

Conscience Sensitive Psychiatry: Clinical Applications:

Retrieval of Life Affirming Values and their Incorporation into a Suicidality Prevention Plan.

(Companion to Assessing Risk in the Suicidal Adolescent: Three Exercises for Clinicians)

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Abstract. This article is intended primarily as a companion piece to provide additional background and illustration for a submission by the same authors to **The Journal of the American Academy of Child and Adolescent Psychiatry**. It is also the second in a series appearing in **Conscience Works** to characterize recently employed techniques to render psychiatric treatment of children and adolescents in a conscience sensitive manner. It consists of a progressive Case Presentation interwoven with Discussion points, which together demonstrate the retrieval of life affirming values in the context of suicidality management and the incorporation of these values in an overall suicidality prevention plan. **Conscience Works: Theory, Research and Clinical Applications**, 2005, 2(2): 24-33.

Case Illustration: Regina.

In accordance with HIPAA regulations all identifying information including the location of the subject of this report and dates of admission to other facilities have been expunged from the record. To ensure fidelity to the case, all dates will be indicated in reference to the date of the admission for example, 'one week prior to admission (PTA).'

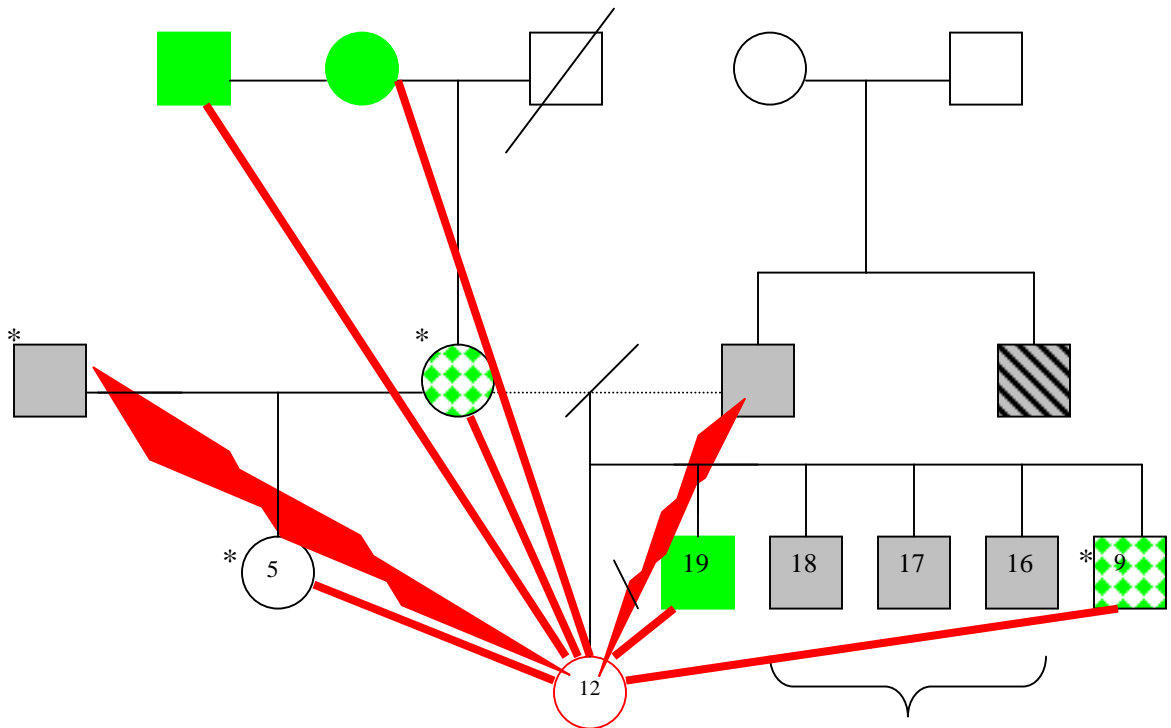
At the time she presented to the emergency room in her local hospital after her school counselor discovered a suicide note in her binder, Regina was twelve years old. Upon arrival at the access center to the psychiatric hospitalization about fifty miles away, Regina told how she had composed the note while she had been frustrated about her homework and upset about an episode of her stepfather's anger dyscontrol. She denied any intent to commit suicide and there was no history of previous suicide attempts. However, her mother indicated having heard suicidal verbalizations during the eight months PTA. She was subject to reduced total sleep time but denied difficulties in concentration and experienced no diminution in appetite. She had been engaged briefly in treatment at a community mental health center for "depression and behavior." There had not been any pharmacotherapy. Her personal history was negative for alcohol and substance abuse. She denied both current and any past sexual activity. She initially denied any maltreatment experiences in the form of physical abuse, sexual abuse and neglect but did indicate exposure to domestic violence. In terms of the mental status examination conducted by the access center worker, she was described as disheveled with holes in the elbows of her knitted shirt, tearful in presentation, avoidant of eye contact, withdrawn and depressed in mood. The case was staffed by telephone. Regina was admitted by authority of the child adolescent psychiatrist on call. Suicide precautions were ordered.

Her first clinical encounter with her assigned psychiatrist was the next morning. Her distress about remaining in the hospital was manifest. She urgently repeated several times that she did not mean to write the suicide note. She spontaneously denied any intention of ever making herself die. Regina became more communicative through her tears, which she ascribed to being away from "my Mommy" for the first time. Her separation anxiety was probably compounded by having to undergo treatment, including temporary isolation, for head lice, which

had been discovered at the point of admission to the ward. The psychiatrist's evaluation was mostly confirmatory for the findings of the access center worker in the mental status domains of Appearance, Attitude and Behavior, Affect and Mood, Sensorium as well as Judgment and Insight. In contrast, while Regina's responses to questions posed in the psychiatric evaluation were pertinent, they were also concrete. Her use of vocabulary and grammatical structures was indicative of less than average intellectual functioning and/or the presence of specific learning disabilities. The psychiatric evaluation was also sensitive to conscience functioning (American Academy Child and Adolescent Psychiatry Practice Parameters, 1997; Galvin et al, 2001; Stilwell, 2003). **Conscience conceptualization** (Stilwell and Galvin, 1985, Stilwell et al, 1991): Regina indicated she was sometimes aware of a part of herself that helped her figure out right versus wrong. She described this part of herself as quite active. **Moral Emotional Responsiveness** (Stilwell et al, 1994): Regina indicated she generally experienced herself as a good person. When engaged in what she considered to be right-doing or good deeds she said she was apt to become excited, but did not somatically localize the corresponding feelings or sensations (as many persons do). In response to what she considered to be engagement in wrong-doing, she said she was apt to feel both sad and mad. She did not discern an appreciable change in her moral emotional responses if either her right doing or her wrong-doing remained unknown to others, although she conveyed she would tend towards self-disclosure in any case. **Moralized Attachment** (Stilwell et al, 1997): she identified her mother and her maternal grandmother as those persons who cared most whether she led a good life and did the right things (ie. principal moral attachment figures). **Moral Valuation** (Stilwell et al, 1996): she identified a single rule, which she attributed to herself (as opposed to authority figures): "Don't drink alcohol and stuff." **Moral Volition** (Stilwell et al, 1998): initially Regina was difficult to engage in discussing success experiences she had had in resisting urges to engage in wrong-doing or overcoming her resistance to engagement in right-doing.

In subsequent sessions with her psychiatrist she was able to elaborate more on the nature of the domestic violence to which she had been exposed and which fueled her worries of harm befalling her mother during absences. She also disclosed having experienced direct physical abuse in the form of being choked by her stepfather during a period of intoxication. In a later session, she was engaged in constructing a moralized genogram, layering moral upon the more familiar biological and emotional connections and disconnections elucidated by that clinical device. While constructing the moralized genogram, she echoed family psychiatric history her mother had provided independently at admission: her mother, her maternal grandmother and her sibling (also diagnosed with "ADHD") being subject to "bipolar disorder", not otherwise specified. She conveyed her impression that her biological father had, like her stepfather, been subject to alcoholism and prone to violence. She knew of a paternal uncle who had been subject to substance abuse and was incarcerated for child molestation. She also identified family members her mother had not: three full brothers, placed with another family out of state, each in later adolescence and each having spent time in corrections for threatening their mother. She also provided the additional history that she had been taken from her mother at age six for a period of three months for neglect. Those persons represented in her genogram whom she identified as caring about her moral well-being were her mother, both her maternal grandparents and a 19 year old brother living outside the home. She represented a highly conflicted relationship with her stepfather and expressed the wish her mother would not be so afraid of him so that she could compel him to leave their home.

Regina's Moralized Genogram



Regina's mother identified only the nine year old among Regina's full sibship. Regina reported that when she was 3 years old, three of her brothers were removed from the home in a Western state and each spent time in juvenile detention prior to placement because of threats they made to kill their mother.

Legend



Alcohol, substances, violence



Perpetrator Child Sexual Abuse



Bipolar Disorder, NOS

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Residing in Regina's home



Relationship with negative valence



Relationship with positive valence



Moral Attachment Figure

The Suicide Walk.

Regina was asked to conduct herself through a ‘Suicide Walk.’ This clinical device was introduced to youth psychiatric inpatients about fifteen years ago by author J.F. The instruction given to the patient is:

Write a story in first person as if you actually killed yourself. Write about what led up to your suicide, how you felt, why you did it, and how you did it. Write about your funeral, who is there, what they are saying, and what they are feeling. Write about how your suicide affects your family and friends and how they feel. Then write about life afterwards for your family and friends. (This assignment may take several pages to write.)

This was Regina’s written response, which was completed on hospital day #2:

*I led up was very frusted one day
I a enough I felt like killing myself.
I got on the bus. Then after I did I got off at my bustop. I walking to home from my bustop and there was a car going really fast. I ranned out in front of it. The next day they had my funrel going on. A lot of people was there like my mom, brother, sister, grandmal, grandpal, freinds. I don’t know exaltery they were saying. But all I could hear how my sayed I wish hadn’t done that. My family was destroyed. My friend was destroyed. My family hearts was broke. My friends hearts were broke too.
That’s my story.*

In our collective clinical experience of over thirty years using it, The Suicide Walk has proven to be a valuable clinical tool. The assignment of this therapeutic task may elicit resistance from many patients. In some cases the resistance arises in patients who, after the rigors of medical stabilization in the emergency room, exposure to distress among family members and acute psychiatric hospitalization, have enjoyed ‘a flight into mental health’ and insist that the suicidal behavior was anomalous, guaranteed never to occur again. In other cases, resistance issues from the extremes of demoralization. On the other hand, the exercise may be undertaken with an excess of enthusiasm for an opportunity to demonstrate a flair for the dramatic or to engage in compensatory grandiosity. From the psychiatrist’s standpoint, it enriches psychodynamic understanding of the patient and provides a view on the nature of the patient’s suicide planning and deliberation or lack thereof. Once undertaken, it often assists the patient in recapitulating the state of mind from the patient’s perspective that eventuated in suicidality. It prompts, with varying degrees of success, self-examination resulting in clearer identification of the strongest suicidal motives. It prompts consequential thinking. It also becomes the springboard for an exercise in moral imagination.

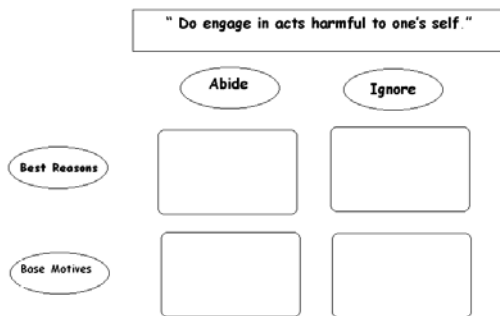
In the next clinical encounter with her psychiatrist, Regina was instructed to read aloud her Suicide Walk. As is often the case with patients, she attempted to avoid the reading by

handing over her narrative. Upon redirection, she began to read aloud but at a rapid pace. She was redirected to begin again and slow down. The rationale shared with her was to have her listen carefully, together with her psychiatrist, to what she was reading. As a practical matter, the read-through also clarified what the patient attempted to communicate in writing but was hampered in so doing because of grammatical and spelling weaknesses. At the conclusion of the read-through, the inquiry was made to her: “How do you react to what you’ve written and read just now?”

Retrieval of a Life Affirming Value

Pursuant to this inquiry, Regina was able to retrieve the life affirming value that her suicide would cause harm to loved ones, especially her mother. **Non-maleficence** within the ambit of family and friends is commonly adduced as the life affirming value when, following the read through, there is an exploration of best reasons to resist suicidal urges. It is sometimes helpful, as was done in the case of Regina in terms appropriate to her understanding, to let the patient know that ‘first do no harm’ is a value which figures among the bioethical principles governing the profession and so represents a value shared (albeit with different ambits) by both psychiatrist and patient. In the ensuing conversation, both psychiatrist and patient emerge as persons of conscience. Sometimes non-maleficence is not readily adduced as the life affirming value. In some cases fear of pain or of the process of dying or of eternal punishment in accordance with religious beliefs will be adduced first or even solely. In such cases, we recommend accepting these reasons as life sustaining values but exploring further. To conduct the exploration, another conscience sensitive clinical device may be employed.

The Value Matrix



The Value Matrix is an organizational schema to represent the dynamic process in which the psychiatric interviewer facilitates the person of conscience’s self- examination of the valuational contents of her conscience.

Operationally defined, for any ‘don’t’ (or ‘do’) *x*, **base motives** are usually the first (i.e. **baseline**) responses a person makes to

an inquiry in the form:

If you (a person) went along with *x* , it would be *because* ---- (fill in the blank).

The psychiatrist records (dry erase boards are most helpful so that what first appears as an only -and by default *best*—reason can be placed lower in the matrix as the examination proceeds) this ‘*because*’ as a starting point for the dialogue but then stretches the person’s moral imagination by hypothetically blocking the motivational power of whatever was put in the blank

in order to assist the person of conscience in eliciting another *because*. The person of conscience adduces another ‘*because*’ and then is asked to *evaluate* the first ‘*because*’ with respect to the second ‘*because*’ in terms of which is *better* (the interviewer makes clear that what is meant by ‘*better*’ is not ‘*stronger*’). This may turn out to be an iterative process, the end result of which will be the person of conscience’s **best reason(s)**. The person may then be asked to judge the relative *strengths* of all the ‘*because*s’ **she** has differentiated into **best reasons** and **base motives**.

Example: *x* is ‘Don’t make myself die.’

The psychiatrist’s initial inquiry takes the form: “How do you fill in the blank: ‘I will not make myself die because-----’?”

The patient responds: “I will not kill myself because I don’t want to experience the pain.”

The psychiatrist hypothetically blocks the motivational power of the baseline ‘because’ by saying:

“What if you could be very sure you would not endure any pain, then what would be your best reason not to make yourself die?”

The patient responds: “I don’t know. I’m worried about being condemned to Hell for taking my own life. I heard a minister tell me that suicide is the only unforgivable sin.”

The psychiatrist hypothetically blocks the motivational power of this ‘*because*’ by saying:

“And what if you were very sure of God’s forgiveness, what would be your ‘*because*’ then?”

The patient responds: “Because it would hurt my mother terribly—for all the rest of her life.”

To actually complete the matrix the patient would also need to address the ‘*because*s’ for making herself die, again in terms of base motives and best reasons. Patient and psychiatrist would then proceed to sort these ‘*because*s’ according to which the patient thought was best and then again according to which the patient considered strongest. In so doing the patient becomes aware of the value-motive gap.

At the point of admission Regina was able to identify her strongest suicidal motive she would ever know as the loss of her mother. At the point of admission, she was unable to adduce any life affirming or even a life sustaining value. After therapeutic work in the form of the Suicide Walk and Moralized Genogram, she was able to retrieve *moral (as well as emotional) connectedness* as life affirming values. The Value Matrix had limited utility in Regina’s case but nonetheless allowed her to make explicit a ‘because’ that could accurately be called ‘non-maleficence within the ambit of her relationship with her mother.’ Regina regarded the because ‘I don’t want to hurt my Mommy’ as better than-- but still not as strong as--the because ‘I would be away from my Mommy if I killed myself.’

A *Value Matrix* may also be constructed in which “Do allow myself to die” is treated as an urgent demand to which that patient can respond by identifying basic motives and best reasons both *pro-* (to abide the urge) and *con-* (to resist it). The role of the psychiatrist is to imaginatively engage in undermining baser motives in favor of allowing better (albeit weaker) reasons both *pro-* and *con-* to emerge. Usually, but not always, the patient determines that the very best reasons for someone to allow himself to die is not from an egoistic motive at all but rather because an altruistic self- sacrifice is required to save another.

Risk-assessment and self-assessment of risk. Following the generation of all the best reasons and base motives both *pro*- and *con*- the patient can imagine, the patient is asked to gauge the relative strength (and personal applicability) of each. Engagement in the healing process may actually begin with the patient’s acknowledgement that his motivation to allow himself to die or put himself in harm’s way is nothing like what he regards as a **best** reason. His acknowledgment may be coupled with his awareness, now explicit, that his reasons to stay alive ARE BETTER BUT WEAKER with respect to his base motives to end his life. The failure of a patient to adduce any relatively robust life affirming (or at least life sustaining values) is considered *prima facie* evidence that continued suicide precautions, hence continued hospital stay, are warranted **in spite of** the patient’s denial of current suicidal ideation and absence of suicidal behavior.

Suicidality Management Plan

By her third day in hospital, Regina had had two doses of antidepressant medication. She had also been at work on the therapeutic task assigned to her by her psychiatrist: personalizing a conscience sensitive suicidality management plan. The presentation of the assignment is, in essence, a psycho-educational intervention primarily regarding how biological conditions create psychopathological interference with conscience functions particularly in the domains of valuation and volition, vitiating efforts to make use of adaptive coping skills, and to retrieve life affirming values, thereby predisposing to suicidality. We have also found that the visible product of this psycho-educational intervention, a diagrammatic representation of the suicide cycle and the suicide management plan, may also serve to deepen the informed assent process for psychopharmacotherapy. With very little modification in the informed consent process, it serves to address parental concerns about anti-depressant induced suicidality.

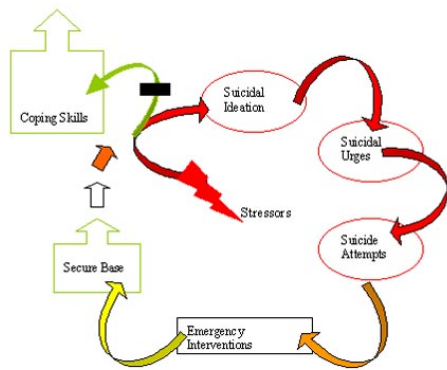


Figure 1: Suicidality Cycle

We have found that it is best to construct the figure on a dry erase board, anew for each patient rather than using a preprinted diagram. The patient is asked about level of her sense of safety. The patient is engaged with the question, “ How are you safe now here?” The usual response conveys the information that there are staff ‘24/7’ keeping an eye on her. Sometimes a sense of safety eludes the patient and can be addressed accordingly. “ A Safe Place” alternatively “ A Secure Base” is designated on the board. With the acknowledgement of being in a safe

place, the patient is then asked about what is given up in order to have safety. Sometimes a patient is surprised that the psychiatrist will point out the various signs of lost autonomy the patient has endured: the locked unit, the prohibition against shoes (to make it harder to escape). The psychiatrist makes explicit that the hoped for outcome of hospitalization is that the patient will internalize what safeguards are needed in order to move from the safe place provided by staff in the hospital to a “better place”, outside the hospital, in which freedoms will gradually be acquired in accordance with demonstrated responsible behaviors. A trajectory is traced aiming at the better place, (somewhere off the board) but there is a diversion (depicted to the right) by what

the patient has come to conceptualize (through milieu therapy, journal assignments, and formal group therapy) as **stressors**. The psychiatrist describes how persons restore themselves to their original trajectory by practicing **coping skills** to deal with the stressors. Maladaptive coping skills exhibited by the patient such as self-injurious behaviors may warrant comment before moving on. Various reasons are sought from the patient for failures of persons to correct their course. The patient may identify impoverished coping skills or overwhelming stressors at this point. Whichever psychobiological conditions afflict the patient (such as depression, post traumatic stress disorder, and/or substance abuse), if not already nominated by the patient, are then made explicit by the psychiatrist as impediments to choosing and using adaptive coping skills.

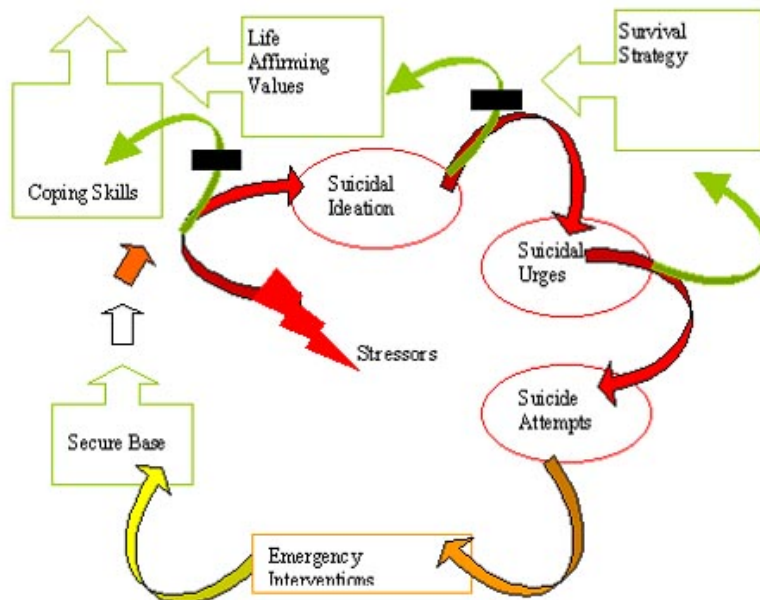


Figure 2: Suicidality Management Plan
(modified to depict psychopathological interferences)

In summary, a conscience sensitive psychiatric evaluation of a suicidal youth can be further strengthened by use of three techniques:

- 1) making explicit the patient's moralized attachment with a moralized genogram (honoring the bedrock value of connectedness),
- 2) stimulating consequential cognitions with an imaginal exercise, the suicide walk, which in turn allows for the elicitation of life-sustaining and life-affirming values (honoring the bedrock value of respect for self-worth and other-worth) and
- 3) utilization of a value matrix to assist the person of conscience currently compromised by suicidality to gauge the gap between best reasons and basic motives, a form of self assessment of risk

The insights gleaned from these clinical procedures are then incorporated into a personalized suicidality prevention plan which the patient must present to his inpatient treatment team and his principal attachment figures with sufficient suasion that they believe his plan will be serviceable.

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