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Suicide and internalised relationships: A study from the perspective of psychotherapists working with suicidal patients

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Suicide and internalised relationships: a study from the perspective of psychotherapists working with suicidal patients

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ABSTRACT *A study was conducted into the personal meanings of suicide. It is recognised that early experiences of relationships can have a bearing upon a later tendency towards suicide. This project investigated the representations which these relationships take on within the person's inner world and their effect upon the person's behaviour. One hundred psychotherapists were surveyed, by means of a postal questionnaire, regarding their work with suicidal patients. Five follow-up interviews were conducted. The main themes that emerged in the patients' relationships were rejection, invasion and engulfment. These were experienced as forms of abandonment. Incidents involving loss or rejection in the patients' present life were found to re-activate these earlier relationships.*

Introduction

Every year, in England and Wales alone, around 4,000 people take their own lives. The drive towards suicide is in no doubt influenced by many factors. However, in working with people who have suicidal feelings, it seems insufficient to conclude that this is merely to do with some external circumstance, such as redundancy or bereavement. Many other people find themselves to be in similar situations and yet are not suicidal. Hale & Campbell (1991) affirm that there are many common assumptions made about suicide, such as that it is a cry for help or that the person feels life is not worth living. All such assumptions are only part of the truth and, if taken as the whole truth, are misleading. They fail to recognise that the feelings inherent in the suicidal state are related to, and affected by, unconscious processes. They also fail to recognise the violence inherent in the suicidal act. Lifton (1989) asserts: 'There is common ground to suicide, no matter who carries it out, as a violent statement about human connection, broken or maintained' (p. 460).

As a counsellor, my main theoretical orientation is a psychodynamic one. I accordingly believed that an object relations model might have something to offer in terms of understanding this human predicament. An important aspect of object relations theory is that the person's inner world contains representations of the self

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and of objects (others), *in interaction and interrelationship with one another.* Maltsberger & Buie (1989), Hendin (1991), Kemberg (1993) and Maltsberger (1993) have all written about the importance of the internalisation of early object relationships in connection with suicide. Maltsberger & Buie (1980), over a period of years, studied a series of patients who committed suicide. They reported:

> 'In the cases we have studied, disturbances in the mothering relationship are frequent. These difficulties are of the kind that disrupt the developmental step of separating and tolerating separateness from the mother with reasonable effort' (p. 61).

As attachment theorists have shown, the continued presence of an emotionally available and responsive significant other is critical for the development of healthy autonomy (Bowlby, 1969, 1979). De Jong (1991) investigated levels of attachment and the relationship that this may have to risk of suicide in late adolescence. Out of a group of students with a history of suicidal impulses, 38% indicated that they had no-one emotionally available to them when growing up; this compared with 12% in a group that were currently depressed but had no history of suicidal impulses, and with only 5% in a normal control group.

Similarly, Benjaminsen *et al.* (1990) compared 30 psychiatric patients who had attempted suicide with two matched control groups, one consisting of non-suicidal psychiatric patients and the other of normal subjects. A questionnaire designed to assess the patients' own memories of child-rearing experiences was used. Suicide attempters differed significantly from healthy persons on numerous sub-scales. Overall, they had experienced more negative and less positive aspects of parental rearing practices. The suicidal patients experienced their parents as more depriving (mother and father), more shaming (father), more rejecting (mother and father), less tolerant (father), less affectionate (father and mother), less performance-orientated (mother) and less stimulating (mother and father) than the subjects in the normal control group.

From these findings it is to be expected that suicidal behaviour will hold a meaning for each person which is both complex and specific and which depends upon the nature and quality of what has been internalised. This then is the central objective of the present study; to investigate whether a person's early experiences of relationships had a bearing upon a later tendency towards suicidal behaviour. It is hypothesised that the development of suicidal feelings and behaviour later in life is related to the nature of the important figures and relationships that have been internalised by the person in their very early years. It is further hypothesised that people who experience suicidal impulses feel themselves to be abandoned in some way by their significant objects.

In order to test these hypotheses, I sought to draw upon the experience of psychodynamic psychotherapists who had worked with patients who had attempted or committed suicide. Through the transference relationship and their own counter-transference responses, I believed that psychotherapists working with a suicidal patient may be in a unique position. Their relationship with the patient allows them to observe the nature, and ongoing process, of the patient's internal and external

object relations, and to explore the possible origins of these relations. The focal point is the therapeutic relationship itself and how the early experiences of the suicidal person are revealed in the relationship. I therefore proposed to pull together the perceptions and understanding of these therapists in order to build up a picture of the kinds of internal and external experiences that may lead a person to attempt to take their own life.

Methodology

The sample group consisted of 100 psychotherapists of a psychodynamic or psychoanalytic orientation. It was a stratified random sample, drawn from the UKCP National Register of Psychotherapists.

The first stage of the enquiry was conducted by means of a postal questionnaire. This was specifically developed for the purpose of the study. The items for the questionnaire emerged from a reading of the existing literature and were divided into four sections. Part 1 asked for biographical details about the psychotherapist and their practice; Part 2 for biographical details about one suicidal patient with whom the psychotherapist had worked; Part 3 for details about the patient's relationships with their significant objects; and Part 4 for details about the patient–therapist relationship. In this paper I report mainly on the results obtained from Part 3, which formed the main body of the questionnaire. I shall therefore describe this part in more detail.

First, the psychotherapists were asked to give their impression of their patient's perception of his or her mother. A list of 12 adjectives were offered: the therapists were asked to tick as many of them as they believed to be applicable. They were also invited to add other suitable adjectives and to describe the relationship more fully if they so wished. The same question was asked in respect of the patient's perception of his or her father. The items were scored separately for the mother and for the father.

The psychotherapists were then asked to describe, on three semantic differential scales, how they believed their patient felt themselves to be in relation to their mother and their father, respectively. Each scale ranged from 1 to 8 for the following pairs of bipolar adjectives: (1) engulfed–unconnected; (2) abandoned–invaded; and (3) overprotected–neglected.

Two further questions asked about persecutory or abusive object relationships in childhood and whether, in the therapist's view, these had been internalised by the patient.

Possible motivations for the patient's suicidal behaviour were measured on a Likert-type scale. The therapists were asked to rate on a scale from 1 (highly improbable) to 5 (highly probable) the extent to which they considered a list of seven possible motivations to form a part of their patient's suicidal behaviour. Again, they were given the opportunity to describe any of these responses more fully if they so wished.

The therapists were next asked what they considered *might* have been the

trigger for the patient's suicidal act. Finally, they were asked whether or not the patient succeeded in committing suicide.

The questionnaire was piloted amongst three psychotherapists and four counsellors known to the researcher, in order to ascertain whether there were any faults with the instrument. Following this, the instructions given for two of the questions were rephrased in order to clarify what was required.

At the end of the questionnaire, the therapists were asked whether they would be willing to participate in a follow-up interview. From those who indicated that they would, five interviewees were selected. This selection included two cases where the patient had committed suicide, and three where there had been a suicide attempt. The interviews were semi-open-ended. A series of prompt questions was used, designed to encourage the participant to further explore the themes that had arisen in the questionnaire responses. The interviews lasted for approximately 50 minutes and, with the permission of the participants, were tape-recorded in order to aid the analysis of the data.

For the quantitative data generated in response to the questionnaire items, analysis was performed using the computer software package SPSS for Windows (Statistical Package for the Social Sciences). Since the data were mainly of a nominal nature (Bryman & Cramer, 1994), and since no assumptions could be made with regard to the characteristics of the population from which the sample was drawn, it was appropriate to apply a non-parametric statistical test for analysis. The chi-square test was therefore chosen in order to test statistical significance where appropriate. The significance level selected was $p < 0.05$.

The qualitative data, produced in response to the open-ended questions within the questionnaire and the interviews, were subjected to content analysis. Summary sheets were used in order to calculate how often specific words or phrases occurred within the questionnaires. Themes within the data were identified and grouped together.

Results

A total of 58 out of the 100 questionnaires were returned. Of these, 35 (60.3%) psychotherapists had worked with a patient who had attempted or succeeded in committing suicide; 23(39.6%) had not. One of the 35 respondents, with a male patient, did not answer all the questions.

Four major themes arose from the study: rejection and abandonment; invasion/engulfment and abandonment; the relationship internalised; and rage. Each will be reported in turn.

Rejection and abandonment

In the opinion of their therapists, over half (52.9%) of the patients perceived their mother as rejecting (Table 1). Those who included a fuller description referred to the mother variously as self-absorbed, neglectful, preoccupied and unavailable. The same number of patients (52.9%) perceived their father as rejecting. Additional

TABLE 1. Summary of patients' perceptions of their parents, as understood by their psychotherapists (N = 34)

Men	Women	Mother		Father	Men	Women
		%		%		
0	18	18 (52.9)	Rejecting	18 (52.9)	2	16
2	11	13 (38.2)	Domineering	16 (47.1)	2	14
2	12	14 (41.2)	Demanding	12 (35.3)	2	10
4	6	10 (29.4)	Indifferent	12 (35.3)	4	8
0	8	8 (23.5)	Abusive	12 (35.3)	1	11
3	10	13 (18.2)	Anxious	6 (17.6)	1	5
0	6	6 (17.6)	Aggressive	12 (35.3)	2	10
0	6	6 (17.6)	Cruel	11 (32.4)	1	10
3	7	10 (29.4)	Intrusive	6 (17.6)	0	6
2	7	9 (26.5)	Loving	7 (20.6)	0	7
2	2	4 (11.8)	Protective	1 (2.9)	0	1
1	2	3 (8.8)	Ideal	1 (2.9)	0	1
6	28	114	Total responses	114	6	28

comments described these fathers as being absent or unavailable in a number of ways; sometimes physically, sometimes emotionally, sometimes both.

The responses to the three (8-point) semantic differential scales appeared to confirm these impressions of the patients' perceptions of their parents. The results from differential scale 1 (engulfed–unconnected) for the father were striking in that 82% of the cases were rated by their therapists as being to the right of the mid-point, i.e. feeling 'unconnected' in relationship to their father; the modal score was 7 (Figure 1). The results from differential scale 1 for the mother were more evenly spread; the modal score, however, was also 7. Differential scale 2 (abandoned–invaded) revealed a fairly even distribution of scores across the total range of the

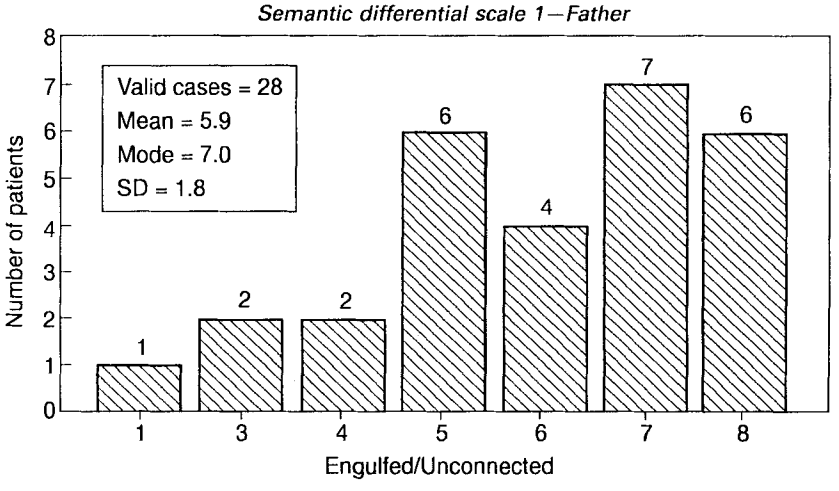

FIG. 1. Patient's feelings in relation to father, as understood by their therapists (Engulfed/Unconnected scale).

scale. The modal score here was 4 in respect of both mother and father. In relation to this, some participants commented that their patients swung between alternate fears of abandonment and invasion. The results for differential scale 3 (over-protected–neglected) showed that, in respect of both mother and father, 80% of the patients were evaluated as being to the right of the mid-point on the continuum. In both instances, the modal score was 8—the most extreme value at the 'neglected' end of the scale.

Differences between men and women. There appeared to be some interesting differences between men and women. Out of the 35 cases, only seven were male; one therapist, with a male patient, did not answer some of the questions in Part 3 of the questionnaire, so six males are reported on here. Even though it was a small sample, it is important to note that whilst a higher proportion of women were reported to perceive their parents as being rejecting towards them, a higher proportion of men were described as perceiving their parents to be indifferent (Table 2). The use of this term to describe the experience of the male patients may indicate that they felt their parents to be uninterested in them. One therapist reported his patient as saying: 'It didn't seem to matter whether I was there or not; they just didn't seem to notice.' This kind of experience may feel as much like abandonment as the rejection more often reported by the women in the sample. However, in comparison, indifference may feel simply empty of any communication or recognition from the other person.

This accords with the findings of De Jong (1991), who discovered a strong gender effect in the relationship of levels of attachment to suicidality. De Jong noted that males with a history of suicidal impulses tended to have had less experience of parental and significant other attachment figures available to them when growing up than any other sex/group category in the study. These males suffered the most

TABLE 2. Perceptions of parents: comparison for men and women

Combined responses for mother and father	Total	Men	Women
Rejecting	36	2	34
Domineering	29	4	25
Demanding	26	4	22
Indifferent	22	8	14
Abusive	20	1	19
Anxious	19	4	15
Aggressive	18	2	16
Cruel	17	1	16
Intrusive	16	3	13
Loving	16	2	14
Protective	5	2	3
Ideal	4	1	3
Total no. of responses	228		
No. of cases		6	28

Note: The figures include separate scores with regard to mother and father, i.e. the possible total for each item is 12 for men and 56 for women.

serious degree of unrelatedness of all the groups examined. It follows that this group might find it more difficult to seek out help and to have trust in the responsiveness and understanding of another person.

The data from the present study show that a higher proportion of men than women actually completed suicide. Again, this suggests that even when they have found their way into therapy, males may find it more difficult to establish a relationship of trust, and are more likely to carry out their suicidal intentions rather than to talk about and share their distress.

Some psychodynamic implications. One of the aims of this study was to explore why and how these early experiences of feeling oneself to be rejected and abandoned are of such importance. What are some of the psychodynamic implications of this kind of experience, and what are their links with suicidal behaviour?

It is probable that the inner world of such a person will be very bleak and impoverished. Instead of comforting and nourishing primary objects having been internalised, there is constant threat of psychological disintegration, arising from an intolerable experience of aloneness and emptiness. The interviewees described their patients as displaying a constant need to search for external resources of comfort and unconditional love. One interviewee described her patient in this way:

> 'She has tried to make all of us (the professional carers) into parents who will take away the pain and look after her. She goes into hospital because she can't bear to be alone at home.... When she was at home she kept ringing the hospital every evening and first thing in the morning.'

It seems that for those whose early experience of relationships has been poor, there is little sense of inner holding and security. They may feel that this can only come from other people outside the self. In contrast, death may be seen as promising to restore the perfect holding and nurturing mother forever (Hale & Campbell, 1991).

Low sense of self-worth may also be present as a result of the processes of splitting and projection. When the open-ended questions within the questionnaire were subjected to content analysis, it emerged that 25 (71%) of the questionnaires contained some reference to patients' feelings of worthlessness, failure, self-blame and self-contempt ($p < 0.05$).

Suicidal trigger. The role of a suicidal trigger as a precipitant to the suicidal act was shown to be very important. Out of the 28 therapists who identified a specific experience or event leading up to the suicidal act, 23 (72%) reported incidents connected with loss, rejection or abandonment ($p < 0.05$). This may suggest that when the protecting function and the feelings of security and worth have been located outside the person, in someone or something external, there is a real problem when anything happens to that relationship. Loss of partner, job or body image was specifically mentioned in 14 cases.

Kohut (1971) postulates that the experience of an empathic, nurturing mother is a prerequisite for the individual to develop soothing introjects and the ability to comfort her/himself in times of loss. The data produced in the current study appear to suggest that the experience of the suicidal person is such that a present experience

of loss reactivates past rejections and feelings of emptiness. When these patients experience loss, it is likely that they feel a narcissistic insult. It is not the size of the insult that matters; rather it is the meaning given to the event in the person's inner world that is important.

Triggers to suicide mentioned in the questionnaire responses included the following examples:

> 'She had visited the GP who had not taken her suicidal feelings seriously.'
>
> 'Loss of first major sexual partner.'
>
> 'Her son's success in going to university.'
>
> 'Having to wait a long time in a hospital out-patient clinic.'

At one level, the person may understand the incident to be perfectly normal and reasonable; but at another, much deeper, probably unconscious level, it acts as a trigger and feels like a repetition or confirmation of something about themselves in relation to another. One interviewee said of her patient:

> 'When she was failed by people for whatever reason, I think she found it incredibly difficult to cope with; it drove her into that level of despair. To her, a small failure would be like a big one; she couldn't differentiate really. Even a little thing would be like being totally rejected.'

Invasion/engulfment and abandonment

The questionnaire responses implied that some of the patients felt themselves to be invaded by their parents. In the experience of the suicidal patient, this was felt to be another form of abandonment. The following adjectives were chosen to describe the way in which these patients perceived their parents:

> *Mother*: demanding—14 patients (41%); domineering—13 patients (38%); anxious—13 patients (38%); intrusive—10 patients (29%).
> *Father*: domineering—16 patients (47%); demanding—12 patients (35%); abusive—12 patients (35%); aggressive—12 patients (35%); cruel—11 patients (32%).

The experience in terms of feeling invaded and engulfed also came across very clearly in the interviews. One patient, having been born with a physical handicap, spent much of her early childhood in hospital undergoing operations to improve her appearance, at her mother's insistence. Her therapist said:

> 'I get the sense that her needs weren't ever really met. She had the experience of being there to become something that was acceptable to her mother, which of course she never did. I have sensed that she's profoundly enraged by what she went through in the hospital and was sort of abandoned there.'

Many of the patients were described as perceiving their parents as being involved with them in ways that had more to do with the needs of the parents than their own needs as a child. They felt themselves to have been intruded upon in various ways, both physically and emotionally, and yet their true feelings had been ignored. The true self, as described by Winnicott (1965), had been abandoned. It appeared that these patients had experienced their lives to be taken over, and yet, at the same time, their real needs and the true inner self felt trampled upon or neglected. One therapist described her patient as being

> '... always "in rebellion". She was tortured because she couldn't ever be herself. She was so hell-bent on preserving herself from her mother's expectations that she never came into her own being. She was "in reaction" always to her mother and, of course, her death was the final ultimate reaction.'

The data suggest that there is fear both of being engulfed and taken over by an all-powerful, overwhelming object, and at the same time, of the true self being neglected, unseen, unheard and abandoned.

The relationship internalised

One of the main factors highlighted from this study is the continual power and enactment of internalised figures, and even more important, of the internalised relationships. The questionnaire asked: 'Do you consider that your patient experienced abusive or persecutory relationships in childhood?' Of the 33 participants who answered this question, 28 (85%) replied 'Yes' ($p < 0.001$). Many of the participants added a description of the nature of those relationships: three included a description of parents who were emotionally or physically controlling; six referred to continual disparagement as being worthless and not good enough; nine described parents who were preoccupied and emotionally or physically absent; and 13 made reference to violent and physically or sexually abusive relationships in the home. For many, there seemingly had been a combination of these features.

In response to the subsequent question, 'Do you consider that the patient was still subject to attacking and persecutory internal objects, resulting in suicide or suicide attempt?', 33 participants replied. Of these, 29 answered 'Yes' ($p < 0.001$). Some further described how they believed abusive relationships with significant primary figures to have been internalised as a part of the child's inner world and as such to have gone on and on acting within the personality. One participant, describing her patient, said:

> 'I think in part she was trying to do away with the warring couple inside her. She sometimes can be very violent and paranoid like her father, and at other times very, very persecuted as she felt her mother to be.'

Patients were reported as experiencing an overwhelming inner despair that anything could ever be different. It is probable that they felt themselves to be trapped in this bind because such internalised relationships go on exercising power

and having their influence, affecting the way in which that person feels and behaves. Internalised objects not only act within the personality: at certain points they may even take over the personality. This accords with the view of Hale & Campbell (1991); 'The suicidal individual leaves the external object intact and assaults an internal object, represented by the body, identified with the engulfing or abandoning mother.... The body must be killed if the self is to survive' (pp. 294–295).

Rage

For the suicidal person, the flip-side of the fear of abandonment is a conscious or unconscious rage, which is also terrifying. One of the seven possible motivations for suicide listed on the Likert-type scale within the questionnaire was 'rage and anger at their significant object'. On a scale of 1 (highly improbable) to 5 (highly probable), indicating the extent to which the therapists considered these possible motivations to have formed a part of their patient's suicidal behaviour, this item appeared as the most highly rated from the list, with a mean score of 4.5. In the opinion of their therapists, rage and anger played an important role in motivation for suicide in the case of 93% of the patients.

It is likely that for the child who has experienced abandonment, there has been no-one available to either hear or receive her/his angry feelings. It is possible that in many of these cases the parents would be too self-absorbed to help the child deal with her/his rage. Without such help in infancy, the child cannot grow to believe that these things are manageable and fails to develop adequate inner resources to deal with such feelings.

Winnicott (1989) describes how the child finds his or her own destructive impulses intolerable if it seems possible that the rage can really damage an object that is both loved and hated: '... if father will be there at breakfast then it is safe to dream that father got run over.... If father is not present such a dream is too frightening, and leads to a guilt feeling or a depressed mood' (p. 68). This rage was experienced by the therapists in the transference relationship. However, the patients were mostly only able to express it by means of their actions and by behaving in a destructive way. One interviewee told of how she experienced her patient's rage and anger:

> 'It is real infantile rage. She has temper tantrums and she'll scream. I've had calls from places saying: "This person is lying down here and we don't know what to do with her". She lays there for a while and then comes for her therapy session. There are triggers, but it goes back much further, to age 5 at least, if not before.... The patient demands: "Why did God allow this?" It's like a child saying: "The parents shouldn't have allowed this" '.

Another interviewee said:

> 'The patient drew a picture. It was an awful picture really: she was tearing her mother apart. It looked like a destroyed foetus. I think that's what she felt and that's what she did to herself: she acted that out.'

These reports convey something of the force and quality of very early infantile states of pain and rage. What seems to characterise the feeling of having to act out the rage is the perception that no other person is able to help and process the anger: it is impersonal. Viewed in this way, the suicide attempt can be understood as an angry attack or revenge, but one that can only be carried through by killing the self's own body. The fear is: if I get in touch with the rage, I will annihilate the other, so I had better annihilate myself. The anger can only be expressed by turning it against the self and the internalised mother.

Conclusions

It is a feature of this present investigation that what has been elicited about the experience of these patients and their suicidal impulses has come from the recollections of their psychotherapists. This could be seen as a limitation in that what has been studied is the therapist's perceptions rather than the direct reports of the patient.

However, as was expected, the advantage of this method is that psychotherapists have been able to record their own observations of their patients as they have experienced them in the therapeutic relationship. The results have revealed a common pattern as their patients' internalised relationships were encountered in the transference relationship.

This study has shown that, in the view of their psychotherapists, over half of patients who have attempted or succeeded in committing suicide have experienced rejection and abandonment in their early years. Parents were often perceived as absent and unavailable, and a high percentage of the patients were reported as feeling unconnected to their mother or father. The evidence suggested that for many of the patients, this has meant the development of a bleak, empty, impoverished inner world which may have led them to seek comfort and security outside themselves. Dependency was noted in many cases, and yet patients also displayed a fear of dependent relationships, believing that these could only end in further rejection.

A gender variation was noted in that men were more likely to describe their parents as indifferent. In accordance with earlier studies, it appears that men may have more difficulties in terms of relatedness and attachment, perhaps making it harder for them to seek help and to trust in the responsiveness of another person. In view of the small sample of men within this study, it was not possible to demonstrate this as significant: it would need to be confirmed in future research. In view of the rising trend in male suicide (Samaritans, 1995), this seems an important avenue to investigate further. It may also carry implications for health-care provision, and particularly for the clinical practice of counselling and psychotherapy.

In the opinion of their therapists, many of the suicidal patients in this study had perceived their parents as intrusive and engulfing. It appeared that such patients had experienced their life to be taken over and yet, at the same time, their real needs and the true inner self felt trampled upon or ignored. For the patient this experience may also be felt as abandonment. It appeared that many patients had experienced elements of both rejection and intrusion in parental relationships.

The findings in this study confirm the importance of the suicidal trigger. Three out of four suicides or suicide attempts had been preceded by a specific incident or event connected with loss, rejection or abandonment. The significance and meaning of these events to the individuals concerned could be discerned as a re-activating of previous rejections and a feeling of emptiness. This is particularly relevant when considering the meaning to the patient of any breaks or holidays and especially of the ending in counselling and psychotherapy.

Feelings of extreme infantile rage were also discerned amongst these patients by many of their therapists. This rage was understood to feel dangerous and destructive to the patients, and as a result they could only act this out in various ways. In almost all the cases, feelings of rage and anger were thought to have featured in the patient's self-destructive acts.

Many of the therapists experienced their patients as attacking the therapy in a variety of ways. In terms of the therapeutic relationship, the suicidal patients were often felt to desire closeness and yet also to be frightened of it. This was understood as revealing, in the transference, something of the patient's inner world and the relationships that existed therein.

The psychodynamics were seen to be complex and very personal. Various suicidal fantasies were perceived which accorded with the findings of Hale & Campbell (1991). These results strongly suggest that in clinical practice it is important to take seriously any suicidal feelings or fantasies and to explore and understand with patients their destructive impulses. Containing these feelings and understanding with the patient what it is that he or she is hoping to communicate by dying can provide crucial relief to the patient and may reduce the risk of suicide.

In respect of many of these points, several therapists pointed out the dangers of working with suicidal patients whilst therapists are still inexperienced. In an ideal situation an initial interview would best be carried out by an experienced assessor. This is not always possible and the dangers cannot always be picked up in a brief assessment. However, the results from this study provide an argument for attempting to implement such a system.

In summary

This study highlights that significantly high numbers of the suicidal patients were considered by their therapists as having experienced persecutory relationships in childhood, and also still to be subject to attacking and persecutory internal objects, which they related to the patient's suicidal behaviour. These findings strongly suggest that relationships with significant primary figures, especially parents, which are rejecting and/or intrusive, and therefore abandoning, are likely to be internalised and as such can increase the risk of suicide in later life.

This does not imply a direct causal relationship as there are many other potentially confounding variables of constitutional or environmental origin. What is indicated is that relationships of the kind which have been described in this study are likely to be taken into the person's inner world and can be acted out in a variety of ways. Suicide can be seen and felt by the person to be one solution to the manifold

emotions, pressures and confusion which seem to be at war within. Further research is necessary in order to identify the specific factors within this constellation that propel a person towards suicide, and also to establish the links with other forms of self-destructive behaviour.

Hendin (1991) has asserted that 'all of the psychodynamic meanings given to death by suicidal patients can be conceptualised as responses to loss, separation, or abandonment' (p. 1154). The findings from the current study certainly support this statement. It is hoped that these results will encourage an awareness of the very personal and complex nature of suicidal acts and their specific meanings in terms of the inner world of each individual. One of the patients reported on within this study had written a poem. It included these lines:

> 'I am honest from within, but cannot bring out all that is a lie
> It is for me just one indestructible knot, that seems to me if undone, I will die.'

This research has indicated that counselling and psychotherapy, and the relationship which these offer, can give a patient confidence and a context in which to look anew at old patterns, and can enable them to dare to voice what previously has felt unspeakable.

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