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Suicide: The Clinical Problem

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In one of the outer suburbs of Sydney, along the jagged Pacific coastline, there is a high cliff known as "The Gap" which is notorious for the frequency with which it attracts, often fatally, the person with suicidal intent. Recently a young man entered a Sydney taxi-cab and asked to be driven to an address in the street which leads to this particular area. Having settled comfortably in the front seat he announced cheerfully to the driver, "Well, this is certainly going to be *my* last ride!" To his apparent surprise and annoyance, his cab promptly deposited him at the nearest police-station, from where he was removed, under considerable protest, to a psychiatric hospital for observation.

The hospital staff, uncertain how they should evaluate this unusual behaviour, took substantial suicidal precautions. Despite these, however, he managed to obtain some street clothes within a few days and took an unauthorized departure, immediately hailing another cab and giving the same directions as before. On this occasion he interrupted his journey in order to buy an analgesic powder for a headache. Arriving at his destination, he stood at the edge of the precipice, only to find a dog yapping at his heels. In retrospect, he was quite uncertain whether he in fact attempted to jump into the ocean or whether he fell in an effort to rid himself of the dog's attentions. As it transpired, he landed only 140 feet below on a protruding shelf of rock, sustaining only minor injuries. After this incident, it proved even more difficult than on the previous occasion to evaluate the genuineness and extent of his self-destructive drive.

This unusual clinical anecdote has been used to introduce this paper in order to emphasize at the outset the fact that every episode of behaviour which has a suicidal connotation—whether it be a completed act, an attempt, or a somewhat flamboyant threat—represents a unique and complex phenomenon. It is at times alarming to observe the frequency with which psychiatrists in training, even undergraduates in some instances, claim an ability to categorize suicidal behaviours in a definitive way, particularly when these have an obvious appeal component. Most of them are familiar with the carefully documented and lucidly expressed ideas of Stengel on this subject, and they have seen the wisdom of his differentiation of the dynamics of completed and attempted suicide; many of them have failed, however, to attach sufficient weight to his frequently repeated statements that these are "two different though overlapping populations" (Stengel, 1960a). Shneidman and Farberow (1961) have written that fundamentally suicide is always "an idiographic and clinical problem". There is periodic justification, therefore, for an examination of suicide from the clinician's viewpoint, emphasizing the almost endless variety of behaviours and motives which is subsumed under the general term "suicidal" and attempting to utilize these clinical observations for the development of individualized management programmes.

There are grounds for suspecting that this type of approach is currently unfashionable; frequently the view is expressed, or implied, that it is essentially inferior to the extensive, research-orientated study which leads to findings on large numbers of cases which can be treated by statistical techniques. It is unnecessary in this context to traverse the well-worn battleground between the supporters of the idiographic and the nomothetic approaches to human personality. Nevertheless the point must be made that the findings of the epidemiologists and statisticians, while essential components of a multidisciplinary approach to suicide, inevitably pose

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problems rather than answer them, such answers as we do have deriving from clinical observation. The numerous papers which have shown the differential rates of suicidal behaviour at different ages, in various professional groups and in contrasting cultures and subcultures tend, almost without exception, to present their conclusions as if some finality were thereby achieved; on the contrary, of course, they can only provide guide-lines towards and suggest the beginning stages of clinical studies which as yet largely remain to be done. An example of this latter type of study is that of Hendin (1964), who has attempted through the use of psychoanalytically-oriented interviews and other techniques to find reasons for the high incidence of suicide in Denmark and Sweden as contrasted with the much lower rate in Norway.

The major emphasis in this paper will be on two exceedingly common and overlapping clinical problems—firstly, that posed by the patient who appears *de novo* or during the course of treatment to present some degree of suicidal risk; secondly, that faced by the psychiatrist when he is required to deal with a patient who has recently made an unsuccessful suicidal attempt. For want of systematic personal experience in the retrospective analysis of those cases in which the suicidal act has been successfully completed, no reference will be made to studies of this latter type except where they appear to illuminate the on-going clinical process. Mention should, however, be made of the special learning which may be derived from close study of those patients who successfully commit suicide *after* adequate clinical appraisal during hospitalization or during the course of out-patient psychotherapy; such learning is, of course, likely to be impeded by the physician's own anxiety, anger and guilt, and very few such reports have appeared in the literature.

The Patient who is a Suicidal Risk

A patient may be assessed as potentially suicidal either as a result of his own verbalizations or because of a series of inferences made by the psychiatrist from his observation and clinical judgment. It then becomes important for each of the following issues to be given careful attention, for experience shows that they are of crucial significance for the understanding of the patient and thus for his subsequent management.

Aggression: It may seem gratuitous to underline the aggressive, destructive significance of suicidal behaviour, but its degree of relevance warrants repeated study and appraisal. The classical psychoanalytic formulations—which have certainly advanced our understanding of suicidal behaviour more than any research findings from any other discipline—require no emphasis, and it is by now well and truly apparent that a completed suicide frequently represents, as has been said, "murder in the 180th degree." The recognition of the destructive potential of suicidal patients is thus of primary importance for their understanding; conversely, underestimation of the patient's aggressiveness, whether this be due to the clinician's inexperience or to his own personal defensive structure, is the largest single factor responsible for errors of judgment in these cases. Where the non-psychiatric physician may detect in a patient only strong positive transference feelings (in whatever language he may use to express this), the psychiatrist observer of the same patient should be better able to decide whether this particular relationship is in fact a highly ambivalent one, and he may recognize verbal or behavioural clues which clearly indicate the strength of the patient's underlying murderous rage.

The communication of suicidal intent, either to the physician or to significant others in the patient's environment, may also have this aggressive connotation. The work of Robins and his group has shown that approximately two-thirds of those who complete a suicidal act have previously communicated their intention of so doing (Robins *et al.*, 1959); what of course has not been shown is the frequency with which such communications are made *without* the subsequent occurrence of suicidal behaviour. Some of the statements made by the patients retrospectively studied in Robins' series clearly indicate a pronounced ambivalence towards dying and death; one can also infer from his material, as from any clinical practice, how frequently such communications were intended, consciously or otherwise, to induce some other person to take preventive and protective action. The aggressive

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undercurrent is nevertheless of paramount importance, and death may well be seen as a technique of achieving omnipotent mastery and of securing a vengeful retaliation (Hendin, 1963).

It is not, however, completely clear whether major suicidal behaviour has in every instance an aggressive, destructive, connotation. Much emphasis is placed in the neo-Freudian literture on states of complete hopelessness and despair, these being considered by some to provide total explanations for the majority of suicides. Basescu (1965) talks of those situations where "the foundations of meaningfulness crumble and the pattern of one's relationships fades away"; Salzman (1964) would go so far as to say that "... hostility is a minor problem". Certainly there are suicides, notably in the elderly or in the incurably ill, where the rage component is difficult to detect on retrospective evaluation, though even in these cases the illness may have led to an altered and less satisfying relationship between the patient and those close to him. While the development of hopelessness as a sequel to object loss seems adequate to explain the genesis of some depressive affects, as has been suggested by Engel (1962), the occurrence of a major suicidal attempt is extremely difficult to understand on these grounds alone. These issues are of more than theoretical significance; management of a patient in whom hopelessness and suicidal impulses are clearly demonstrable will differ according to the clinician's estimate of the extent to which these verbalizations are motivated by rage directed towards the environment or towards the therapist himself. Experience in the therapy relationship shows that rage may easily be induced in the despairing patient by a failure to offer support and dependency gratifications where these are indicated, or by repeated interpretations concerning the punishment he is inflicting on the therapist by his reiterated expressions of hopelessness; on the other hand, preoccupation with the patient's utter despair may lead to his hostile message being ignored at a time when some interpretative comment might crucially alter the dynamic situation.

Adequate appraisal of the patient also requires an appreciation of the frequency of aggressive actions, or threats of aggressive actions, in the childhood environment of the individual who later in life threatens or commits suicide. Kolb (1965) has emphasized that the life history of the suicidal patient may have been such that permissiveness concerning suicide has been established by identification with a parent who acted out or threatened death as a means of coercing his family. In the extreme case, clinical experience also confirms the heightened suicidal risk which is present when there is a history of suicide in other members of the family, this being independent of diagnostic considerations and hardly requiring genetic hypotheses for its understanding.

Suicide as an Interpersonal Phenomenon: The recent literature has paid much attention to the significance of suicidal threats and behaviour as attempts to manipulate the environment and to obtain narcissistic gratifications. Also there is frequently the implication that persons or institutions are to feel punished and humiliated by the suicidal act which, if successful, may grant the individual a status which he failed to achieve in life. On the other hand, relatively little attention has been paid to the psychopathology of the significant other person towards whom the suicidal communication has been directed, and a systematic study of such persons remains to be done.

Stengel has referred to this relationship in passing, drawing attention to the early observation of Federn that "only he who is wished dead by someone else kills himself" (Stengel, 1960b). At the extreme end of the continuum of processes of this type one encounters the so-called "victim-precipitated homicide" (Wolfgang, 1959), where the individual, commonly of low socio-economic status and orientated towards aggressive acting-out as a consequence of early experience, contrives his own death through the provocation of some significant person in the environment, commonly an intimate friend or spouse. On the other hand, Jensen and Petty (1958) point to the rescue motive which is apparent in many suicidal attempts, but they emphasize (and clinical experience abundantly confirms) that salvation may not be forthcoming if the person designated as rescuer lacks sufficient ego strength to enable him to deal with the

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suicidal person's destructive impulses as well as his own. Careful study of the patient's important interpersonal relationships will commonly show that his suicidal gesture or communication has already met, or is likely to meet, an essentially destructive response, though such reciprocal hostility may be heavily disguised.

Robins' group examined this problem briefly, but utilized only superficial description and some social psychology theory. Though they specifically state that only a minority of those who received suicidal communications appeared to desire the death of the suicidal persons, their subsequent commentary scarcely represents a confirmation of this viewpoint, and it is clear that their opinion derives only from an evaluation of manifestly defensive statements. Clinical evidence makes it apparent that flagrant denial mechanisms are commonly utilized by those who are the recipients of such bewildering and often multi-facetted messages; though the affects against which the denial is erected are invariably complex, repressed destructive feelings towards the suicidally inclined person are frequently of great significance. In the extreme case the expression of suicidal intent is greeted by an overtly hostile response; much more commonly the manifest message which is evoked, whether expressed verbally or in action, gives the superficial impression that the respondent's feelings are totally lacking in ambivalence, and that he is motivated only by concern for the well-being of the suicidal person.

The following case illustrates such a situation:

The primary patient was a middle-aged woman, who had had previous episodes of depression which had been treated by another psychiatrist and which appeared to be of neurotic type. Her previous history showed much evidence of neurotic character disorder. Admission to hospital followed a long domestic wrangle which had lasted through the greater part of one weekend. On the Sunday evening she announced to her husband, who was reading tranquilly in front of the fire, that she had taken ten sleeping tablets, but his response was only one of jocular disbelief. An hour later she climbed out of bed to tell him that she had taken a further ten tablets, but received the same contemptuous rebuff. He went to bed, according to his own statement, "without giving the matter any further thought," and was puzzled to find that she could not be properly roused on the following morning. However, it was not until he returned from work that day that he took steps to have her admitted to hospital.

Subsequent interviews, both individually and jointly, highlighted the sado-masochistic quality of the couple's relationship; it would be impossible to say that either of them was more destructive than the other. The husband's anger was repeatedly provoked by even the slightest emotional demands made on him by his wife (whose narcissistic needs were, in fact, very great), and he responded with particular vehemence to her never-ending attempts to control and emasculate him. His jealousy had always been extreme, and he had slashed his wrists when, before their marriage, he had discovered that she was going out with another man. During one of the joint interviews he made the bitter comment, "The more a man gets to know you, the less lovable he finds you."

This unusually striking case is in line with the views of Tabachnick (1961), who sees the "significant other" in the life of the suicidal patient as being himself dependent and masochistic, and feels that the two relate to each other "in a dependent and sado-masochistic manner". We have certainly observed many other marital relationships which confirm the comment of Litman, Shneidman and Farberow (1961) that "often *both* of the partners in the dyad are potentially suicidal". In other instances the parties in conflict are a parent and a teen-age child, the clamorous threats and appeals of the latter serving to make manifest the parent's previously repressed or suppressed resentment and hostility. In the words of Fellner (1961), " . . . A suicidal attempt is the direct outcome of an interpersonal conflict situation with a specific, psychologically important figure . . .".

It might be thought that the interpersonal transaction is only of serious significance in the clearly neurotic, manipulative patient, whose appeals are obvious, patently full of aggressive intent and, therefore, meeting a not altogether unexpected hostile response. Certainly the messages transmitted by the psychotic patient may be more obscure and symbolic, yet the dynamic structure of a depressive psychosis leads to a distortion, not to complete abolition, of interpersonal communication. Freud (1917) clearly saw the interpersonal significance of the melancholic's delusional self-reproaches, but it is not uncommon to find this insight ignored in contemporary clinical practice. Nor should it be thought that the importance of the interpersonal transaction is diminished by the significant incidence of suicide in those who have

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lived alone. Quite apart from the fact that their isolation may be causally connected with the incidence of completed suicide in several possible ways, their separateness from society is only true in a relative sense; they retain some degree of interpersonal contact, however tenuous, and transference-based fantasy may make important figures out of neighbours and strangers whom they see but rarely. Moreover, they are still bound by further fantasies to major figures in their earlier life. Though their expectations that their aloneness is itself a form of communication and should produce a constructive response from some person in the environment tend to be quite unrealistic, they see the absence of such response as having a destructive significance.

This interpersonal view of suicide has three consequences of great clinical significance. Firstly, the psychiatrist will find on numerous occasions that his therapeutic efforts with the primary patient are opposed by the overt or covert hostile destructive behaviour and attitudes of the specific important figure to whom the patient is relating; though a prolonged and intensive psychotherapeutic contact may permit the patient to mature in spite of these oppositional forces, this is by no means always the case, and certainly in briefer therapy some active programme designed to deal directly with them is likely to be required. Tabachnick (1961) suggests that the guilt of the non-suicidal person may need to be brought clearly into the open, at worst to allow therapy of the primary patient to proceed, at best to encourage his own entrance into an individualized or conjoint therapeutic programme. The second problem relates to the need for hospitalization, which may be particularly desirable in order to achieve a temporary interruption in the pathological relationship, in addition to the other valid indications which may exist for this course of action. Understanding the magnitude of this reciprocal hostility means that family members cannot always be trusted to remove from the patient's orbit all significant instruments of suicide; for example, the wife of a recent patient had not taken any steps to dispose of a bottle of poison in the house despite her husband's obvious suicidal preoccupation and his several references to this particular means of death. If an actively suicidal patient has to wait even a few hours to be admitted to hospital (and the suggestion of hospitalization may increase his depression, his rage and his suicidal potential), it may be desirable to have a social worker or nurse accompany him during this time, rather than leave him in the care of a family member or friend, when there is any reason to doubt the strength of this person's loving feelings towards him.

The third consequence arising from this stress on interpersonal factors in suicidal behaviour is the challenge which is thereby posed to the psychiatric hospital and the psychiatrist himself. Duncan (1965) has pointed out that certain countertransference problems in the psychiatrist may lead to the patient's receiving a thinly veiled hostile or contemptuous response to his aggressive demands or dependent supplication. Responses of this kind are even more likely to be forthcoming from less highly-trained staff or from other patients; it therefore becomes crucial that, as these situations cannot be avoided, they must at least be adequately ventilated in a setting where they can be interpreted and understood.

The Issues of Life and Death: Psychotherapeutic experience and psychoanalytic writings bear ample testimony to the frequency of the equation of sleep and death, and the patient who has taken a moderate overdosage of hypnotic drugs often reports uncertainty about which of these two states he intended to achieve. Study of the suicidal patient frequently reveals that death to him has a unique meaning, often very different from its connotation for the non-suicidal individual. Whether or not it be literally true that all human beings are incapable of conceptualizing the state of personal non-being, certainly an extreme degree of narcissistic orientation is likely to be found in the person who is actively contemplating suicide, and his fantasies about the likely effects of his imminent death may carry the implication that even after his demise he will be able to enjoy the remorse and lamentations of others. Such primary process thinking will be found in many people who deny the reality of an after-life, though more simplistic beliefs of this kind are also of

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importance. If the conviction of a life after death is strong, then a fantasied reunion with a lost loved person is often of importance. These areas of the patient's fantasy warrant very specific attention, for an appreciation of his mode of of approach to the concept of death may significantly affect his management programme.

Impulsiveness: The ego strengths of patients who appear to be suicidal risks repay careful study; interview performance, developmental history and behaviour on the ward (where applicable) will all provide valuable material. In a recent well-documented Western Australian series it was found that two-thirds of suicidal attempts were of an impulsive nature (James *et al.*, 1963). Though many such attempts are minor, the type of ego disorder which is associated with reduced frustration tolerance and minimal ability to handle tension is also associated with reduced objectivity and foresight, so that the consequences of the suicidal behaviour are unlikely to be seen with the clarity which would be expected in a person with more adequate time perspective. The well-known association of suicidal attempts with a history of chronic alcoholism is also relevant in this connection. Of patients whose attempts are serious enough to warrant admission for resuscitation to the Royal Prince Alfred Hospital, Sydney, 30 per cent. give a history of recent, sustained alcoholic excess. Past history or current evidence of impulsivity must be given considerable weight in determining the most appropriate management of any potentially suicidal person.

Diagnostic Considerations: The labelling of a patient in traditional diagnostic terms does not add very much to one's awareness in the individual instance, except when there is unequivocal evidence of a depressive illness with psychotic features. Examining the subsequent fate of a population of hospitalized veterans, Pokorny (1964) concluded that the risk of suicide in those diagnosed as depressives was 25 times the expected rate for a normal population of similar composition, but the risk was also 7 times as high for schizophrenic patients and 3 times as high for those with organic mental syndromes. The recognition of any particular patient as psychotic does raise important issues, regardless of the nature of the psychosis. Some suicidal notes, for instance, display primary process thinking and loss of differentiation between the self and the object world, often associated with gross semantic confusion. One of the most serious suicidal risks encountered in this Department was posed by a man who expressed self-destructive intent "because I realize that all my life I have been a sexual imbecile and now, as a result, my brain is turning to fibrous tissue". Such a patient is clearly not going to evaluate the consequences of his actions in any predictable way.

Suicide in schizophrenic patients has received relatively little attention, though patients with this diagnosis are probably those most likely to commit suicide whilst in the psychiatric hospital. Although traditionally the suicidal behaviour of the schizophrenic is thought of as highly impulsive and inevitably bizarre (and, of course, many attempts *do* occur as a response to the panic associated with an awareness of ego dissolution), the series studied by Shneidman, Farberow and Leonard (1962) shows that many occur in those who have been regarded as "good hospital patients", quiet and co-operative, and often at a time when they appear to be moving into a remission of their illness. Experience in this hospital confirms the validity of their observation that the suicidal behaviour is often well-organized, showing evidence of careful planning, and based on the patient's need to extricate himself from a life situation perceived as intolerable and from which there seems to him to be no other escape possible. Other patients, with a degree of insight into the fact that they are psychotic, and sometimes possessing a stereotyped conception of the long-term prognosis of schizophrenia, may attempt suicide at the conclusion of a course of treatment which they themselves recognize to have been a failure. Shneidman's group emphasizes that ataractic drugs do not necessarily reduce the suicidal potential of these patients; on the contrary, the tranquillized schizophrenic may give a quite false impression of improvement, while his feelings of rage, frustration and futility remain potently active beneath his calm exterior.

In a general hospital population at least, suicidal behaviour is not infrequent amongst

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those with organic brain syndromes. Here in particular there is likely to be an element of unpredictability and bizarreness, contributed to by the patient's emotional lability and his generally inadequate ego resources. Certainly the most unusual (and one of the most serious) of all suicidal attempts treated in this unit recently was that carried out by a middle-aged woman who had sustained a cerebral vascular accident eight weeks before her admission; she tipped petrol over herself and set it alight, shortly after the ritualistic Buddhist suicides of a similar nature had been reported from South Vietnam.

Parental Deprivation and Death: Several studies have underlined the frequency with which a history of parental loss or gross deprivation of parental care during childhood and adolescence will be found in the developmental history of the suicidal patient. Moss and Hamilton (1956), studying persons who had made serious suicidal attempts, found that 60 per cent. had lost one or both parents in early life, the majority during puberty or early adolescence, the remainder in childhood or infancy. (Corresponding figures for normal control groups range from 17 per cent. to 33 per cent.). These figures are confirmed by Dorpat, Jackson and Ripley (1965), who find that 64 per cent. of suicidal attempters have had one or both parents missing for a period of four years prior to the age of 18, the figure for those who complete suicide being 50 per cent. Their figures strongly suggest that, although divorce is the more common form of loss for suicide attempters, loss through death has been particularly significant in those who succeed in killing themselves. Four additional points arise from detailed study of individual case histories: (i) the person lost may not necessarily have been a parent, but may have been another family member—grandparent, aunt, cousin, sibling—to whom an unusually strong attachment existed; (ii) the loss may have been especially traumatic, as Zilboorg (1937) has suggested, if it occurred during the Oedipal or pubertal periods; (iii) death through suicide may have a unique relevance; (iv) the pathological effects of the loss may be greatly heightened if the work of mourning, with its concomitant free expression of grief, anger and perhaps guilt, is not adequately performed at the time (Deutsch, 1937) or if the child is too young to work through the experience to a satisfactory outcome (Bowlby, 1963).

Certain types of anniversary may also have a special significance for the potentially suicidal patient. If there is evidence that he was strongly but ambivalently bound to a deceased parent or other relative, most particularly if that person committed suicide, the actual date of the death may be of importance in some instances, for there may be a heightened risk of suicide at that time. Hilgard *et al.* (1960) have also drawn attention to the fact that there may be an increased risk of mental illness, including suicidal behaviour, as the patient himself reaches the age at which his parent died, and clinical experience suggests that once again this factor may have particular relevance when the parent died as a result of suicide. Hilgard's most original contribution has been her observation that if, for example, a young girl during her development undergoes a major crisis in her relationship with her mother, either through the latter's death, departure or psychosis, she may herself be exposed to considerable risk of mental illness when, many years later, her own child with whom she is identified reaches the age at which she herself suffered unresolved loss. Here again suicidal behaviour is one type of disorder which may become clinically manifest at this time.

The implication of all these findings is clear, especially when considered in conjunction with the observations recorded earlier in this paper on the importance of early exposure to violence or threats of violence. The management of a potentially suicidal patient can only be informed and adequate when there is available a detailed personal and developmental history, with particular attention paid to the elucidation of major experiences of loss during childhood and adolescence, most especially if these were due to suicide, and with recognition of the extent to which defences against such loss appear to have been pathological and are currently operative in the individual's adjustment.

The Patient who has made a Suicidal Attempt

Much of what has been said in the previous section is equally applicable to what follows, but

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clearly the clinician is faced with a somewhat different situation when he confronts a patient who has already given clear-cut proof of his capacity to perform a suicidal act, whatever the severity of this may have been. In the great majority of cases the patient has not been previously known to the consultant psychiatrist, who, in general hospital practice at any rate, is often required to formulate a fairly rapid decision concerning the management of a person who has commonly been inadequately prepared for psychiatric consultation and about whom his knowledge is in many ways sketchy.

The mental state subsequent to a suicidal attempt is of great interest, though understanding of it is often inadequate. Frequently the consultant is confronted by a patient who has made a deliberate suicidal manoeuvre, often of quite desperate intensity, yet who several days later appears to be in a state of remarkable tranquillity, lacking any obvious psychiatric abnormality. One may speculate that denial mechanisms are of paramount importance in such cases, but these are not always able to be clarified during the interview, however skilled the psychiatrist's technique. Moreover, it is not always possible to be satisfied that this remarkable change in mental state has been brought about by some positive environmental response to the suicidal behaviour. Stengel has pointed out that in some of these apparently improved patients survival after a desperate gamble with death is magically interpreted as indicating the beneficence of fate and is seen, at least in the short-term view, as a rationale for an attempt to build a new life; clinically, this type of fantasy may be accompanied by quite considerable euphoria.

On the other hand many patients are encountered, following a suicidal attempt of any degree of severity, in whom continuing depression and hopelessness, perhaps heightened by shame at their recent behaviour or anger at their survival, still pose an acute management problem. Harrington and Cross (1959), using a simple question and answer technique, found that only 42 per cent. of general hospital patients stated that they felt better after a suicidal attempt, and this finding seems important in disposing of the commonly propagated myth that the suicidal risk is usually much lessened after active suicidal behaviour.

The crucial task of the clinician, who in a general hospital practice of any size is likely to see several such patients every week, is to decide which individuals are most likely to fall into the group, forming approximately 10 per cent. of the total population of attempted suicides seen, who without treatment will successfully complete suicide within the next 10 years, for it is to these that his most specific management programmes will need to be directed. The preceding material has seemed within this hospital to provide the most effective guide-lines towards the making of such decisions on an individualized basis; it must be stressed that while the continuation in the post-suicidal period of a mood of deep, unremitting depression must obviously warrant special attentiveness from the staff, the absence of such depression by no means ensures an untroubled progress in the immediate future. But some attention must be given to the difficulty of instituting care for many suicidal patients, commonly but not exclusively in the milder group, whose defences of denial and rationalization may prevent them from acknowledging the need for further care once the medical emergency has passed.

Experience at the Royal Prince Alfred Hospital suggests strongly that the patient brought to the Casualty (Emergency) Department because of suicidal behaviour, should he not be considered in need of admission to hospital for resuscitation or urgent psychiatric care, is highly unlikely to keep any appointment which is arranged for him at the Psychiatric Out-patient Department. Furthermore, only half the patients who have been admitted to hospital and who have seen a psychiatrist in consultation but who have not been transferred to the in-patient psychiatric unit will report for subsequent out-patient care as requested; as only one patient in five admitted for resuscitation appears to require in-patient psychiatric treatment, according to Clifton, Mackey and McLeod (1965), this means that two in every five fail to receive adequate follow-up. Clearly, in both these sets of circumstances, the patient's contact with the hospital has been so tenuous

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that it has not given him any grounds for believing that it is able to provide continuing help with his problems. Furthermore, this experience, particularly when he has not been interviewed by psychiatrically trained staff, has failed to break through his defences against admitting helplessness and the taking up of a dependent, help-seeking role.

This is hardly surprising when one notes the extent to which failed interpersonal relationships are significant precursors or precipitants of suicidal behaviour. All our experience re-emphasizes the validity of the traditional psychodynamic concepts of object loss in these patients, and from this one can derive clear implications as to the appropriate initial therapeutic procedure, even though this may not always be easy to institute. Yet it seems essential that the first step in the management of such a patient should be the offering of the psychiatrist—and, in a sense, the offering of the hospital—as a new object, creating for the patient a relationship which hopefully may be the beginning of more satisfactory ways of relating to the environment. It should be added that this step is also essential when there has been an intense crisis of suicidal feeling, even though suicide has *not* been attempted, for the risk of successful suicide in such patients is particularly high throughout the ensuing three months, even though the degree of distress might appear to have abated considerably.

This interpersonal contact must therefore be regarded as the first and most crucial step in the management of *any* suicidal patient. Where possible and desirable, this initial relationship should proceed to a more structured psychotherapy, often beginning as an in-patient but continuing in many instances for a year, two years or more in an out-patient setting. Clearly this second step is inappropriate at a time when the patient is unequivocally psychotic or is unable to make psychotherapeutic contact for some other reason, and in these instances the various symptomatic treatments are of value. In this context, we have found the anti-depressant drugs to have only a very limited usefulness; those who pose such a serious continuing suicidal risk as to warrant urgent physical intervention nearly always require electro-therapy, whereas the much larger "neurotic" group rarely show the clinical features which would lead us to expect a significant remission from the use of drugs.

It is beyond the scope of this paper to discuss in detail the problems and techniques of psychotherapy with seriously depressed persons, but it must be emphasized that the classical analytical model is certainly an inappropriate one for the early stages of such treatment. Some psychiatrists may find it difficult to offer themselves in an active fashion as a source of gratification for the patient's dependency needs, especially when it may appear to be essential in the short term to gratify desires which are clearly regressive in nature. The patient's appeals for love and protection will be clamorous in many cases, even where such needs are explicitly verbally denied, and it has already been pointed out that it may be an error for the psychiatrist to interpret such behaviour as evidence of the patient's desire to make him suffer, even though in other cases such an interpretation, precisely timed, may be highly significant. As the psychotherapeutic relationship is developing, the therapist must be prepared to consider granting the patient's wish for unscheduled appointments in a way that he would not consider advisable in a more orthodox psychotherapeutic setting, and he may need to make himself available on the telephone and in person in ways and at times which may be highly inconvenient. This type of procedure obviously involves two risks—firstly, the gratification of essentially neurotic needs may continue for so long and in such a manner that a regressively dependent transference is established which it is difficult or even impossible to interpret; secondly (and perhaps accounting for the former situation), countertransference problems may bedevil the relationship up to the point of therapeutic impasse. The psychiatrist in this situation must be secure in his ability to tolerate demanding dependence, and flexible enough to be able to provide auxiliary ego support during crises of hopelessness and despair.

Summary

Rage, externally or internally directed or both, appears to be a necessary though not a

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sufficient condition for the occurrence of significant suicidal behaviour. An ego structure which permits impulsive acting out, and personal fantasies concerning the meaning and significance of death, are of great importance in many cases. Kraepelinian nosology is of little or no assistance in the estimation of suicidal risk in clinical practice. Careful study of the patient's developmental history and current life situation may, however, provide many significant clues.

In particular, this paper has emphasized the interpersonal significance of suicide, a viewpoint which is complementary and not alternative to an intensive study of the patient's intrapsychic life. More than usual attention needs to be given to the specially significant individual to whom the suicidal patient is often ambivalently bound in a virtually symbiotic relationship, for highly relevant psychopathology will very frequently be found in this person, exerting a destructive effect on the primary patient which runs directly counter to the psychiatrist's interventions.

Whether the patient is talking of suicide or has already carried out a suicidal act, the relationship between patient and psychiatrist will be of crucial significance in management, whatever use is made of ancillary treatments. Quite apart from the meaning to the patient of such a relationship, only a study in depth can begin to unravel the complexity of the patient's motivations, without which proper understanding and treatment are impossible.

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