

# CLINICAL WORK WITH SUICIDAL YOUNG PEOPLE

**George Halasz\***  
**Child and Adolescent Psychiatrist**  
**Monash Medical Centre**  
**Victoria**

IN CLINICAL WORK WITH SUICIDAL YOUNG PEOPLE, I MAKE ONE ASSUMPTION that many people find difficult to tolerate, namely, that children may react to life's developmental struggles with the same anguish and 'unthinkable anxiety' (Winnicott 1962) as adults. Further, that the affective component of adult anguish (as distinct from its intellectual context) is, in fact, a derivative of this intense childhood state.

If we accept this assumption, it will offer us some common ground for creative communication. Such communication is especially difficult due to the controversies surrounding the subject of suicide in the young which tends to polarise opinions, while the rich variety of experiences at this Conference, from professionals involved in education, health, welfare, legislation and law enforcement, runs the risk of further diverging rather than converging views.

Defining who is a 'suicidal young person' is riddled with great difficulties. If only all suicidal young people were as articulate as Shakespeare's Hamlet. 'To be or not to be' is rarely uttered by the child or young adolescent to indicate their profound life and death struggles. Yet, to equate such absence of articulation with less intense or severe suffering is to erroneously trivialise children's capacities for and depths of despair.

I have adopted a developmental perspective (Rutter 1980) to the understanding and treatment (Holinger 1989) of suicidal young people meaning that all aspects of the young person's past are potentially relevant to the development of his or her suicidal condition. This includes family history, temperament, life events since birth, relationship patterns within and beyond the family and coping qualities summed up in creativity, vulnerability and resilience.

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## Conceptual, Clinical and Ethical Difficulties

Clinical work with a suicidal minor requires parental permission and consent for intervention. Occasionally (to be described), parents who are reluctant to give such consent become the focus of special confrontations. With older adolescents and young adults, parents participate less directly. In fact, issues of confidentiality may prevent the therapist from disclosing the privileged clinical information, paradoxically also bringing the therapist potential confrontation.

Based on my ten years of clinical experience with suicidal young people I have found that a number of clinical concepts and models are particularly useful. These are derived from psychoanalytic and psychodynamic views on death 'If you want to endure life, prepare yourself for death' (Freud 1914), (Laplanche 1976), of suicide as 'murder in the 180th degree' (Shneidman 1985), the notion of 'the expendable child' (Sabbath 1969), 'the suicide sequence' (Novick 1984), 'the matrix approach' to the spheres of vulnerability in the domains of psychiatric diagnosis, personality factors, psychosocial factors, family history and biological factors (Blumenthal & Kupfer 1986), 'familial and intra psychic splits' (Orbach 1989) and others detailed in Shneidman's (1985) epic contribution.

The empirical research literature also fortified my initial reluctance to accept the fact that children are capable of suicidal ideation, attempts and suicide (Shaffer 1974; Kosky 1982, 1983; Hawton et al. 1982; Hawton 1986; Rosenthal & Rosenthal 1984; Brooksbank 1985; Pfeffer 1986). This reluctance was based on the naive view that children are not capable of thinking about death (Orbach & Glaubman 1979), or to experience the depth of distress and desperation to lead them to suicide (Pfeffer et al. 1979; Pfeffer 1981, 1986, 1989).

The ideas and approaches of most experienced and intellectually and clinically sensitive teachers like Dr Murray Jackson, Mrs Sadie Gillespie, Dr Chris Dare, Professor Michael Rutter and Dr Eric Taylor are expressed in various aspects of this work.

Clinical confrontations with suicidal young people have raised many disturbing issues.

- Why think of self-injured children as suicidal rather than as 'accident prone' or inclined to more 'risk-taking' behaviour than the general population?
- Is suicidal behaviour an expression of self-destructive behaviour or an indication of the failure of a self-preservation system?
- If the definition of adult suicide behaviour depends on the notion of 'intent', given children's immature cognitive development and inability to think in terms of consequences of their action should such criterion be used with the young?
- If parents insisted that their child was essentially 'happy', how could the clinician override this view? When parental assessment and professional opinion differed, to what lengths did the professional's responsibility extend in determining the decision about a child's safety? And would raising the issue of suicide actually 'give ideas' to a non-suicidal young person?

These and other conceptual, clinical and ethical difficulties are familiar issues for clinicians working with suicidal young people. But there exists another level of difficulty. It arises in the course of longer term therapy work with suicidal people due to the unique clinical manifestations and psycho-dynamic aspects of the suicidal patient's core conflict—ambivalent struggles with **life itself**.

## Ambivalence, Splitting and Confusions

To state the obvious, the core issue for the suicidal young person is deciding 'to be or not to be'. The difficulties in clinical work with such young people are due to the psychological struggles which accompany this mental state.

The young person may not be able to articulate clearly his or her inner state. As one adolescent honestly declared when confronted with the severe disruptions of his past, 'I had not even thought of thinking about it before today'. What is happening in the mind of such an adolescent? The difficulty is that we do not know. However, very likely a process is occurring whereby a distance is introduced between the conscious appreciation of distress due to past events and the current anguish that is communicated through the suicidal behaviour. Clinical work in this situation involves appreciating two closely related psychological processes, ambivalence and splitting, which clinically manifest themselves as states of confusion.

Ambivalence can be defined as the 'simultaneous existence of contradictory tendencies, attitudes or feelings in the relationship to a single object—especially the coexistence of love and hate' (Laplanche & Pontalis 1983). The permutations of ambivalence observed in clinical practice are in part a result of the states of ambivalence being located in the will, the intellect or the affect, and its occurrence both in the normal states of mind (as in jealousy and mourning) as well as in pathological conditions (psychoses and obsessional neurosis). Similarly, the process of splitting—referring either to the splitting of the ego (Freud) or splitting of the object (Klein)—describes the existence of two psychical attitudes toward the one external reality.

The reason for mentioning these psychological processes is that they underlie a great deal of the confusion, ambiguity and uncertainties that characterise the clinical assessment and treatment of suicidal young people and their families. An awareness of the different states of confusion often helps to locate the developmental level of the patient in relation to other life struggles. These may include family conflicts, intimate relationship crisis or breakdowns, financial failures, frustrated ambitions, difficulties related to sexual identity, or threats to the sense of self-esteem.

These additional dimensions of the patient's mental landscape, initially often condensed, are revealed later in therapy as two distinct contributions to the suicidal behaviour. On the one hand are the pathogenic influences (directly causing the suicidal state), while on the other, the pathoplastic (giving the individual colouring to the expression of the basic struggle). Appreciating and interpreting the interplay of these factors becomes one of the great challenges of psychoanalytic psychotherapy. At other times, tolerating periods of not knowing, breakdown of understanding or pregnant silences between therapist and patient are experienced like sitting on a time-bomb. The major therapeutic difficulty during these times is to retain a sense of symmetry, avoiding distancing oneself from the patient's core conflicts, which may create an illusion of mastering the situation, while at the same time avoiding the over-identification with the crisis—stepping into the patient's shoes—that may create a helpless paralysis at the expense of therapeutic potency.

Finally, we need to remind ourselves of the coexistent psychological and psychiatric conditions that increase suicide risk:

- severe depression or psychosis especially where hallucinations or delusions containing themes of destructiveness, murder and suicide;
- altered states of consciousness associated with psycho-active drugs including alcohol;
- young people who have witnessed or survived a suicidal parent or sibling, or whose boyfriend, girlfriend or school friend has suicided;
- where a family history includes an unusual amount of violence and/or abuse (this includes sexual abuse, not necessarily associated with physical violence).

In summary, the clinical assessment of the suicidal young person relies on the appreciation of the clinical processes of ambivalence, splitting and confusion, the distinctions

between pathogenic and pathoplastic forces producing the suicidal state and the coexistence of a number of psychiatric conditions known to increase the suicide risk.

### **Phases of Clinical Work**

These are divided into the traditional areas of the referral, the assessment, the treatment and the ending.

#### *The referral*

In my experience, suicidal children never refer themselves and suicidal adolescents and young adults more commonly are referred by their parents, schoolteachers or counsellors or other mental health professionals (psychologists, therapists) and doctors.

For a child referral, it is important to note whether the parents initiated the referral, indicating that they have the capacity to notice, accept and act on their judgement about their child's distress. Commonly, the referral arises from a schoolteacher's suggestion who notices the distressed child and contacts the parents suggesting that they seek professional assessment.

Normally, adolescence is a time of emergence of independence and self-assertion (Freud 1958, Blos 1962). Not surprisingly, the acknowledgment and owning of serious problems 'goes against the grain' of these developmental requirements. Indeed, the usual mechanisms of problem solving at this stage involve denial ('nothing's wrong!'), displacement ('it's all the teacher's fault') or splitting ('everything's OK today, that overdose was yesterday'). Hence, we should expect as a matter of course **not** to elicit suicidal despair in suicidal adolescents easily. However, the professional is entitled to have an index of suspicion of suicide risk in certain presentations discussed above.

#### *The assessment interview*

The assessment interview with children and adolescents follows well-known sequences that include introductions, explanations regarding the purpose of the meeting, history taking both of the specific presenting problems and the developmental history of the patient and their family and relevant physical examination and investigations: all routine, except for one critical point. The clinician needs to maintain an **index of suspicion** regarding the possibility of suicidal ideation, intent or actual active plans.

The process of assessment is often accompanied by the confusions described before, increasing anxiety to a point of confrontation when the therapist realises that the young person has a life-threatening condition. This moment of realisation paves the way for a number of subsequent patterns of relating with the family. The patterns depend on the family's acceptance or denial of the formulation.

Essentially, the therapist needs to explain the nature of the suicide risk, the processes likely to occur with and without treatment, the immediate therapeutic recommendations and finally the therapist's availability. The overall aim of such communication is to empower the parents to retain their decision-making capacity—stretched to the limit at this stage—and support their taxed resources in the service of their 'at-risk' child. This communication between therapist and family contains elements of supportive understanding, education, and therapeutic planning. Beyond these ingredients, the therapist needs to be mindful of the legal and ethical issues that may arise if parents cannot appreciate the life-threatening nature of their child's condition. In the extreme, the therapist's responsibility in acting as the advocate for the child's welfare, may include overriding parental decision making. However, this should not be undertaken until and unless all other avenues have been exhausted. In such a

situation, the added responsibility would be to bring the matter to the courts (Truman & Van Eys 1984).

Even this early stage of the clinical encounter with suicidal young people may be associated with considerable stress and distress both for the family and the professional. As Crisp (1982) has commented 'to acknowledge distress in others we need to acknowledge our own distress and our failure'. As we all know, one risk in working with suicidal young people is their completed suicide. This may be experienced as a clinical or personal shortcoming in the therapist. The professional's response to both the 'distress' and the 'failure' of such work will be discussed in the clinical cases.

### *The treatment*

**Clinical Case:** A 19-year-old adolescent was referred by a colleague who was treating the boy's mother for depression.

I shall call this young man 'Greg'. He walked into my consulting room, greeting me with a warm smile and an almost giggling 'good-bye, how are things?' It seemed to me that this was more appropriate to a social meeting with an old mate, perhaps in a pub than a professional consultation. After a nervous beginning, he wished to smoke. I suggested that if he did, his attention might drift from the very issues he wished to think about, that were making him so nervous. He did not protest.

This young man had major worries. He wondered about his sanity, feeling that between the age of 6 and 15 he 'went mad'. Aged 17, two years ago, he left high school and began to drift, travelling around Australia, using a variety of drugs, drinking and holding only temporary jobs. At this stage of the interview, I started to ponder about whether he belonged to one of the special 'at-risk' groups mentioned before.

He went on and spoke about being 'paranoid' but was not very clear what this meant. He was obviously likeable, verbally fluent, and yet I felt increasingly uncomfortable as the interview progressed. Was he pretending to be a patient? Was he dreading going insane? I was confused by his confusing presentation so far. Yet he did impress me as a person in genuine distress, but distressed by what? The questions about his quest for sanity seemed unconvincing. Was there a deeper level of concern?

Later he described how his friends commented about him being 'like a house with the lights on but no-one at home' and elaborated that his family and friends felt him to be intelligent, kind and generous; that he had good looks but he felt himself to be 'garbage'. His fading facade and the discrepancies between how he was perceived by others and his own self-perception stirred questions about ambivalences and splitting the psychological mechanisms that allow for the coexistence of contradictory tendencies and attitudes.

At this point, let us shift the focus from the clinical relationship to the processes that were occurring in me in relation to the clinical material. A constant difficulty confronting the clinician is the selection of relevant material to respond to from the patient's material. Should one clarify the pathogenic or pathoplastic factors that are presented and link the suicide ideas or plans to personal difficulties? Would emphasising one or other theme alienate the delicately evolving rapport between the patient and therapist and thereby risk increasing the suicidal patient's resolve?

I began to wonder about my past experiences with similar troubled adolescents. Was this person struggling with normal adolescent tasks, the quest for an identity and independence and wishing understanding, support and acknowledgment? Was he troubled by his drug and alcohol addiction, or the feelings of madness that he was beginning to experience? I was increasingly concerned at realising that he entered with such a trivialised attitude, almost denying that this was a professional meeting. Or was he terrified, anticipating my opinion about his condition. Finally, the contradictions between his family's and friends' views and his own conflicting self-perceptions rang alarm bells in my mind. His

reference to feeling like garbage, did this mean he felt ready to be thrown out of the mainstream of life? Was he suicidal?

With this hypothesis emerging in my mind, I mobilised my courage and asked if he had in fact any suicidal ideas or plans.

Now to return to the clinical setting. 'Greg' was not at all surprised by this question. He became more serious. He explained that his suicide plans were the cause of his greatest conflict. Whether to overdose on heroin, or some other substance, or not to suicide. In any case, he felt that first he had to clear up his debts, money that he owed. He also wondered if he should leave a note or make a tape recording of his suicide and interestingly added 'of course not to do it at home or near friends, but to drive out into the country'. Maybe this was a concrete expression of his feeling like garbage and still retaining a wish to spare those close to him cleaning up the rubbish or was this a more malicious intent to become a missing person?

From this exchange, I understood that this adolescent was in fact hanging onto life by the thinnest of threads. His coping mechanisms were running out. He had travelled for nearly two years (defensive escape and denial), abused a variety of drugs (anaesthetising himself) and recently increased his social isolation (withdrawal). His defensive manoeuvres were no longer protecting him from himself. His belief was that, if he could talk with me, somehow (perhaps magically), I would remove his difficulties which I did not even fully understand.

I declared that he must be really desperate to know if anything would change his life before he does in fact kill himself. With this reconstruction of his unbearable state, his giggling facade now completely gone, he seemed to think for the first time before talking. He said words to the effect that he already had one foot in the grave. I continued to explain that 'this throwing out of yourself like garbage' was really his suicide plan and that perhaps he felt that it was a waste but that he had no other options. I offered to meet with him to see if there were alternatives which we could discover.

By providing this brief description of the clinical encounter with a suicidal adolescent, I wish to bring home the confusions, anxieties, ambiguities and uncertainties surrounding such clinical work.

Since therapy involves making accurate empathic contact with our patients, and the ubiquitous fear of death is an inherent part of therapeutic 'death work' (Pontalis 1981), as occurs in the therapy of suicidal patients, it follows that we as therapists, by remaining in contact with such material, expose ourselves to the vulnerabilities that accompany the helplessness of being witness to a potential murder scene, that is suicide (sui-of oneself, cidium-kill). 'No one kills himself who has never wanted to kill another or at least wished the death of another' (Stekel 1910).

Not surprisingly, such work makes great demands and comes at a personal and professional cost. Currently, my own rule is to restrict my work to two suicidal young people at any one time. This allows a safety margin should I need to cope with the impact of the aftermath of a completed suicide.

### *The ending*

As Goldney et al. (1987) note: 'it has become increasingly recognised in the last decade that attention should also be paid to those who survive the death by suicide of a relative or a close friend'. To this, I would add the surviving therapist and treating staff in the clinical setting.

This aspect of clinical work occurred in the aftermath of a teenage suicide in a hospital setting. Obviously, the focus of concern shifted from the adolescent to the surviving family and the hospital staff who remained in a state of shock. The detailed management has been discussed in a previous publication (Halasz 1988). The key factors are summarised here.

Surviving therapists and staff in a hospital setting need to be aware of the added vulnerabilities and risks for further suicide attempts in surviving patients. There is an urgent need to institute preventative measures to avoid the possibility of suicide clusters (Halasz 1987). The great danger for staff is that, during the phase of shock and disbelief in the suicide which is often accompanied by professional and personal questioning of decision making, roles and competence, professional boundaries and responsibilities often become blurred, authority in senior staff decision making is eroded and the risk of suicide clusters increases.

The surviving staff may reaffirm, in group and individual meetings, their unambiguous attitude aimed at preventing further suicides. The unambiguous directives, although value laden, minimise the risks of confusions and misunderstandings in the surviving patients, who may be tempted or inclined to idealise or glorify the suicidal act. Such repeated declarations attempt to prevent propagation of suicide clusters by suggestible young people, as occurs in hospital settings, through neutralising identifications with the suicide act.

## Summary

In approaching the subject of clinical work with suicidal young people, I have chosen to focus on three different phases of the clinical encounter. First, the assessment phase and the special stresses faced in allowing the realisation, both for the family and the therapist, that a child or adolescent has a life-threatening condition. Some management principles have been offered to facilitate this difficult and potentially confronting phase. Recommendations were made to invite a third party to arbitrate should a conflict of interest arise between the family's and therapist's perception of the risk to the young person's life.

Second, I have detailed some of the psychotherapeutic processes involved in the treatment of a suicidal adolescent. By detailing the patient's account of his difficulties, both in the past and as they related to his present life struggles, a picture emerges of a young person desperately weighing up his fate—to live or die. Such ambivalence directed at life itself imbues the therapeutic relationship with the unique stresses that characterise work with suicidal patients.

Third, by detailing the profound impact on surviving hospital staff of the adolescent suicide of a recently treated in-patient, certain management principles directed at reducing the risk for suicide clusters are highlighted. Whilst there are conflicting reports regarding the possible modelling effect of suicidal behaviour (Werther effect) (Phillips 1974; Walsh & Rosen 1985; Rosen & Walsh 1989; Modestin & Wurmle 1989), the clinical approach taken adopts the position that it is better to be safe than sorry. That is, all endeavours were taken to minimise the risk of copycat suicides, notwithstanding that there may be controversies in the research literature.

In conclusion, the emphasis of this paper has clearly been on the considerable stresses associated with the clinical work with suicidal young people. Lessons drawn from such experiences may have more general application in suicide education, prevention and research. I should like to finish on a positive note and add that beyond the stresses, there is also a sense of reward and achievement unparalleled in clinical work when one contributes to the survival of a suicidal young person.

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