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Suicide prevention: the contribution of psychoanalysis

Stephen Briggs

“excessive individuation leads to suicide [and] a lack of it has the same effect. When a man is detached from society he is liable to kill himself, but he may also kill himself when he is too firmly integrated in society’ (Durkheim 1897/1997 page 234)

Reducing suicide rates is a key mental health social policy objective worldwide, and has been so for the past decade. The prioritisation of suicide prevention is justified on moral, clinical and ethical grounds (Reulbach and Bleich 2008); the psychological impact of suicide is massive, and yet also difficult to quantify, since the self-destruction of a life – itself a grievous loss - is accompanied by manifest and significant impact on the lives of others connected with the suicidal person. The costs in terms of mental health and well-being are immense.

In this chapter I will show that psychoanalytic thinking and practice makes a significant contribution to current practice and policy and I will propose that some currently problematic areas of prevention strategy and clinical practice would benefit from the application of psychoanalytic knowledge and practice. For this discussion it is necessary to identify the strengths and limitations within current practice and policy, and, secondly, the role of and potentiality for psychoanalytic thinking and practice. Although psychoanalysis and national suicide prevention strategies appear, at first inspection, to occupy different domains, or, even, incommensurable paradigms, there is a potential synergy between these, and I will suggest that psychoanalysis has the conceptual and practice-technical capacity to bridge the social and psychological dimensions of suicide to enrich understanding of both and generate more effective policies and practice. This requires, in return, that psychoanalysis engages with the aims, aspirations and methods that drive suicide prevention policies.

For the purposes of this discussion I will identify two particular domains in which I believe prevention practice and strategy need the contribution of psychoanalytic thinking. These domains are, firstly, the quest to assess risks for suicide and the application of the risk assessment model in clinical practice and, secondly, the aim of preventive policies in reducing the impact of stigma and taboo about suicide.

Suicide prevention strategies

The development of suicide reduction policies and strategies arose in the context of concern about rising suicide rates in the 1990’s. Governments were increasingly preoccupied with generating policies that promoted health and well-being, and addressed the major causes of ill health. These aims were

underpinned by evidence that inequalities affected health chances, and anxieties about societal cohesion and exclusion.

The strategies that have been introduced and developed in many countries are concerned with practical and immediate responses to suicidal behaviour and risks. These responses aim to assist the better identification in communities and in mental health services of high risk groups and individuals and to protect people from suicidal acts through restricting access to means, through targeting 'hot spots' used by people to jump to their deaths and individually wrapping for medicines used for self-poisoning. A second and related aim for prevention strategies is to engage communities to raise awareness and improve recognition of suicidal states, and address stigmatising interactions associated with suicidal behaviour and its impact on others. Strategies thus aim to address the taboo that can exist of talking about suicidal feelings, often linked with a fear of the emotionality of and around suicide and a fear of contagion.

Currently suicide rates are reducing worldwide and this decline coincides – or correlates - with the introduction of coordinated national strategies for suicide prevention based on these principles. In England, the national strategy was introduced in 2002, to implement a government target to reduce suicide rate by 20% between 1997 and 2010¹. The most recent reports show that the rate is significantly reduced, and stands at the lowest rate for over 30 years (NIMHE 2008). The national strategies appear to work, though – perhaps like the economy – suicide rates sometimes appear to be under control, only to then demonstrate that they are not. Changes in suicide rates follow social change, as is evidenced by trends over significant periods of time. Suicide rates increase in periods of economic depression² and decline in times of war, or more optimistic periods of peace time. In the UK the 'optimistic' 1960's recorded the lowest suicide rates for the century as a whole outside the years of the two world wars (Biddle et al 2008).

This perspective is useful as it counsels against leaping to imply a causal connection between declining suicide rates in the first decade of the 21st Century and the impact of national strategies. On the other hand, the lack of demonstrable causality does not negate the usefulness of the investment in suicide reduction policies which demonstrate concern with the problem, and the state acting 'as a good parent should'. The national strategies were developed in response to high and increasing suicide rates in the 1990's and identified problems that were common to a number of countries, including the high rates of suicide amongst young men, and the difficulties services experienced in making effective contact with suicidal people in this and other high risk groups.

One of the most striking of statistics is that people that kill themselves are not in contact with mental health services. For example, following the Bridgend suicides, the Welsh Assembly heard evidence that three quarters of suicides

¹ The baseline rate was 9.2 per 100000 of the population, for 1995/6/7 and the target is therefore 7.3 per 100,000 for 2009/10/11 (NIMHE 2008 page 3)

² 'It is a known fact that economic crises have an aggravating influence on suicide' (Durkheim 1897/1997). It is widely expected that rates will rise in the current global economic down turn

in Wales were not in contact with services, and had not been in the 12 months before the suicide (Welsh Assembly 2008). Rob Hale (2008) cites the studies in the USA by Luoma et. al. (2002); these show that only 33 per cent of suicides have been in contact with secondary psychiatric services in the previous year, but 75 per cent had been in contact with their GP. In the month prior to death 20 per cent had been in contact with mental health services, whereas 50 per cent had consulted their GP. Often the reason for contacting the GP is not explicitly about suicidal thoughts or intentions, and the reason for the consultation would not have introduced a thought about or a connection with suicide in a suicidologist, never mind a busy GP. Since most suicides occur in those not in contact with services, it is implicit that mental health services either miss those most at risk, or, alternatively, they provide a protection against suicide, since there are fewer suicides amongst those in contact with services.

Thus a key focus for prevention strategies in recent years is on reaching those who are vulnerable but do not seek help and those who do not communicate openly about their suicidal intentions. This has led to adaptations to the approaches of mental health organisations in order to increase their reach into the community. In this respect, suicide prevention strategies connect with policies that aim to make mental health services more comprehensive, inclusive, community focused and responsive (see, for example, the CAMHS review, DCSF 2008).

Linked with these trends is the aim of reducing the stigma or taboo associated with suicidal behaviour in society, and training community based professionals – including those in schools, for example – to be able to encourage talking about suicide as something which helps prevent suicide rather than constituting a dangerous intervention which might ‘put ideas in people’s minds’ and make the problem worse.

The idea that talking about suicide makes things worse can be a powerful and pervasive notion; when working with schools I have seen it affect teachers, young people who cannot bear to talk to adults and peers and research ethics committees, who can become very anxious that in sanctioning research about suicide prevention, they may be sanctioning suicide (Briggs 2009, Briggs and Buhagiar 2008). This is not rational; the fear of instilling suicidal behaviour by talking about it indicates a particular process is taking place in which words lead to action rather than to thought, a process which Bion described as the reversal of Alpha function (Bion 1970). In these examples, suicide appeared to stir up intense emotions in school staff, students, parents and members of research ethics committees; fear of talking leading to destructive action and fear of contagion pervaded. One 15 year-old student, for example, told us:

‘But it’s not that good to talk about it because it might influence other people to have a go as well, because they’ll think that if so and so can get their anger out by doing this behaviour, maybe it will work with me’.

The fear of contagion indicates that something can be transmitted like bacteria, which locates the problem in the transmitter as well as the recipient.

This is a helpful image as it describes contagion taking place in a dyadic, projective relationship (Moylan 1994), and opens up for discussion the question about what it is exactly that we are exposed to when addressing the issue of suicide, and what it is in each of us that can be so powerfully affected by it. From this the possibility of a less anxious and more containing approach to talking about suicide can be developed, a point to which I will return later in this chapter.

A coordinated and community centred approach to suicide prevention is central to some national strategies. For example, the Australian strategy is one which has been admired widely and it forms the basis for the strategy recently developed in Wales following the spate of suicides amongst young people in Bridgend during 2006-8 (Welsh Assembly 2008)³. Its goal is to reduce deaths by suicide and reduce suicidal behaviour by:

- adopting a whole community approach to suicide prevention to extend and enhance public understanding of suicide and its causes; and
- increasing support and care available to people, families and communities affected by suicide or suicidal behaviour by providing better support systems. (Australian Government 2008)

In Scotland, where considerable resources have been committed to suicide prevention since 2002, a coordinated strategy has been launched to encourage early recognition and engagement through reducing inhibitions and stigma about talking about suicide. The strategy –‘Choose Life’ – aims to ensure national engagement in schemes to build skills and evaluate effective interventions. The Scottish strategy recently featured a national campaign 'Don't hide it. Talk about it', directed to the general public and supported by poster, press and radio advertising and a ‘public-facing’ website (Choose Life 2008)

These are innovative approaches to the problems of stigma and the inability to talk about suicide. How effective they are – or will become- is not known. How the emotional and relational can be connected to the social in this kind of setting and around this issue needs further exploration and discussion.

Attempted suicide and self-harm; assessing and managing risks

Frontline health services experience a heavy burden in responding to people that have attempted suicide or deliberately harmed themselves. This is attested by the numbers presenting to hospital following an episode of self-harm, which are in the region of 140000 per year in England and Wales (Bennewith et al 2004). Many studies (e.g. Hawton et.al. 2003; Isaacson and Rich 2001; Kapur et al 2005, Owens et al 2002) now show the connection between an episode of self-harm, heightened risks for repetition and completed suicide. Management of the immediate period following an episode of self-harm has been recognised as extremely important for prevention

³ On ‘All in the Mind’ Radio 4 11th November 2008. Simon Armson, former Chief Executive of the Samaritans discusses the Welsh Assembly’s plan and welcomes the approach which encourages open discussion of suicide in a thoughtful and concerned way

(Bennewith et al 2004) and guidance for the management and delivery of services for self-harm have been developed accordingly (NICE 2004).

The connection, as a factor of risk, between self-harm or attempted suicide and subsequent fatal and non-fatal repetition of the attempt cuts across the previous –and potentially dangerous – distinction between self-harm and suicide as being diagnostically different. The notion of parasuicide in particular is seen now to be a pedantic category, which treats effect, or outcome, as revealing intention (conscious or unconscious) and meaning. Hale (2008) has maintained for some years now that the motivation for suicide and ‘parasuicide’ is the same and the difference is only that the outcome is different; suicide is either completed, or not.

However, the risk assessment approach can only offer an inaccurate guide to what may happen in individual cases. The mainstream position, central to national suicide prevention strategies is to identify risk factors and groups at high risk for suicide. This is, of itself, a reasonable and on the whole helpful epidemiological task. It has been informative to recognise the greater risks in different age groups, for example, young men and older people, and within some occupations – farmers, doctors, police. This evidence generates further thinking and research about the characteristics of these groups, and leads to the prioritisation of resources to meet these areas of identified need. On the other hand, there are considerable limitations of the risk assessment approach and these become evident when this model is applied to services in which the aim is to identify risk levels in individual cases.

The problem of using the risk assessment approach in practice arises from a mistaken notion of the status of ‘risks’ when they are treated as objective, impartial and neutral (O’Byrne 2008). Cohen (2002) points out that this is erroneous:

‘the construction of risk refers not just to the raw information about dangerous or unpleasant things, but also to the ways of assessing, classifying and reacting to them’ (Cohen 2002 page xxv).

To place knowledge outside social and relational contexts is an epistemological fallacy, which distorts. The *practical* fallacy of this position occurs when ‘risk factors’ are used to initiate action in the social domain. This is illustrated by the evidence- as recorded in the NICE (2004) guidance - of the weak associations between risk factors and the prediction of suicidal behaviour, that is, the proliferation of false negatives and positives. Though self-harm is a strong risk factor for further repetitions and completion, in most studies the percentage of people with multiple episodes of self harm is about 50%. This shows there is a one in two chance of repetition NOT occurring. The experience of self-harm heightens the chance of repetition but does not identify which individuals will repeat, and those who will not. Further assessment criteria are required therefore before risk levels can be allocated to individual cases. Similarly, depression is a strong risk factor for suicide, but the highest estimates show that 40% of suicides have a recognisable depression. This identifies, as Maltzberger puts it, the ‘depression

conundrum'. Most depressed people do not commit suicide, many people that commit suicide are depressed, but many suicides are not depressed.

Management of risk assessment is also not neutral or objective, since, apart from being organised to fulfil political agendas, it is operationalised within a system that usually employs a tariff method whereby the aim is to apply the lowest, safe category that fits the immediate circumstances. Thus the patient progresses upwards through tiered systems if risks escalate. In this model the last resort is in-patient care. In-patient care is an environment which holds high risks of suicide, during care and on discharge (NIMHE 2008, Gunnell et al 2008)⁴

Reliance on the identification of risk factors through statistical association has the effect, in Robert Castel's words, of 'dissolving the notion of the subject...and puts in its place a combination of factors, the factors of risk' (1991 page 281). This process, again as Castel suggested, "dissociates the technical role of the practitioner from the managerial role of the administrator" (page 293). Thus the application of risk assessment to clinical work occurs through assuming that the risk assessment is objective and outside the clinical paradigm through which the patient/subject is assessed. Through placing risk assessment outside the professional relational contexts, overvaluing the evidence of risk assessment leads, not to rationality and objectivity but, in target driven organisational cultures, to a blurring of boundaries, producing blaming/naming/shaming (Kraemer and Souter 2004) and omnipotent organisations (Bell 2008). In practice, risk assessments may be used more in the service of enhancing understanding within a clinical and theoretical framework, but the logic of the literal application of risk assessments leads to nonsensical formulations. Examples of these include the following formulations, made in a CAMHS service, which illustrate dissociation of clinical sense and 'objective' risk assessment:

"she took an impulsive overdose with low intent; however she left a suicide note",

and

"This was her second overdose, at the time of writing she has taken another, her third, significant yet again in intent, overdose"

This discussion is not aiming to suggest that we can do without risk assessment; risks are ubiquitous, and we are always calculating risks, consciously or otherwise; risk assessment is useful and valid when applied to and embedded in a working theoretical model; for example the individualisation thesis offers a strong analysis of contemporary 'risk society' in conditions of weak collective organisation in society (Beck 1992). From this it must be concluded that we must ask not which are the most important risk factors, but how can the knowledge from epidemiology be harnessed to a

⁴ Suicides in inpatient care in the UK are reducing through the prevention strategy (NIMHE 2008), an example of the appropriate targeting of a high risk area.

viable theoretical framework in order that the practice of identifying suicide risks in people presenting to health services can be effective. Finding suitable approaches is the next step. To date, evidence has not been forthcoming about what is the most reliable framework for these assessments:

“There are no consensually agreed on or valid, reliable risk assessment scales or other instruments that have standardized or simplified the task of assessment. There is no agreed on strategy for intervening in the life and death decision of the suicidal mind or for treating the suicidal character’
(Berman et. Al. 2006, page 7)

It follows from this that assessing and relating to suicidality cannot be reduced to a mechanistic process of risk assessment, and that the wish for a simplified method of assessing risks arises from the anxious needs of the worker to have certain knowledge rather than work within a field of possibilities, which may be more or less understandable. The costs of attempting a risk averse approach are considerable, including, as is suggested above, the loss of the patient as a ‘subject’ to the anatomy of risk.

At this point we can step back and explore how psychoanalysis explains suicidal acts in order to explore how this framework can be applied to the two particular needs identified thus far, namely, of providing a framework for understanding suicidality in individuals, and hence making sense of risk assessments, and secondly, of linking the internal with the social in understanding the taboo or fear of talking about suicidality in society and the stigma surrounding suicide.

Psychoanalytic understanding of suicide

Over the years, there have been many approaches to understanding the nature and meaning of suicide. Current thinking stands on the shoulders, so to speak, of the work of Durkheim and Freud, who provided parallel theses about the social and internal factors that lead to suicide. Durkheim (1897/1997) identified different suicidal types –egotistic, altruistic and anomic –and the social conditions in which these are more likely to have an impact, principally the quality of the individual’s relationship with the community. In Durkheim’s thesis, suicide occurs in states of imbalance between social cohesion and moral regulation. Freud’s contribution was to identify suicide as an activity that can be understood in relational terms. Psychoanalysis has subsequently elaborated and deepened this understanding of the relational and hence emotional qualities of suicidal states of mind and actions, through theory generated by clinical experiences. The relational approach permits connections between internal and social worlds.

From Freud’s (1917) formulation of the suicidal act arising from the reaction to the loss of an ambivalently loved and hated object, with which the self has identified, the nature of suicidality as a problem of relatedness became a possible and necessary area for study. Unlike Durkheim, Freud did not devote a discrete work to suicide. He was in fact often preoccupied with suicidality and the range of his full contribution to understanding suicide has been

understated (Briggs 2006) but 'Mourning and Melancholia' has been the point of departure for the development of psychoanalytic relational understanding of suicide. This fruitful exploration of suicidal dynamics lies in understanding the *constellation* of suicidal relatedness. Hale (2008) summarises this as:

'Suicide is an act with meaning and has a purpose, both manifest and unconscious. It takes place in the context of a dyadic relationship, or rather its failure, and the suffering is experienced by the survivors, or rather, part survivors of the suicide attempt' (page 9)

The model of dyadic relatedness of suicide is derived from Freud's (1923) discussion in *The Ego and the Id* of the conflict between ego and super ego in particular pathological states, particularly melancholia. From an object relations perspective, the dyadic conflict involves different internalized aspects of others, and poses the key question 'Who is hurting or killing whom?' (Bell 2008). The clinician's need to understand different constellations of suicidal dynamics within this underpinning dyadic conflict, has contributed to the development of models of suicidal relatedness. In North America, Maltzberger and Buie (1980) began to identify distinctive 'suicide fantasies', that is, patterns of unconscious dyadic relational dynamics that power suicidal behaviour, a concept that was further developed in UK by Hale and Campbell (1991) and Hale (2008) leading to the description of dynamics of merger (or reunion/rebirth), punishment, revenge, elimination (assassination) and dicing with death. The essence of the dynamics of suicide fantasies is that an impossible 'no-win' conflict exists. Glasser's (1979) 'core complex', applied by Campbell and Hale in their formulations of suicide fantasies, captures the dilemma for those patients for whom neither separateness nor intimacy are possible; the former stirs terror of abandonment and the latter engulfment. In such cases suicide appears to be a 'solution', and one which is based on an unrealistic appraisal of the dynamic impact of suicide on the self, particularly the apparently delusional sense that the self can survive the self's body's death (Hale 2008).

Thus suicidal acts take place in a psychotic moment or state of mind. Maltzberger (2004) introduced the theme of suicide as a traumatic state of disintegration, in which, totally overwhelmed by overpowering emotions, the active attack on the body has a calming effect. The impairment of reality testing indicates the transient psychotic moment. The fear of break up of the self and total disintegration is, for the suicidal person, a possibility which is felt to be far worse than physical death. In a state of panic and being traumatically overwhelmed a suicide bid appears to be the only solution (Ladame 2008). In Maltzberger's (2004, 2008) thinking, it is the internal state of disintegration that constitutes a traumatic experience. Ladame (2008) views a suicidal crisis is a psychic trauma, in which, the psychic apparatus is disabled, temporarily frozen through the rupturing effect on containment of a suicidal act. Shneidman (1976) discusses the state of psychic numbness experienced by people after a suicidal act.

Aggression and hostility have central roles in psychoanalytic formulation of suicidal relatedness. The role of aggression is either extremely sadistic or,

alternatively, aggression which, in the delusional or psychotic moment, has the motive of attempting to ensure –paradoxically – survival⁵. Contending with these different aspects of aggression is critical to clinical practice; the suicidal patient aims to involve the therapist/analyst in the suicidal struggle through enlisting her/him to play a part in the dyadic conflict.

Elaboration of the constellation of suicidal relatedness has been possible through the exploration of transference and counter transference. Suicidal patients pull therapists and analysts into re-enactments of (failed) dyadic relationships. Don Campbell (2008) names these as: the omnipotent mother, the rescuer, the saviour, the executioner and the failure (page 35). Thus, Campbell states: ‘suicidal patients frequently try to draw the therapist into taking responsibility for their living or dying’ (page 35). The often unconscious attempts by the suicidal patient to affect the therapist, to make her/him responsible for the suicidal struggle, forms a very important insight, and helps to understand some of the reactions that occur in those in contact with suicidal people. Blurring of the boundaries of responsibility is something that psychoanalytic approaches equip professionals to recognise and address through conceptualising the transference- counter transference relationship. This application of the relational theory of suicide – the suicidal relational constellation - is, of course, central to the clinical task of treating suicidal patients, but it also has wider applications and has a powerful explanatory function in situations outside the consulting room, in social interactions and in organisations. I will apply psychoanalytic thinking, in this broader sense to address two issues raised so far in this chapter- the question of stigma and, secondly, the assessment of risks. Both of these issues impact deeply on current practices and prevention strategies.

Stigma and the traumatic dimension of suicide

Exploration of transference and counter transference experiences in the clinical setting leads to the elucidation of particular ways in which the internal suicidal constellation can be played out in the clinical setting. It is a particular feature of working clinically with suicidal people that the therapist or analyst can be pulled to play a particular part in this conflict, as Campbell and others have discussed. Professionals in contact with suicidal people can thus respond inappropriately, or become caught up with the suicidal conflict, and be unaware that they are being compelled to play a part in the suicidal struggle. In this emotional field, the powerful impacts on the professional often include being invested with some of the cruelty, hostility and sadism of the suicidal relational constellation. In both clinical and wider professional contexts there is a high risk of distortion and thus of unhelpful responses. In the wider professional context there is increasing recognition that suicidal people can be treated unkindly, sometimes cruelly- not necessarily consciously – by professionals in mainstream services (NICE 2004). Sometimes these responses can be dangerous as the professional unwittingly enacts the suicidal struggle. Bell (2008) narrates an anecdote in which a

⁵ Melanie Klein (1935), in one of her few communications about suicide wrote that the aim was, simultaneously, to destroy bad objects and preserve good ones. Bell (2008) adds ‘mad as it may seem, some acts of suicide aim at preserving what is good’ (page 50)

professional unwittingly takes on the role of 'executioner'. A teenager turned up at A and E after taking 5 paracetamol and reports having taken an overdose. The doctor on duty explained that an overdose of at least 20 tablets is needed to do serious harm, and the next evening the teenager was readmitted after taking more than 20 tablets.

In many other ways there are accounts in which hostility and aggression towards the suicidal or self-harming patient are elicited, with the effect that suicidal patients are punished or blamed. The NICE self-harm guideline includes the advice that front line professionals need supervision to process the emotional impact of being in contact with suicidal people; the guideline could explain – but does not – that this is because the work itself is traumatising and because there is an ever present risk of distortion. Processing of the toxic aspects of contact with suicidal dynamics, or, in other words, containing the emotional impact of the work leads to a more balanced approach to the suicidal person, and this in turn has the potential to reduce the number of people with histories of suicide who have negative experiences of accessing services and feel themselves stigmatised by these contacts.

Applying understanding of the traumatic dimension of suicide further illuminates the nature of stigmatising responses and dynamics. The traumatising aspect of suicide impacts on both the person who has attempted suicide and those who are involved with this person. Shneidman (1980) suggests that a minimum of six people are involved and directly affected by every suicide attempt. The impact of suicide is both profound and wide-ranging; there are of course many clinical and practice examples that illustrate this, but I find that all aspects of the traumatic dimension are vividly present in an example from literature; this example is Shakespeare's (1607/1997) depiction of Ophelia's funeral in *Hamlet*. Here I can briefly describe some of the key conflicts that are best experienced, of course, through seeing the play itself.

Ophelia's brother Laertes attempts to idealise his dead sister and to displace his rage into the societal representative, the 'churlish priest' to blame the priest for failing to understand ('A minist'ring angel shall my sister be / When thou liest howling' (V, 1, 233-234). In the face of this onslaught, the priest appears to be trying to hold a balance between maintaining the need to name this reality – it was a suicide - and offering what solace can be given without denying the reality, but he is taken to task nevertheless and has to withstand Laertes' attacks.

Hamlet attempts to ward off guilt about his contribution, through his rejection of her, to Ophelia's suicide, and to project into Laertes the hatred, murderousness and rage, which he has previously recognized in himself ('Yet have I in me something dangerous' V,1, 255). He makes an extraordinary, inflammatory statement after grappling murderously with Laertes

'I lov'd Ophelia. Forty thousand brothers
Could not with all their quantity of love
Make up my sum' (V,1, 264-266).

Following Ophelia's suicide, the relational field consists therefore, as Shneidman stated, of attempts to deal with a 'psychological skeleton':

'the person who commits suicide puts his psychological skeleton in the survivor's emotional closet; he sentences the survivor to deal with many negative feelings and more, to become obsessed with thoughts regarding the survivor's own actual or possible role in having precipitated the suicidal act or having failed to stop it.' (2001: in Berman et al 2006, page 363)

The 'psychological skeleton' is experienced by the participants as a projective field, in which suicide fantasies are active *before* the suicide, often over many years. Ophelia's passive 'giving up on life' (Freud 1923)⁶, merging with the waters in which she drowned, conceals aggression from - or more accurately projects it into - others.

Because of this, the experience of a suicide *attempt* also means being in receipt of a phantasied attack, and can have a similar devastating effect. The difference – probably the only difference- between a completed suicide and an 'unsuccessful' attempt is that the latter does allow for the possibility of reparation⁷.

For example, Annabel, a young woman of 18, took an overdose, with the unconscious intention of showing her parents through their remorse after the loss of their daughter, how much they had failed to love her enough. Her father visited her in hospital and told her he loved her. This was the first time, Annabel later told her therapist, that he had said this to her (Briggs et al 2006).

Additionally, a particular difficulty in mourning can be identified in the responses to suicide. In *Hamlet*, this is located in the provocative comments (particularly those of Hamlet but also of Laertes). The problem of bearing guilt and evaluating responsibility is evidenced as blaming or aiming to punish, alongside a fear of being blamed or punished. In this state of mind the 'survivor' seeks - and sometimes finds - someone, or a part of someone who will indeed point the finger of blame and criticism. In the aftermath of a suicide or suicide attempt critical self observation and realistic reflection are often unavailable and instead we find hypercritical, abnormal super-ego function (O'Shaughnessy 1999), that projects or points the finger of blame and criticism; it is ego destructive, strips meaning through processes of splitting and projection, and attacks containing functions.

Suicide is always traumatic for other people connected with the suicidal person, and, in attempted suicide, for the suicidal person. The effects of trauma include loss of the capacity for symbolic functioning and increased

⁶ Freud (1923) described the ego's helplessness in the face of the torrent of sadistic attacks from the super ego.

⁷ This restates from a different perspective the important point made earlier that the distinction between completed suicide and a suicide attempt is one of outcome, not motivation; 'parasuicide' is not a helpful concept for understanding suicidal dynamics

concreteness of thinking. Identifications are as a consequence more destructive and negative. Mourning is impaired through the aim of narcissistic restoration rather than facing and working through loss (Levy and Lemma 2004). Ophelia's passive, even 'beautiful' (pre-Raphaelite) death leaves the others traumatized with the mess of it all, and their guilt.

Recognising the traumatic dimension and the painfulness of the predicament of the suicidal person and those involved with her/him has the effect of changing the professional orientation to suicidal people. Facing the emotional dynamics of suicide, recognising the traumatic dimension requires also recognising the need for emotional support, or containment, for the professional and, with this kind of support the possibility is increased of being more open to the narratives, emotions and relationships, internal and external, that drive or have produced the suicidal situation. Too often, as Seager (2008) points out, in mainstream health care, suicidal people feel that their "personal feelings, needs and their stories get lost, disregarded or rejected by the system" (page 221).

Recognition of suicidal people's needs for their narratives and feelings to be taken seriously is central to the operation of a different kind of provision for suicidal people, Maytree, a residential respite centre for the suicidal. Maytree offers a four-night stay for people in a suicidal crisis. During the stay, Maytree offers opportunities to talk and relate, as well as to relax. The benign experience that Maytree aims to introduce for this brief stay contrasts with the often persecutory worlds of people in suicidal crises. People who stay in Maytree feel helped, and, although the intervention over four days is brief, they appear to sustain these gains after leaving (Briggs et al 2007). Additionally, the benign relatedness introduced by Maytree leads the 'guests' to report that they experience a contrasting kind of care to that they have experienced previously in mainstream services, experiences that are felt to be not judgemental and critical. This encourages these people to talk about their suicidality without the fear of stigmatising experiences and with the hope of understanding. In these dynamics there is a strong contrast with the kind of experience discussed earlier in this chapter in which talking about suicide led to the fear of contagion and escalation.

Re-evaluating risk assessments

Some shortcomings of the risk assessment approach have been discussed earlier in this chapter. Psychoanalytic understanding of the relational constellations of suicide hold greater possibilities for making coherent and more accurate assessments of levels of suicidal risks; these risks are assessed within the paradigm of psychoanalytic understanding of the suicidal relational configuration. Coherence and accuracy are dependent upon the clinician's own containment, which is gained through the capacity to process the emotional impact of suicidal dynamics. If the worker, team or organisation is beset by the need for self-protection from blaming organisations, practice will be inevitably defensive and the clinician forced to operate in a paranoid schizoid field. In these contexts, as we have seen, the capacity to set a boundary between the responsibilities of the professional worker and those of

the suicidal patient or client is threatened. When these boundaries become blurred, or when the worker and organisation assume total responsibilities, the potential for reasonably accurate assessment is not possible, partly because in these circumstances the worker becomes anxious about herself (persecutory anxiety) and cannot relate appropriately to the patient/client.

Coherent and accurate risk assessments are possible when they are placed within a holistic approach provided by a theoretical and practice framework. To provide a suitable holistic and containing framework, I argue that, Instead of focussing on assessing risks, the task of assessment needs to be reformulated to concentrate on two key dimensions of assessment; the implications of suicidal behaviour and the provision of sufficient containment.

The implications of suicidal behaviour are closely connected with the traumatic dimension, namely, that after experiencing suicidal thoughts or actions, the implications are traumatic for the individual and those involved with her/him. As Ladame and Shneider have shown, an uncontained, traumatised state exists after a suicide attempt, for which the immediate need is containment. Therefore the focus shifts to identifying what constitutes sufficient containment in any particular case. This assessment is made through, firstly, being able to hear the suicidal patient's narrative, and the narratives of those concerned with this suicidal episode, including family members, close friends and professionals. Secondly it depends on assessing the suicidal relational constellation and its meaning for the individual in each case. It is from this assessment that a formulation can be made about what is sufficient containment in each case.

The emphasis on dyadic relatedness and the discussion of different patterns of suicidal internal dynamics is important in distinguishing different kinds of suicidal presentation. Not only does suicide transcend localities and cut across social, cultural and diagnostic boundaries, but is also appears in different ways in both the consulting room and community settings. In particular, in clinical settings suicidal patients can either generate intense anxiety and worry about suicidal risks, or, in complete contrast, they give no clue that suicidal thoughts and threats are present, leaving the therapist unaffected, or unworried, and then, later, surprised when suicidality appears- often explosively- on the scene. To illustrate aspects of the range of suicidal presentation, I will provide some examples from working with suicidal adolescents.

The traumatic dimension of suicidal thoughts is understated in the risk management approach in which ideation is thought to be lower down the 'hierarchy' of risk than actions. In fact, suicidality lies on a spectrum: the impact of suicidal thoughts, the transition from thoughts to actions (through breaching the body boundary) and from a first attempt to a repetition. Moses Laufer (1985) made a helpful distinction between having suicidal thoughts and resorting to action in adolescence: suicidal thoughts permit the possibility of the continuation of relatedness to parental care and internal parents through having doubts about suicidal action'.

“The adolescent who has been thinking about suicide but is able to seek help still has available the quality of being able to *doubt* his thoughts and actions and to maintain and protect some feelings of concern for the parents whom s/he carries around within himself” (page 79)

Can having suicidal thoughts be traumatic? They are if the threat to internal parents is experienced as troubling. For example, a young man, I will call John, I saw for psychotherapy, experienced suicidal thoughts as having terrifying implications. He lived with his mentally ill single parent mother and during his late teens was violent towards her. The violence usually occurred when his mother’s health was in one of her periodic deteriorations. After one of mother’s admissions John got into a terrible state, as he began to have suicidal thoughts. He was overcome by a realisation he had damaged his mother (external and internal) and thus in a state of internal recrimination, he camped out in the kitchen until it was time for his weekly session. He talked to me about his panic of realising he was suicidal – and feeling overcome by an unbearable guilt. ‘I won’t do it though’ he told me – a communication I heard with some scepticism, but I managed to see despite my anxiety that I could trust what he said, that he was communicating a traumatised state which threatened him with a catastrophic situation. He was telling me, I thought, that he had encountered a suicidal solution, but had turned away from this and would try to bear whatever might ensue.

Laufer describes the implications of a suicide attempt as leaving ‘a dead part inside himself; this dead part remains there until the person finds active means of understanding what happened at the time of the attempt and why it needed to be carried out’.

When there is an attempt, leaving a dead part within, or numbness that Shneidman linked with trauma, the primary question is: how can there be adequate containment for the adolescent, to enable the work of identifying meaning and insight to take place?

This is part of the traumatic dimension. For Ladame, as I said earlier, a suicidal crisis can be understood *primarily* as a psychic trauma.

‘A collapse occurs in the usual way of functioning of the psychic apparatus’. Boundaries between internal and external worlds are dissolved; similarly, boundaries between different aspects of the mind no longer function. Thus ‘mental representations are no longer able to freely circulate, since such circulation relies on the binding capacity of the psychic apparatus’ (p 72).

Psychic functioning is temporarily frozen by the rupturing effects of the attempt. Thus Ladame emphasises that the first priority after a suicide attempt is that sufficient containment is provided so that psychic functioning may recommence “at the level of symbolization, thus allowing words to have the meaning of words and thus to act as symbols rather than being experienced as things without symbolic content or ‘symbolic equation’” (page 76).

Ladame assumes that suicidal behaviour will be repeated because, in the traumatic state characterized by concreteness rather than symbolization, there is, therefore, a propensity to reenactment. Through attention paid to containment after the attempt, the aim is to allow re-functioning of the psyche at the level of symbolization and prevent denial of fantasies that led to the enactment and are 'washed out' by it. This fits with other observations –e.g. by Rob Hale – about the role of denial after an attempt – the image of the attempt 'washing out' the fantasies and painful emotional states that trigger the attack is an apt and powerful one.

I can give a brief case example of an adolescent presenting a dead or traumatized part of herself, together with an attempt to 'wash out' her painful emotional states and the troubled hidden relatedness that she had encountered at the time of her attempt.

Gemma, an 18 year old, adolescent patient I saw came in the early part of treatment to a session and, in a very matter of fact way, told me she had overdosed after the previous session, had been taken to hospital and discharged. It was a very serious attempt and she was saved by vomiting, which her mother heard and responded to. She reported this account to me in a way that made it seem quite unreal and I had to struggle within myself to hold on to what I had heard, as if there was strong projective pull for me to instantly forget. When I had managed to 'hang on' I began to think that this was her state of mind – a wish to instantly forget, and thus to re-enact a murder, this time to her mind, to her psychic experience, rather than her body. The force urging forgetting might be thought of as what Caroline Garland (2004) describes as a 'projective imperative'. A sense of alarm within me was heightened by her communication that she had declined treatment in hospital and told staff that she was in therapy, and this was accepted by the staff, and she was discharged. She continued to deny having had any suicidal thoughts and only when I was insistent did she agree that her suicidal actions showed she was suicidal.

There was insufficient containment available in this setting, at this time, for this patient. Gemma was able to slide between parts of the system; and the opportunity to undertake a sufficiently thorough assessment after the attempt was difficult to attain because it was difficult to keep her in contact with me in her therapy; most of the effort in therapy was spent in trying to make and retain a containing space. Gemma represents one kind of suicidal constellation; her main psychic priority is to avoid herself and others knowing she has problems at all (Bell 2008), and her suicidality is governed by a dismissing/avoidant attachment strategy (Wright et al. 2005) in which she downplays, denies and negates her emotionality. For adolescents like Gemma sufficient containment can only be provided initially in a residential setting. The inpatient methods used by Ladame in Geneva have been designed to include features that are key to the process of containing the adolescent after a suicide attempt and thus offering an optimal approach to preventing repetition.

In this model, in the first stage in-patient admission for a maximum stay of 1 month is offered as the only way of providing enough containment after a suicide attempt. 'Admission to the crisis Unit acknowledges the psychic breakdown enacted through the suicide attempt. It offers a 'controlled' break with the outer world, giving the adolescent a temporary haven from the concrete burden of everyday life. Thus we routinely propose a complete break with the outside for 48 hours, with no visits or phone calls.' (Ladame 2008 page 76)

Containment is effected through promoting "psychic functioning temporarily 'frozen' through the rupturing effect of the suicidal episode" (page 76). In the in patient setting, the approach pays "great attention to the issue of containment in order to allow re-functioning of the psyche at the level of symbolization However painful it may be to the patient, they have to focus on the panic-like anxiety and moment of loss of control, on the fear of madness that traumatically overwhelmed the patient, and left him/her without another solution but enacting a suicidal bid. Such a technique is appropriate only with the guarantee that the patient is contained by the structure and environment of the ward as well as by the caring environment. Once inner containment becomes strong enough and [symbolic mental life] begins to work again, it is possible for the young person to move towards reflecting on meaning instead of acting." (page.77)

The second phase of treatment, after leaving the unit, "is based upon the knowledge that unless real change occurs in the underlying mental and dynamic structures, what happened once might well happen again. It is therefore important to build in adequate and reliable protective strategies against the risk of repetition." (page 77)

I have covered this approach in some detail, because Ladame's work is not well known in the English speaking regions, and because this thinking poses a considerable challenge to ways of working and organising services. The implication of the traumatic dimension or implications of suicide is that the first requirement is to provide a sufficient containment and for some adolescents this requires a particular kind of focussed, time-limited in-patient (or residential) treatment initially, following specific practices.

From assessment of the internal suicidal relationship constellation, another group of suicidal people can be identified as being more suitable for outpatient treatment. With these people, there are intense communications, both direct and projectively, of anxieties about suicide, and people in this group stir up tremendous anxiety in the therapist. In attachment terms they fit the pattern of preoccupied insecure attachment (Wright et al 2005). Containment in an out-patient setting is possible when the therapist has access to a containing reflective supervision structure.

The content of this discussion is based primarily on research and clinical experiences with suicidal adolescents and young adults. In this life stage, suicidality needs to be understood in the context of the developmental

processes that are so vital to the mental life of young people. The question is then raised whether the principles around which this discussion is based – the implications of suicide and the need for sufficient containment – can apply to other life stages, namely adulthood and later life.

The evidence that is emerging from Maytree provides some support for the idea that a time-limited residential, non-stigmatising resource, to an extent similar in aims and methods to Ladame's unit in Geneva, is important, helpful and possibly necessary for providing sufficient containment for adults in a suicidal crisis. This evidence includes findings that show that this kind of containment can have beneficial effects. With regard to suicidality in later life, studies from the Centre for Therapy and Studies of Suicidality (TZS) in Hamburg show that difficulties older people have in making contact with professional organisations can be overcome by approaches that focus on understanding the narratives suicidal people have and that these can be understood as organised into different patterns of relatedness (Lindner et al 2006). Focusing on difficulties experienced in talking about suicidality leads to the emergence of narratives that indicate acceptance and a lessening of the fear of stigmatisation.

Psychoanalytic therapy for suicidal people; the evidence

The discussions in this chapter are supported by research evidence that demonstrates the effectiveness of different kinds of psychoanalytic therapy. Guthrie et al (2001) showed that a very brief intervention of 4 sessions, based on Hobson's *Forms of Feeling*, reduced repetitions of self-harm. Bateman and Fonagy (2001, in press) demonstrate evidence, at the other end of the spectrum, of the effectiveness of an intensive long-term study including partial hospitalisation. In USA, Clarkin et al (2007), in a year long study of three different treatments of borderline personality, show that all three treatments had good outcomes, and that the outcomes for 'transference-focused' psychotherapy reached across a wide range of outcome criteria, reducing self-destructive behaviour and the underlying problems in relatedness. Suicide prevention is therefore an area where psychodynamic therapies have begun to demonstrate effectiveness within the specific requirements for outcome studies.

Additionally, in this chapter, I have drawn on research which demonstrates the underpinning of psychoanalytic thinking including the formulation of different kinds of internal relationship patterns, including my own work on attachment patterns of suicidal adolescents and evaluating the effectiveness of Maytree. In contrast, Mark Williams (2004) has pointed out that 'prescriptive' therapies such as CBT can show equivocal findings in working with suicide. That the more 'exploratory' therapeutic approaches may have greater success in working with suicidal people fits with the importance of the relational understanding of suicide from a psychoanalytic perspective. Strengthening or emphasising the relational component of treatment appears to be a central factor when working with suicide.

It is usual to conclude that ‘further research needs to be done’; of course this is true, but it seems, above all, that what is really needed, at this point, is not a discussion about ‘what works’ in the domain of positivistic outcome studies, but a more active engagement in exploring the implications of the discussion in this chapter, of the primacy of establishing different ways of relating to self harm and suicide and, through focusing on the implications of suicide and the need for sufficient containment to explore how the organisation of different services impact on their client or patient population. There are a number of innovative approaches to working with suicidal people, some of which have been discussed in this chapter – Ladame’s work in Geneva, the Centre for Therapy and the Study of Suicidality in Hamburg, Maytree and the Tavistock’s Adolescent Department among these; it will be helpful to further study what is being learned from these approaches and the implications for mainstream services.

Conclusion

In this chapter I set out to explore the role of psychoanalytic approaches to suicide prevention. Through outlining current preoccupations within prevention strategies with the perceived gap between communities and services, difficulties that arise thus in discussing suicide, connected with stigma and taboos, I have aimed to locate psychoanalytic approaches as having a significant contribution to make to understanding suicidal relatedness. Psychoanalysis has a robust and well articulated theoretical framework that can be applied to preventing suicide. In this chapter, I have concentrated in applying these to key issues in service delivery, and I argue for a shift in emphasis from risk assessment to understanding the implications of suicide for those affected by suicidal thoughts and acts. At the centre of this discussion is the concept of providing sufficient containment, based on assessment of the suicidal relationship constellation. This approach impacts not simply on the actual delivery of services – though it is important in this arena - but also on the attitudes and approaches through which there is engagement with suicidal people, and these are aimed at reducing stigmatising interactions between suicidal people and services, as well as helping professionals work with the intense emotionality of suicide. The implications of this discussion, therefore are that the impacts of psychoanalytic approaches to suicide include making links between clinical and social domains in suicide prevention.

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