from a fear of public speaking to those of being close to another person. In many cases, these clients are listening to self-attacks related to the activity or situation that they are afraid of. Before therapy, their behavior has been in accordance with their voice; that is, they have been acting on their fears and have generally become demoralized in relation to the goals they want to pursue. Verbalizing the voices that operate to paralyze clients' actions can facilitate changes in attitudes that allow them to challenge their fears. By understanding the roots of their fear, they can develop the courage to initiate corrective suggestions to move toward situations that were previously too threatening.

Corrective Suggestions for Suicidal Clients For clients who are unusually depressed or facing a suicidal crisis, establishing a strong therapeutic relationship and trust is essential. Even then, evaluation of the client's ego strength is necessary before considering which specific techniques or suggestions will be used and in which order. After rapport has been achieved, the therapist can begin to help the client identify his or her self-destructive thinking and suicidal ideation. With more seriously disturbed or suicidal clients, a cognitive approach is usually introduced first; cathartic methods can be used at a later stage of treatment when the client's ego is stronger and acting out is more under control.

With depressed or suicidal clients, voice therapy methods are particularly useful in separating attitudes of hopelessness and helplessness from a more realistic or hopeful view. Suicidal clients are ambivalent about taking their own lives, often up to the last minute. Therefore, any technique, suggestion, or therapeutic statement that supports the self system and the client's desire to live is helpful and perhaps potentially life-saving. At the same time, therapists should avoid making any suggestion or interpretation that would support the antiself system, such as guilt-provoking statements, "How could you think of doing this to your wife and children?"

The therapist needs to be sensitively alert to *any* communication that would provide a clue as to activities or relationships that are potentially meaningful to the client. For example, therapists can attempt to identify an activity that was at one time of special interest to the client or a relationship that held special meaning and support the client's reinvolvement in such activities or relationships.

Corrective suggestions directed toward altering self-destructive behaviors that lie along the continuum (Table 11.1) should be employed, including:

- Discouraging time spent alone, encouraging communication with a friend, and helping clients schedule activities in a social context.
- Helping clients pursue activities in which they have invested any modicum of energy and excitement.
- Discouraging substance abuse or any other addictive patterns and encouraging the client to substitute activities and relationships that are real and constructive.
- Helping clients struggle through increased voice attacks and painful anxiety states involved in renewing personal contact with friends and family—in this context, simply being cognizant that they are attacking themselves is a valuable technique that intrudes on voice attacks that suicidal or depressed clients experience.
- Encouraging clients to recognize the anger involved in passive-aggression (holding back from others) and helping them maintain generous attitudes and at the same time develop the capacity for accepting kindnesses and generosity from others.

- Helping clients to discover that which they find to be most meaningful in life—a person, a cause, a raison d'être (R. Firestone, 1997b).

Amelia: A Case Study

Case Description and Analysis

Diagnostic Picture

DSM-IV Diagnoses: Axis 1, 296.31-2, Major Depressive Disorder, recurrent, mild to moderate; Axis II, 301.83, Borderline Personality Disorder; Axis III, no known physical ailments; Axis IV, break-up of a relationship, 3 major ones, financial problems, occupational problems; Axis V, GAF, 30 (at her lowest points), 90 (at her highest points).

Case History

At intake, Amelia presented herself in an open, talkative manner. She was attractive and looked younger than her 22 years. She cried frequently as she spoke. She stated that she was referred by the counseling center at her college. She reported that she had called them many times in suicidal crisis, and they felt she could benefit from ongoing psychotherapy.

Her presenting problem was depression, which she believed stemmed from childhood physical and sexual abuse. She was experiencing a low mood, fits of crying, problems sleeping, difficulty concentrating, lack of energy, and suicidal ideation. She reported a history of one suicide attempt at age 16, when she took pills. No medical treatment was sought for this attempt. The attempt was precipitated by a fight between Amelia and her parents.

Amelia reported that her current suicidal ideation centered around the breakup of a two-year relationship with a boyfriend. She reported feeling homicidal toward him as well as suicidal. She described an incident where they struggled over a knife, and she expressed being unsure of whether she wanted to hurt him or herself. The relationship had been intense, and it was her first sexual relationship.

Family History

Amelia grew up in a family composed of her mother, father, older brother, and much younger sister. She described her parents as having emigrated

from an eastern European country and having very Old World values and ideas. Her parents ran a shop below their home, and she and her brother were expected to work in the shop after school and on vacations and holidays. She described her father as stern and hard-working. She described her mother as warm and more accessible, taking care of everyone. The family played music together and performed at ethnic festivals. They were actively involved in their church and attended regularly.

Amelia reported frequent beatings by her parents throughout her childhood. She felt her parents imposed Old World restrictions and would not allow her to do what most Americans her age were allowed to do. She reported getting around this by lying to them about her whereabouts and activities. Her parents were supporting her going to college and were apparently generous with her financially. Amelia worked as a policewoman while she was attending school, which also brought in a considerable amount of income.

Amelia reported that the beatings stopped when she was 16, when her high school coach found out and confronted her parents. She also reported sexual abuse by an older man down the street. This was a one-time incident. Amelia said her father also touched her inappropriately when she was younger, but that he had stopped this when she got older. She reported attempting to protect her younger sister and asking her if her father did these things to her as well.

Amelia was alienated from her older brother, who had also received beatings from her parents. Her strongest apparent attachment was to her younger sister, toward whom she felt protective.

At the time of intake, Amelia lived with her mother, father, and younger sister.

Psychiatric and Psychological History

Amelia denied ever having sought or obtained psychological or psychiatric care previously, except for the calls to the campus counseling center.

Initial Treatment Plan

The initial focus of treatment was on reducing Amelia's risk for suicide and on targeting her symptoms of depression. A psychiatric referral was made, and Amelia was prescribed Prozac. An antisuicide contract was established, where she would call if she was feeling suicidal. Initially, Amelia called often, and I made myself available for these calls

throughout the course of treatment. We discussed her suicidal ideation directly and explored the flaws in her thinking processes. The focus was on the cognitions and feelings she was experiencing that were contributing to the development and maintenance of her depression. Later we addressed these thoughts directly with the techniques of voice therapy.

I worked on establishing trust and rapport with Amelia and attempted to be supportive. We also focused on the other side of her ambivalence about suicide, on her reasons for living. Amelia expressed a strong desire to move to New Zealand, a place she had visited on a student project, and where she felt she could establish a better life. This dream was life-sustaining for her, and we discussed steps she could take to achieve this goal. She reported that her parents objected to this goal, and her motivations in relation to them were mixed. She wanted to get back at them, hurt them, yet she wanted to maintain a close bond with them.

Ongoing Treatment and Case Conceptualization

Amelia's personality style and manner of coping contributed to the fact that her life seemed to be a series of crises. Her frequent difficulties in relationships were often brought about by behaviors she engaged in, such as manipulation, lying, promiscuous sexual activity, drinking too much, overspending, and acting out vengeful behaviors. Examples of these include lying about being pregnant to manipulate her boyfriend back into the relationship, lying to her parents about going on a trip with girlfriends when she was with her boyfriend, cruising for men with her best friend when she was supposedly in the committed relationship, not taking her Prozac so she could go out drinking, spending too much money on credit cards, stalking ex-boyfriends, and reporting her friend to the INS when she felt her boyfriend was paying too much attention to the friend.

Amelia's relationships with men were intense, difficult, and turbulent. She went through two major breakups during the course of our treatment. The first relationship was rekindled (by her pregnancy lie) but tumultuous before a final blow-up where she revealed her many sexual infidelities. Next, she became seriously involved with a married man at her place of work.

Her female friendships were also intense and unstable. She had one particularly close friend she had known since childhood and who had a similar background. They seemed to have similar personality styles.

Coworker relationships were also difficult. She often felt she was the victim of the gossip in her places of work, a fact that was often precipitated by her affairs with men in these settings and her unpredictable acting-out behaviors.

Amelia's base of social support was often in a state of flux. At times, she was close to a friend, her family (especially her sister), or a man, but at other times she quickly became distant or at odds with these same people as a result of her behavior. Many self-precipitated crises also occurred in the work setting. She was fired or let go over incidents with coworkers, sometimes leaving her financially strapped. Often her work environments became very tense.

Amelia did have periods of high functioning, where she moved forward in her life and achieved goals. She applied for and completed a highly competitive school program. She also entertained dreams of moving to New Zealand and took steps toward this goal. When Amelia set her mind to it, she could accomplish many difficult tasks. Although she struggled with employment opportunities, she sought and obtained a series of jobs.

I administered the FAST to Amelia, as I was concerned about her suicide risk and wanted to focus my treatment plan on the areas where she was experiencing the most distress. Amelia scored high on the suicide intent scale, the substance abuse scale, and suicide ideation level. From the test results, I had direct information about her negative thoughts toward self or voices, so I could address these with her in sessions.

I also assessed Amelia's ego strength, particularly her ability to experience strong emotion and not dissociate or become overwhelmed. Amelia demonstrated ego strength in a number of ways despite her diagnostic picture. She had a great deal of personal drive and had accomplished many tasks that required sustained focus and stamina. Amelia's dissociative tendencies were not evident in her interactions in therapy but could be deduced from her recounting of outside interactions. For example, she worked in settings where she was exposed to tragic situations and was able to "remove herself" from gory situations and not react emotionally. Amelia's relationships were strained, but she did maintain long-term connections with others. She also evidenced a strong self system in some aspects. She had interests and pursued activities that she enjoyed. Amelia was bright, as indicated by her academic achievements

and could also be quite likeable. She had strong feelings for her younger sister, toward whom she felt protective and motherly.

Mock Voice Therapy Session

Therapist: So you have indicated on the FAST that you experience a lot of negative thoughts toward yourself, with a serious degree of intensity. I was wondering if it might be helpful to address these thoughts directly.

Amelia: I'm not sure what you mean. Do you mean we should talk about the things from the FAST test? Like about how I sometimes feel worthless or that life feels pointless? Or thoughts about killing myself?

Therapist: Yes, exactly. Why don't you start with any negative thoughts you have had this week or even today.

Amelia: Well, mostly I've been feeling bad about things with Mike recently. I feel really insecure and angry a lot of the time, and I'm not sure what to do with it. Like this morning, I tried to call him first thing, but he didn't answer. I left a message, and he still hadn't called back by the time I left this afternoon. It kind of makes me crazy thinking about it. When I was driving over here, I started thinking things about what if something had happened to me and he didn't call me back and then he found me hurt or dead, and wouldn't he be sorry then? Then he'd really feel like a bastard. The thought was actually compelling. But it was also compelling in another way, like that if he hasn't called me back after six hours, he really doesn't care about me anyway. He doesn't love me, I'm not worth anything, he wouldn't even care if I *was* dead. Maybe no one would care. Is that what you mean?

Therapist: Yes, exactly. But now I want you to try saying those thoughts as though another person were saying them to you, about you. So instead of saying, "He doesn't like me," try saying "He doesn't like you." Or instead of "Nobody cares about me," say "Nobody cares about you." See what I mean?

Amelia: Yes, I think so. Like "He doesn't even care enough about you to call you back. He doesn't love you." Like that?

Therapist: Yes. Just let the thoughts flow.

Amelia: Okay. "See, he doesn't care about you. He's just like all the rest of them. You're such a fool for thinking he gives a damn about you. You're such a stupid fool. No one cares about you." [crying, pause]

Therapist: Try to really let go. You might as well say it all, get all of the feelings out.

Amelia: [loud voice] *"You don't matter to anyone. No one gives a damn if you're alive or if you're dead. You're worthless! You're nothing. Maybe you should just kill yourself. You'd be better off dead, you worthless bitch!"* [pauses, crying] *"Then see how he feels! Then he'll know how bad he hurt you. That'll really show him. That'll get him. That'll show him! The bastard!"*

Therapist: That seemed to make you sad.

Amelia: Yeah. That was so weird, like suddenly someone else was talking through my mouth. Sometimes I think things like that, but this felt like someone else was yelling them at me. And the thing is, that's how it feels, like there's someone in my head telling me these things. Not to be a fool, not to trust anyone, that I need to stand up for myself or I'm just a stupid jerk, that I am a stupid jerk.

Therapist: Try saying those thoughts as if someone else were talking to you.

Amelia: *"You're such a stupid jerk! You think the world is a good place? Well, not for someone like you, you dumb girl. You are just trouble and pain to everyone.* [pause] *I can't wait for you to die. Everyone will be better off! You should just die, you stupid girl! Why don't you just die? Why don't you just kill yourself?"* [crying loudly]

Therapist: [after waiting for the full experience of her emotions] Where do you think that way of thinking about yourself came from?

Amelia: That was very powerful. I felt so sad and so full of rage. It's like it wants me to die. When I was talking, yelling those things, I really felt the rage toward myself, like I deserved to be dead. The amount of anger I felt really surprised me and scared me. It was almost like my father was hitting me and yelling at me. Or my mother.

They both used to hit on me a lot. Sometimes I was afraid they wouldn't stop and they would actually kill me. It's like they wanted to kill me. They wanted me dead. It's like they are the ones yelling at me, telling me I should die. [sad, crying]

Therapist: That makes you sad.

Amelia: I never really thought about how they felt toward me. I never realized how my own feelings that I should die might come from them, and not from me. I don't really want to die. I like being here. It made me sad to realize that maybe that's not me. Maybe I'm not so terrible.

Therapist: How are these thoughts affecting your life now?

Amelia: Yes. Sometimes it feels like the only way to get rid of the pain is to kill myself, like I'd be killing the pain, stopping the hatred. But then that makes me angry, too. I get angry and start hating everyone—thinking everyone hates me. I don't want to die, but I'm so angry! I want to hurt because I feel hurt.

Therapist: Why don't you try to express some of those thoughts as a voice, as if someone else were talking to you?

Amelia: *"You are such a fool! He's just jerking you around. Can't you see that? You think he cares a bit about you? You're only good for one thing, and once he's done with you, you're out of his mind. He's just using you, you know. He doesn't care if you're around, except to be his housekeeper and his whore. You are so stupid, so dumb. Such a fool!"* [yelling] *"You're not even smart enough to live! And he's just a stupid bastard like the rest of them. Only hurting you all the time. Using you all the time. You need to show him how bad he is. Get him back! You need to make him hurt!"*

Therapist: [after a pause for the emotions to be spent] How are these thoughts coming together in your mind?

Amelia: Well, I don't know if that's really how I feel or if it's my mother. I mean, Mike is an asshole a lot of the time, and that hurts my feelings, makes me mad. Then I want to lash out, and I feel justified. But also I think some of those thoughts are my mother's. She was always the victim of my father, his house servant. She waited

on him hand and foot, took care of him, but all the time resented it. And all the time thought he was a helpless baby, like he was so lame he couldn't take care of himself and so that was her job. And she acted like she was somehow better than him, even though she acted like his slave. I get angry at Mike when I think he's acting like I should take care of him, and that makes me mean to him. But also I get angry when he's not around. Then I want him to suffer. I think killing myself would be the ultimate revenge on him. On them. I want them to suffer.

Therapist: But at your own expense. Hurting yourself to get back at Mike or your parents is not exactly taking your side.

Amelia: Yes, I guess you are right. It's much more sane to move forward and do things for myself than to lash out by hurting myself. But at those moments when I'm into thinking that way, I'm not thinking about myself. My world narrows and I'm only thinking about him, what I want him to feel, how I want to make him suffer. It's like I don't exist in those thoughts, like my body is just a vehicle I can use to get back at him. Not like my body is myself. [Sad, crying] That made me sad to say that.

Therapist: To realize your body is yourself?

Amelia: Yes, to feel connected to myself.

Therapist: How do you feel after letting out some of those feelings?

Amelia: I feel so much clearer. I don't really want to hurt myself, or Mike. I feel almost a physical sense of relief, like I just finished swimming a hundred laps. My body is more relaxed. Also the pain and agitation I was feeling are gone. My mind is quieter.

Therapist: Let's talk about what you can do this week, actions you can take that would be in your self-interest, instead of actions based on those destructive thoughts.

Amelia: Like not sitting around obsessing about how Mike has hurt me and how I can hurt him back?

Therapist: Yes. It might help to make a plan of action. When those thoughts come up, what could you do instead of being alone and losing yourself in them?

Amelia: Well, I could leave my room and see if there's anyone else to hang out with—my sister. Also, maybe I could leave the house and try to do more things with friends.

Therapist: Okay, that sounds good. Now, having said those feelings, you may feel some anxiety this week, especially if you don't give in and allow yourself to ruminate about all of Mike's shortcomings. So if you do, don't be surprised, and feel free to call me. Going against these thoughts will initially make them louder, like a parent yelling at you to get back into line, but if you can keep resisting them and don't do what they are telling you to do, in this case isolating yourself and spending hours thinking about Mike, you will begin to relax and feel better. The thoughts will fade into the background almost like a parent who gets tired of nagging. Also, it might help to journal about any negative thoughts that come up this week, and then we can talk about them in our next session.

Amelia: Okay. I feel so much better than when I got here. I really feel positive, but I also feel like there's a lot more there. I want to keep talking about this.

Discussion

In introducing voice therapy to Amelia, I began by asking her about the items she had endorsed on the FAST. Would she say these thoughts out loud as though someone else were saying them to her?

She felt awkward at first, but then got into a flow with it, saying more than she realized was there. The anger and rage associated with those thoughts started to surface, and I encouraged her to let out this rage, say it louder, let the feelings out. After verbalizing a stream of voices, she paused, and then very destructive core beliefs about herself and others surfaced. Her rage was directed at herself and at others that she felt betrayed, hurt, or used by. These expressions were followed by sadness and pain, a mournful feeling. It pained her to realize how vicious her tirades against herself were. She spontaneously expressed insights about the origin of these thoughts. She traced them back both to specific interactions with her parents when they were enraged at her and she felt they wanted her to die and leave them alone, and also to a general feeling she picked up from them that she was a burden, not a child they wanted.

She was also able to connect both the thoughts toward herself and those toward others as being related to her self-destructive behavior and disrupted relationships. She realized that the acting-out behaviors she was engaged in, such as lashing out at others, were driven from a point of view that was hostile toward herself and bent on her destruction. These forces kept her from sustaining a relationship, first by directing her to be suspicious and attacking of her partner and then by belittling her for failing in the relationship and confirming that she would never be loved, that she was unlovable and better off dead. Her suicidal thoughts came from a desire to "punish the man who had betrayed her" but she became aware that she was ultimately hurting herself with this attitude and endangering her own life.

As Amelia voiced her self-attacks in the following sessions, her suicidal impulses wielded less power over her and she began to feel relief. I also addressed behavioral changes she might want to make, actions she could take that would go against the voice and would be in her self-interest. For instance, when she felt the impulse to attack her partner, she would control her behavior, keeping in mind her goals for the relationship and the behaviors that would reflect those goals.

We discussed other healthy strategies she might adopt for coping with her feelings, in particular her anger, so that she could keep her behavior in line with the goals she wanted to achieve in life, that is, maintain the relationship, keep her job, and so on.

Amelia also needed to address her substance abuse problem of binge drinking. This obviously self-destructive behavior pattern also led to additional behaviors while intoxicated that were counter to her personal goals. Once we achieved a reduction in Amelia's suicidal thoughts, we addressed the issue of her substance abuse directly.

By identifying the voices that could precipitate her use of substances, Amelia was able to recognize the type of thinking that would get her into trouble, acting against her personal goal of staying sober. Once she identified these thought patterns and connected them with her father's pattern of "drinking away his pain," she was able to catch herself falling into this pattern and begin to avoid situations where she was more likely to drink and to make better choices for herself. She came to feel more comfortable expressing the emotions she had been trying to suppress and began dealing with them in a more constructive manner. Strong feelings

of wanting arose as she gave up this defense against feeling, this self-soothing pattern of behavior. Amelia felt more vulnerable and began to take chances on getting her needs met in interpersonal relationships rather than leading a self-soothing style of existence. There were struggles as she went through this process, but she gradually developed an ability to be open to expressing her wants and seeking gratification in her real life as opposed to fantasy.

FURTHER CONSIDERATIONS

Separation theory makes a significant contribution to our understanding of people's self-destructive behavior and the suicidal process. It provides a developmental perspective and allows us to understand the basis of self-destructive behavior. In addition, an understanding of the voice process provides a window into the mind of the suicidal individual. It allows us to assess suicide risk and target our interventions to effectively intervene in the suicidal process. Voice therapy provides us with a methodology for addressing the underlying forces driving the suicidal process directly. Bringing these voices out into the open allows clients to start to separate this overlay on the personality from a more realistic view of themselves, other people, and the world. It allows them to subject these thoughts to a realistic evaluation, loosening their hold on the person's behavior. Accessing the strong emotions that accompany these thoughts allows these persons to change core beliefs about self and develop compassion for themselves and others.

The overall goal of this type of psychotherapy is to help clients come to terms with painful feelings and frustration that cause them to retreat to an inward, self-nurturing pattern and self-destructive behaviors. The essential therapeutic task with suicidal individuals is to support the development of their self system, which involves helping them become aware of their ongoing desires, priorities, and sense of meaning in life so that they are better able to pursue what they want and need directly and become more willing to take the chance on being vulnerable to the realities of life. The therapist's goal should be to help these individuals to live more in the real world than depend on fantasy, to have real gratification and meaning in life, and to reach their personal potential.

ASSESSMENT, TREATMENT, AND PREVENTION OF SUICIDAL BEHAVIOR

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