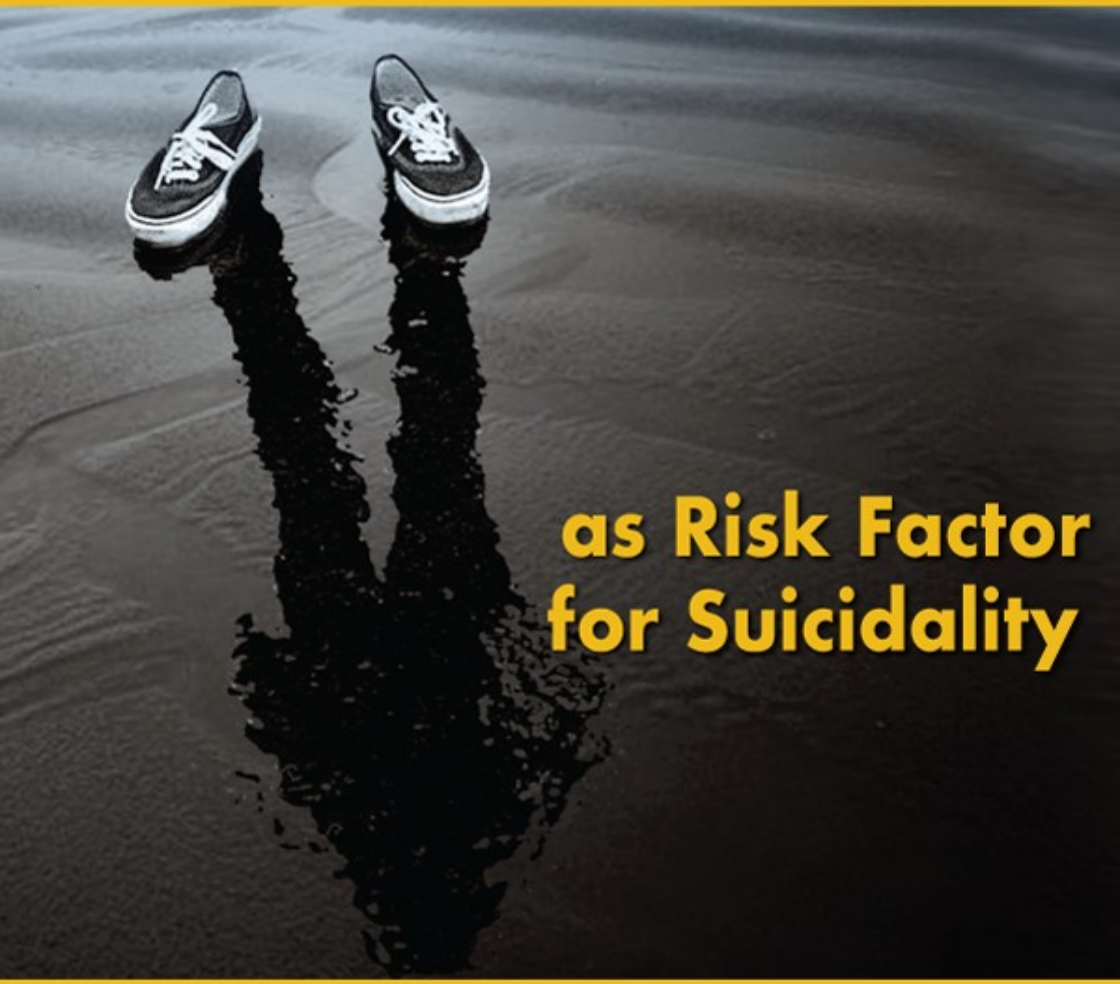
Separation Individuation Difficulties



Alice Pozzi

Separation Individuation Difficulties as Risk Factor for Suicidality

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Introduction

In the United States, suicide ranks as the second leading cause of death for individuals aged 10-34 years, and the tenth leading cause of death across all age groups (Centers for Disease Control and Prevention [CDC], 2018). In 2017, the CDC (2018) counted 47,173 suicides across the United States, and an average of 129 suicides per day. Although there is no complete count of suicide attempts, it is estimated that the numbers of attempted suicide were 1,400,000 in 2017, and that, on average, there are 25 attempts for every completed suicide (Substance Abuse and Mental Health Services Administration [SAMHSA], 2018). Recent suicide statistics show that suicide rates have increased by 30% in

the United States since 1999 (Stone et al., 2018). The latest data on suicide show that 46% of individuals who die by suicide have a known mental health condition (Stone et al., 2018). This percentage might not be exact due to the numbers of possibly unreported, unknown, or undiagnosed mental health conditions. Regardless of mental health status, however, the same study reported that *relationship problems* is the most common contributing factor to suicide (Stone et al., 2018). These statistics highlight both the significant social and clinical implications of suicide and the importance of the relational realm in this phenomenon.

The aim of this book is to provide a literature review on the psychodynamic literature of suicide and to present a new qualitative study on the etiology of suicide from a relational

perspective, focusing on the role of the separation-individuation experience in the development of suicidality.

Chapter 1

Seminal Theories of Suicide

There have been a few sociological and psychological models attempting to explain the etiology of suicide (Durkheim, 1897; Van Orden et al., 2010). Sociologist Emile Durkheim (1897) studied the social forces behind suicide, and was one of the first researchers to emphasize the feeling of *social disconnection* as a fundamental source for an individual's desire to die. He also introduced the concept of *perceived burdensomeness* in suicidal individuals, which was later adopted in one of the most popular etiological models of suicide: *the Interpersonal-*

Psychological Theory of Suicide (Van Orden et al., 2010). According to this model, a person who desires to end their life experiences two different feelings that concern their relational world: (a) the sense of not belonging and (b) the sense that they are a burden to significant others. Both of these theories of suicide emphasize the importance of the relational realm in the etiology of suicide. Recent statistics on suicide, which showed *relationship problems* to be the most common factors in individuals who died by suicide in 2017, also highlight the relational dimension of this phenomenon (Stone et al., 2018).

Psychoanalytic views of suicide also revolve around the individual's external and internal relational world. Sigmund Freud (1922) was among the first psychoanalysts to address the

complex topic of suicide. Although Freud never developed a theory of suicide or synthetized his view into an organized presentation, he emphasized the importance of object loss and of guilt over hostile impulses against primary caregivers in suicidal individuals. *Object loss* refers to a real or perceived loss of a caregiver or attachment figure (i.e., death of a parent, emotionally unsatisfying parent, parental relational disappointment). According to Freud (1922), object loss translates into an ego-loss in suicidal individuals. In other words, in an attempt to deal with the unacceptable negative feelings associated with the omnipotent caregiver, *melancholic* suicidal individuals internalize the object and identify with it. By doing so, object-hate becomes self-hate and self-destructive and suicidal impulses ensue.

The framing of suicidal ideations as the ultimate aggressive impulse turned inward (Freud, 1922) is consistent with Klein's concept of introjection and displacement in child development (Klein, 1940). *Introjection* describes the process in which an individual takes in attributes and behaviors of another person (i.e., an object). *Displacement* refers to the shift of affects, feelings, wishes, and fantasies from an object to another or, in the case of depressed (i.e., melancholic) and suicidal individuals, to oneself. Klein states that the murderous impulses that arise in early infancy and continue sporadically throughout the other stages of childhood are fueled by the relational disappointments from the primary caregiver (i.e., object loss). Because it seems less dangerous to the ego to attack itself rather than

an external object (i.e., the caregiver), the hideous aspects of the object get internalized (i.e., introjected) and the murderous feelings and anger previously directed toward the object are displaced upon the self. Based on the aforementioned psychoanalytical underpinnings, one could speculate that most suicidal individuals have a history of early relationship disturbance and present with some type of narcissistic injury.

Kohut (2009) held that for an individual to develop in a healthy manner, the experience and introjection of a nurturing, available mother figure is paramount. If an individual lacks this experience, he or she will not have the opportunity to develop a soothing positive introject, which is the prerequisite for a cohesive sense of self. The latter represents an integral

concept in Kohut's (2009) theory and refers to a robust self-esteem in the face of challenge. In fact, these narcissistically wounded individuals might have a difficult time when dealing with loss and disappointments and might develop pathological internal object relations. In other words, based on this theory, suicidal individuals should present with relational conflicts and struggles that are rooted in their problematic early parent-child relationships. These mechanisms are the foundations of a psychodynamic, object-relational view of suicide, which is the focus of the current study. Specifically, the author is interested in the level of disturbance in relation to the developmental step of separation and individuation in suicidal individuals (Mahler, 1974). Separation concerns an intra-psychic process in which the mother

comes to be perceived as separate from the self. Individuation, on the other hand, refers to the development of the child's self-concept, which evolves with the progression of his or her autonomy. Under optimal conditions, the mother encourages the child's growing independence. On the other hand, if the mother is resistant to the child's individuation by being neglectful or controlling, the child's development will be stunted.

Mahler's (1974) separation-individuation theory clearly illustrates two phases of child development that refer to the development of object relations. The first phase, called normal symbiotic phase, occurs in the first 5 months of life and is characterized by no sense of individuality, as the infant perceives the mother as non-external and devoid of a separate

existence. The second stage, the separation-individuation phase, ranges from 5 to 36 months and beyond and is divided into three sub-phases: hatching, practicing, and rapprochement (Mahler, 1974). During hatching the child starts to become aware of the differentiation between him or herself, the mother, and the world. During practicing, the child starts to explore and becomes more independent from his or her mother. This gives the child elation and his new found physical ability counter the fear of separation or object loss. In the rapprochement phase, the child comes to the realization that mobility means physical separation from the mother and is overwhelmed with anxiety, or fear of love loss. At this stage, the child is tentative in his exploration and needs his or her mother to be in sight to regulate his affects while exploring

the world (Mahler, 1974). The presence of certain unfavorable caregiver qualities, which we can overall label as *misattunement*, would suggest a rupture in the developmental process of separating and becoming an autonomous individual (Kramer & Akhtar, 1994; Mahler, 2000).

Chapter 2

Literature Review

This section will include an overview of the studies on and of the psychodynamic theoretical underpinnings of the etiology of suicide. The focus will be on the role of early parent-child relationships in later suicide. In fact, it is speculated that suicide is the result of a disruption in the separation-individuation step of human development. There are different parenting styles — which in turn evoke different child's reactions — that can negatively interfere with separation-individuation (Kramer & Akhtar, 1994). Regardless of the type of parental interference and of the child's reaction, an

individual will fail to separate and individuate in reaction to the undue threat of loss of the parent-child relationship, which is a vital relationship in infancy. In other words, the inconsistency or conditionality of the parent's support will make the child fear object loss (i.e., experienced in the form of rejection, neglect, or engulfment), thus separation and individuation will be stunted. The main underlying mechanisms associated with the disruption of the process of separation-individuation include: (a) faulty introjection and identification, which lead to borderline functioning and vulnerability in the face of future object loss and life disappointments, (b) the emergence of a false self, and c) anger and aggression (Kramer & Akhtar, 1994). In this work, the author refers to Mahler's (1974, 2000) psychological birth model when discussing the

separation-individuation process of development. This literature review will first cover the concept of a symbiotic relationship and the development of pathology through the disruption of the separation and individuation process.

The dynamics of suicide will later be analyzed based on the aforementioned theories and on several studies. Lastly, the therapeutic relationship with suicidal clients will be examined, focusing on the issue of transference and countertransference.

The Symbiotic Relationship

One of the first psychoanalytical glimpses on the etiology of suicide comes from the essay *Mourning and Melancholia*, in which Freud

(1922) examined the nature of this phenomenon from a relational perspective. In fact, he describes how certain unhealthy ways of relating and loving are precursors of suicidal ideation and behaviors. Specifically, Freud (1922) stated that being intensely in love and wanting to commit suicide are characterized by the same relational dynamics, in which the ego is "overwhelmed by the object" (p. 252). Freud's followers and later psychoanalysts have attempted to explain that, when one is overwhelmed by the object, one's internal representations of the self and the other are fused (Shneidman, Farberow, & Litman, 1970). In other words, this type of attachment to an object is what we would modernly refer to as a *symbiotic* relationship.

Many historical psychoanalysts have included the concept of a symbiotic phase in their understanding of child development (Mahler, 1974; Winnicott, 1960). For example, Mahler's (1974) psychological birth model incorporates a primitive stage that extends for the first five months of an infant's life and is called Normal Symbiotic Phase. In this particular stage, the infant has no sense of individuality and no formed representations of self and others, as the mother is perceived as part of the self. Winnicott's (1960) developmental model also includes a phase of *undifferentiated unity*, in which the infant does not perceive the mother as separate. In this initial phase, an infant is supposed to acquire a sense of omnipotence (i.e., feeling competent, powerful, and safe), which is dependent on the

mother's ability to readily respond to the infant's needs. The Winnicotian (Winnicott, 1960) concept of *primary maternal preoccupation* further underlies the developmental importance he placed on this first initial stage. In fact, Winnicott (1960) believed that a *good enough mother* — one who is emotionally and physically available — is able to provide this symbiotic relation for the first year of a child's life. In other words, Winnicott believed that an infant needs to be fused with the mother for him or her to develop in a healthy manner.

The Development of Pathology: Disruption in the Separation-Individuation Process

Although most theorists hold that a phase of symbiotic functioning is necessary to

development, they also agree that pathology might develop if the infant is not able to move out of this stage at the appropriate time (Mahler, 1974; Winnicott, 1960). Even though traumas that stunt development can be of different natures, psychoanalysts believe that an unhealthy early parent-child relationship is among the most common risk factors for the development of pathology (Kernberg, 1975; Kohut, 2009; Mahler, 1974; Winnicott, 1960).

In their review, Chapman, Dube, and Anda (2007) conclude that childhood abuse — including physical, emotional, sexual abuse and neglect — is a major risk factor for adverse mental health consequences both in childhood and in adulthood. More specifically, McCauley and colleagues (1997) found that as compared to women who reported no abuse, women who

reported childhood abuse had significantly higher scores for anxiety, depression, and somatization (as cited in Chapman et al., 2007). Moreover, studies have shown that a history of traumatic childhood experiences is associated with the development of Borderline Personality Disorder (Gunderson & Chu, 1993 as cited in Chapman et al., 2007). Furthermore, Dube et al. (2001) found that adverse childhood experiences (i.e., abuse or neglect) were associated with a significantly increased risk of attempted suicide ranging from two- to five-fold. As compared to a 1.1% rate of suicide attempts among respondents who reported no adverse childhood, respondents who reported seven or more adverse childhood experiences reported a suicide attempt rate of 35.2% (Dube et al., 2001).

According to Mahler's (1974) model, an infant starts to separate from the mother and individuate when he or she reaches 5 months of age. Winnicott (1960), on the other hand, believes that a child will ultimately move into what he calls a phase of *relative independence*, in which he or she will be physically and psychologically distinct from the mother. In both instances, the mother plays a very important role in the transition from the symbiotic to the individuated phase. In Winnicott's (1960) model, the good enough mother provides a *holding environment*, in which she both accepts and facilitates the child's physical and psychological separation. Mahler (1974) also believes that the parent is to accept the loss of participation in the child's adaptive growth

process and be able to provide emotional support in the separation-individuation phase.

The developmental dilemma of the infant stems from the innate need to separate and individuate from the parent, upon whom the child is dependent. Because the parent is vital for survival, the child will sacrifice his or her developmental needs in order to maintain the relationship with the parent. Pathology arises when the process of separation and individuation is stunted and the child is overwhelmed with anxious and angry affects aroused by the threat of loss of the parent-child relationship (Kramer & Akhtar, 1994).

In light of Mahler's (1974) separation and individuation theory, Kramer and Akhtar (1994) list different ways in which misattuned parents

can negatively influence the process of separation and individuation: (a) *parental failure to sanction and encourage separation-individuation*. When parents cannot tolerate the loss of the parent-child relationship and have high separation anxiety, they tend to hold on to their infant. This dynamic then perpetuates dependency and stunts growth toward autonomy. (b) *parental difficulty in regulating the child's distress around the separation-individuation process and parental failure to re-establish a viable developmental relationship*. When the parents have difficulty modulating their own affects, they will most likely fail to empathize and regulate their child's emotions and subsequently repair the ruptured relationship. (c) *parents' excessive need to control the child*. Parental need to control can take different forms.

Some parents, in an attempt to manage their need for control will intrude on the child's spontaneous, independent, and developmentally appropriate assertive behavior (i.e., the engulfing parent). Others will emotionally withdraw from the child, leaving him or her at the mercy of impulses and feelings that the child cannot yet regulate on his or her own (i.e., the rejecting, neglectful parent). Either way, the child's needs will not be met, and he or she will not experience the needed parental support and pleasure in his or her growth (Kramer & Akhtar, 1994).

Faulty Introjection and Identification

Kramer and Akhtar (1994) enumerate different ways in which children react to these parental influences on the separation-

individuation process. One way the child adapts is by identifying with the parent. Identification with the parent figure is a well-discussed concept in child development. In fact, the identification of the child with the primary caregiver is a normal step included in many models of human development (Freud, 1953; Kohut, 2009). In normal development, through Kohut's (2009) process of *transmuting internalization*, the experience of the nurturing and available mother is internalized and, by the process of identification, eventually integrated into the core of oneself (Kramer & Akhtar, 1994). Identification with the same-sex parent is also part of the normal resolution of Oedipal stage in Freud's psychosexual model (Freud, 1953).

However, as Kramer and Akhtar (1994) pointed out, identification does not always take place appropriately. Specifically, when children are constantly afraid of losing the love and support of their parents, they can engage in a pathological identification. Developmentally, the child needs to experience their parent as omnipotent — a competent, powerful, and reliable being. If the child has this experience, they will be able to internalize positive introjects that will provide the child with a robust sense of self and self-esteem in the face of life's setbacks (Kernberg, 1975; Winnicott, 1960). *Introjects* can be described as internalized attributes of outside objects that become part of the self or ego. When the parent disappoints the child by being inconsistent in his or her emotional availability, the child will experience intolerable

levels of frustration. In an attempt to manage this distress and salvage the so-needed image of parental omnipotence, the child will internalize and identify with the parent's negative aspects. This polarized identification (i.e., the child introjects only the negative aspects of the parent and dismisses the positive ones) will hinder the fundamental step of separation and individuation from the parent. In other words, because the child cannot accept the fallibility of the parents, he or she internalizes and identifies with the object's inadequacy, thus maintaining the illusion of the omnipotent parent. In doing so, the child will not be able to develop a soothing, realistic introject with integrated positive and negative features. This will make the child more vulnerable in the face of life disappointments (Kramer & Akhtar, 1994).

False Self

Another way children respond to disruptions in the separation-individuation process is to become overly attuned to the emotional state of the parent. This is an attempt to maintain the parent-child relationship and avoid interpersonal conflict. By becoming their parents' empathic confidants and consolers, these children are able to stay in a relationship with them yet at the expense of development and individuation of the self (Kramer & Akhtar, 1994). This type of adaptive response is consistent with Miller's (2008) idea of the *gifted child,* and with Winnicott's (1960) concept of the *false self*. A gifted child is one that appears to be more aware, overly sensitive of, and attuned to his or her parent's needs and feelings. This type of child will sacrifice his or her true self to

maintain the role of the perfect child, and, ultimately, to stay in the parent-child relationship that he or she so fears to lose. Developing a false self, an artificial persona that is accepted and approved of, leads to feelings of emptiness and isolation.

Anger and Aggression

Regardless of the type of parental influences and of the child's respective adaptive responses, repressed anger and aggression seem to be the common denominator in the development of pathology that stems from a stunted separation-individuation process.

Kramer and Akhtar (1994) believe that one effect of repressed aggression and anger is injury to the sense of self and feelings of unworthiness.

This mind state clearly resembles that of Freud's melancholic individual, who is ultimately overwhelmed with self/ego hate. This development occurs because the individual, in an attempt to maintain the necessary idealization of the omnipotent parent figure, internalizes the negative aspects of the parent (i.e., object). In line with this theory, Freud (1922) and others have described suicide and suicidal ideation as the ultimate form of anger and aggression turned inward. Therefore, there seems to be a link between anger, aggression, and suicide that stems from pathological early relationships, characterized by faulty introjection and identification, and stunted separation-individuation processes.

The Dynamics of Suicide

Two defense mechanisms seem to play a role in the dynamic of suicide: *introjection* and *displacement* (Menninger, 1933). Menninger (1933) says that when an individual unconsciously hates the object, he or she may destroy the latter by identifying oneself with that person (i.e., introjection), and then destroying the self (i.e., displacement). In other words, Menninger (1933) states that one of the components of suicidal ideation and behavior is the aggressive *wish to kill* the object. However, because the object is internalized, the individual's displaced anger leads him or her to murder oneself instead of the object. It is believed that a pathological identification with the parent, that Kramer and Akhtar (1994) have deemed characteristic of faulty separation-individuation processes, is therefore central to

the dynamics involved in suicidality. Menninger's theory is also congruent with Freud's (1922) concept of suicide being an attack on the object that has been internalized.

Maltsberger and Buie's (1980) clinical work with suicidal individuals also support the idea that faulty introjection-identification processes underlie the dynamics of suicide. In fact, the authors attempt to understand suicide as the *wish for riddance of an enemy*. In the majority of the cases observed, the suicidal individuals described feeling as if there was a part of their self that was charged with hateful energy, and which was experienced as "an intolerable and exhausting enemy who will either kill or be killed" (Maltsberger & Buie, 1980, p. 406). In light of this, suicide can be conceptualized as an effort to get rid of intolerable hostile introjects,

or better, to free oneself from the internalized parental object that one has pathologically identified with.

Moreover, Maltsberger and Buie (1980) found that the majority of their suicidal patients presented with a history of difficult mother-child relationships, and that these disturbances were of the type that disrupts the developmental stage of separating and tolerating separateness from the mother with reasonable ease. Specifically, the authors explained that developmental failures in the separation-individuation phase result in the adult's inability to tolerate separateness.

Haunted by hostile introjects, and lacking realistic well-integrated introjects, these individuals are overly vulnerable to suicide, especially when they experience real or

perceived object loss (Maltsberger & Buie, 1980). In fact, individuals lacking comforting soothing introjects tend to form unhealthy relationships in which other people are seen as extensions of themselves. Because of this, when these individuals perceive the loss of these objects (i.e., real or imaginary), they experience an ego/self loss. These findings are congruent with Kaslow et al.'s (1997) idea that suicidal individuals show impaired reality testing when faced with relational problems such as abandonment or loss of self-esteem.

Kaslow et al.'s (1997) study observed four concepts of suicidal behavior in 52 hospitalized psychiatric patients that attempted suicide. The four concepts include self-directed aggression, object loss, ego functioning disturbance, and pathological object relations. Kaslow et al.

(1997) found that attempters had more impaired object relations and lower levels of separation-individuation, consistent with more borderline organization. This study also indicated that, as compared to controls, attempters are more likely to have a history of childhood loss combined with adult loss. No significant difference was found between controls and attempters in regard to self-directed aggression.

Novick's (1984) psychoanalytic research on seven suicidal adolescents from England revealed that in each case, suicide — even when it appeared to be the result of an impulsive act — originated from a long-standing, severe disturbance rooted in the experience of failure in the attempt to separate from the mother figure. In all seven cases, the author found that the emergence of suicidal thoughts was associated

with: (a) feelings of or fear of abandonment, (b) wish for or fear of engulfment, and (c) guilt over or fear of aggressive, omnipotent wishes toward mother. Based on the seven cases, Novick (1984) developed a *suicide sequence,* which he describes as a series of psychological steps that lead to suicide attempts in adolescents.

Firstly, Novick (1984) says the individual usually presents with a severe pathology that has been long-lasting and of a depressive nature. The adolescents have usually been depressed, preoccupied with death, and often felt sexually abnormal for some time before the act. Secondly, the severe pathology in this suicide sequence is the occurrence of external events that require the adolescent to break their tie to their mother. The third step involves the experience of failure to separate from the mother

and the realization of the adolescent's developmentally inappropriate dependency on her. Subsequently, the experience of failure to move away from the mother puts the adolescent back into an intense symbiotic relationship with her. At this point, the adolescent, fearing the loss of the relationship, regresses to a state of symbiotic functioning and to the experience of the omnipotent mother. A subsequent step in Novick's (1984) sequence involves appealing to another person in a further attempt to break away from the damaging dependency with the mother. In a way, the adolescent is hoping that a new person (i.e., an outside object) rescues him or her from the dangerous enmeshed relationship with their mother. However, Novick (1984) notices the adolescent soon splits (i.e., she or he sees the object as being *all bad*) and starts to see

the new object as an enemy onto whom he or she displaces all the hurt, anger, and disappointments that are originally felt toward the mother. This, in turn, leads the adolescent to return to idealize the mother and their dependent relationship ensues. The seventh event in Novick's (1984) suicide sequence evolves from the fact that displacement, the adolescent's main defense until this point, ceases to work and he or she experiences a breakthrough of extremely aggressive feelings toward the mother, resulting in an experience of loss of control over their impulses. Novick's (1984) cases reported being faced with a somewhat conscious choice between killing their mother or killing themselves. One adolescent specifically reported that prior to attempting suicide, she felt as if she was either going to kill someone else or herself.

The eighth step in Novick's (1984) sequence illustrates a desperate adolescent who starts to think of suicide as a way out of his or her developmental dilemma. During the ninth step, the suicidal adolescent is still feeling guilty about the aggression he or she feels toward the mother. Propelled by the unconscious need to displace the blame away from the mother, the adolescent seeks a rejecting, disappointing object in the outside world. In other words, by subconsciously provoking rejection from someone other than his or her mother, the adolescent ceases to view suicide as an aggressive act toward the mother. Because the adolescent no longer feels guilty about hurting the mother, the suicidal act can finally occur. The remaining steps describe how suicide is thought to provide a sense of control over people

(i.e., enmeshed mother) and external events, and a sense of calm and release from built-up tensions. Novick (1984) also noticed that in all his seven cases, the adolescents were unaware of feelings of guilt associated with their parent. Also, they were in denial of the reality of death. Unraveled in a psychotic state, they viewed death unrealistically and thought that they had the ability to survive the suicide and only kill certain aspects of their self. In fact, in most of the cases, the adolescents shared the contradicting thought that, once dead, they still hoped to be around to enjoy the benefits of their act.

Wade's (1987) research also builds on Mahler's developmental theory of separation-individuation. Specifically, the author attempts to frame suicide as a resolution of the

separation-individuation process in teenage girls. The author believes that suicide is a borderline phenomenon that stems from faulty separation-individuation processes. The term *borderline* in Wade's (1987) study does not necessarily reflect the DSM personality disorder, but rather, it refers to McWilliams' (2011) level of character development. A person who functions at a borderline level is a person whose sense of self and others is fragmented and unstable, and who relies on primitive defense mechanisms such as splitting. These individuals will have trouble in relationships because of their fear of engulfment and abandonment. The work of Masterson (1981) and Rinsley (1982) has shown that the borderline syndrome originates from disruptions in the rapprochement subphase of the separation-individuation process (as cited in

Wade, 1987). Specifically, individuals who develop a borderline character often have mothers who also function at a borderline level. That is, the enmeshed relationship is perpetuated intergenerationally, as the borderline mothers — unable to separate from their own mothers — continue the symbiotic relationship with their own daughters. Because the child's mother cannot tolerate separation, when the child separates in the rapprochement phase, she will withdraw her emotional support. In other words, the mother's support becomes conditional during this subphase, as she will only maintain her availability if the child is dependent. Thus, the child is faced with a dilemma in which she or he must either completely lose the mother-child relationship, or give in and endure the enmeshment of the symbiotic relationship.

Using the Separation Anxiety Test (SAT, Wade, 1987) and the Diagnostic Interview for Borderline Disorder (DIB, Wade, 1987), Wade hypothesized that the currently suicidal girls were more likely to be less individuated and more symbiotically attached than the girls in the non-suicidal group (i.e., the girls who were not currently suicidal). Also, the authors expected suicidal girls to generally score higher on the borderline measure. The results confirmed the author's predictions and the theory that suicide is often the result of disruption in the rapprochement period of the separation-individuation process. In fact, on the SAT, the girls in the suicidal group scored significantly higher on the Hostility and on the Attachment subscale, and significantly lower on the Individuation scale as compared to girls who

were currently non-suicidal. The suicidal group also scored significantly higher on all but one subscale (i.e., Social Adaptation) of the DIB, suggesting that borderline syndrome is more present in currently suicidal individuals. The findings are congruent with the idea that disruption in the rapprochement phase of the separation-individuation phase, characteristic of the borderline level of character development, underlies suicidality.

Richards (1999) attempted to examine internalized relationships in suicidal individuals. Her study design was mixed: she collected data from 100 psychotherapists of a psychodynamic orientation through a questionnaire, and then interviewed five of them. The most important part of the questionnaire was comprised of questions about the patient's object relations as

perceived by the psychotherapists. Specifically, the clinicians were asked to report their impression of their client's relationship with his or her mother and father. Three scales — ranging from 1 to 8 on a spectrum of bipolar adjectives — were used to describe the early relationships: (a) engulfed-unconnected, (b) abandoned-invaded, and (c) overprotected-neglected (Richards, 1999). The results showed a few major themes: abandonment (i.e., either by rejection or engulfment), internalized relationship, and rage.

Over half of the patients perceived their mothers and fathers as rejecting (Richards, 1999). A significant number of patients experienced their parents as engulfing, domineering, intrusive, and anxious. Both parenting styles seemed to trigger the feeling of

abandonment. Specifically, Richards (1999) reported that many patients were described as experiencing their parents as being involved with them in a way that was sanctioning the needs of the parents and not those of the child. This is consistent with the idea that the development of a false self (Winnicott, 1960), which is one reaction to the parental interference with the process of separation-individuation (Kramer & Akhtar, 1994), is a possible precursor to suicide.

Moreover, twenty-nine out of the 33 participants who answered that part of the questionnaire, reported that their suicidal patients presented with hostile internal objects, resulting in suicide or suicide attempts (Richards, 1999). This is consistent with the hypothesis that faulty introjection and

identification, which are characteristic of internalized hostile object relations, play an important role in the dynamics of suicide. Rage was another main theme that emerged from this study. In fact, the therapists reported "rage and anger at their significant objects" (Richards, 1999, p. 94) to be the most important motivation for suicide in 93% of their patients. This is consistent with the idea that suicide involves a wish to kill the hated object, which is perceived as an enemy (Maltsberger & Buie, 1980; Menninger, 1993), and can be conceptualized as the result of anger — originally directed toward the object — turned inward (Freud, 1922).

Transference and Countertransference

Suicide, the tenth leading cause of death across all age groups in the United States (CDC,

2018), is a common phenomenon in the clinical populations and most psychotherapists will work with suicidal patients or will lose a client by suicide over the course of their careers (Chemtob et al., 1988). Suicide is often experienced by clinicians as a therapeutic failure and suicidal patients are usually considered to be one of the most stressful populations to work with. In fact, clinicians working with suicidal patients report anxiety, anger, sadness, a sense of guilt, and loss of self-esteem (Chemtob et al., 1988; Menninger, 1991).

In her 1999 study, Richards (2000) examined the nature of the therapeutic relationship with suicidal patients in 35 psychotherapists of a psychodynamic orientation. Specifically, she focused on the type of transference and countertransference. The author defined

transference as a process in which the client's previous experiences — including wishes, expectations, and feelings — are played out with the psychotherapist in therapy (Richards, 2000). *Countertransference*, on the other hand, can be defined as any reaction to the patient on the end of the therapist. Her findings suggest that the themes associated with the patient's early relationships (i.e., abandonment by rejection or engulfment, anger) also emerged in the transference and countertransference relationship. Thirty-one percent of therapists reported that the patients showed a dependency on the therapeutic relationship, and 20% observed a patient's strong need to be loved and valued. However, the therapists also reported that the patients experienced "fear and hatred of the dependent relationship upon the therapist" as

they perceived it as ending in rejection or engulfment, thus abandonment (Richards, 2000, p. 330). This type of transference is congruent with the idea that suicide is the result of disrupted early child relationships, and that it is a borderline pathology (Novick, 1984; Richards, 1999; Wade, 1987). Moreover, Richards (2000) reported that the most common feelings experienced in the countertransference included: a sense of failure, hopelessness or helplessness, distress, feeling upset, sadness, and anxiety. This is consistent with the literature on psychotherapists' reaction to suicidal clients (Chemtob et al., 1988; Menninger, 1991).

Chapter 3

The Study

Rationale for the Study

A paucity of studies have attempted to examine the hypothesis that suicidal individuals have pathological internal object relations originating from problematic early parent-child relationships. Maltsberger and Buie (1996) reviewed several cases of suicidal patients and identified frequent disturbances in the mothering relationships that disrupted the developmental process of separating and tolerating separation from the mother figure. In line with this research, other studies have shown the importance of stunted or failed separation experiences in relation to suicide (Novick, 1984;

Richards, 1999; Wade, 1987). The results from the most recent study on the psychodynamics of suicide (Kaslow et al., 1997) have also supported an object-relational view of suicidal behavior. A mixed-design study on the experience of psychotherapists working with suicidal patients also explored this phenomenon through a psychodynamic lens (Richards, 2000). Kaslow et al.'s study (1997) is a quantitative study in which data was collected directly from the hospitalized suicide attempters. The majority of the aforementioned studies are case studies (Maltsberger & Buie, 1980; Novick, 1984; Richards, 1999), and are exploring the early relationships of adolescent suicidal individuals (Novick, 1984; Richards, 1999; Wade, 1987).

The current study is an interpretative phenomenological analysis on the etiology of suicide as it relates to early relationships in adult individuals. This qualitative study aims to observe

relational patterns not only in individuals who have completed or attempted suicide but also in individuals who suffer from severe or chronic suicidal ideation. By interviewing clinicians about their suicidal cases, the author examined the relational history of the suicidal individuals from a psychoanalytic and object relational perspective. Specifically, based on a priori literature review, the author was expecting to find a pattern of pathological internal object representations in suicidal individual, as well as a history of disturbed parent-child relationships, and a stunted separation-individuation developmental experience. It was also expected that these idiosyncrasies would transpire in the therapeutic relationship.

Contemporary psychoanalytic thought emphasizes the importance of the intersubjective field of therapy, which includes the mutual influence of transference and countertransference

interactions (Stolorow, 1997; Stolorow & Atwood, 1996;). Bringing about insight through interpretations of the patient's past, or making the unconscious conscious, is no longer the only focus of psychoanalysis (Mitchell, 1988). The experiential dimension of therapy, what Stern calls the *implicit relational domain*, is where therapeutic change occurs (Stern et al., 1998). The author believes that the phenomenological design of the present study provides an opportunity for more adequate consideration of this experiential dimension, which is a fundamental component in contemporary psychoanalytic theory and treatment. In fact, as opposed to Richards' (2000) mixed-design study, which targeted transference and countertransference phenomena, the current project aims to explore the therapists' overall experience of the patient, which includes diagnostic impressions, early life relationships, and later life relationships,

including countertransference. The open-ended nature of the questions allows for the participants' experience of the patient to always be the focal point.

Method

Participants

The sample consisted of 8 licensed clinicians with a psychodynamic/psychoanalytic orientation. The authors used a demographic questionnaire to screen for inclusionary criteria and to ensure that the clinicians possessed adequate professional experience and knowledge. All participants met the inclusion criteria of being licensed clinicians, having a psychodynamic orientation, and having received psychodynamic training. The participant pool consisted of 5 males and 3 females. Seven out of the eight participants were licensed psychologist

(i.e., PhD, PsyD) and one participant was a licensed Marriage and Family therapist (LMFT). Five clinicians were over 55 years old, and the other participants' age ranged between 30 and 55 years old ($\bar{x}$ = 54.5, *SD* = 13.06, range = 34). Six clinicians identified as Caucasian, one clinician as multiracial, and one as Hispanic. All clinicians reported having been licensed for longer than 4 years, four of them reported having been licensed for longer than 25 years ($\bar{x}$ = 18.8, *SD* = 13.47, range = 32). All clinicians received psychodynamic/psychoanalytical training and described their orientation as being psychodynamic/psychoanalytical. All clinicians reported having worked with the case they presented for more than 3 months and four of them reported having worked with their presenting patient for over a year ($\bar{x}$ = 30.5, *SD* = 60.58, range

= 177). Table 1 contains descriptive data for each clinician.

Table 1
Participants' Data

#	Gender	Age	Ethnicity	Degree	Licensed	Orientation
1	female	66	Caucasian	Psy.D	36 years	psychodynamic
2	male	33	Caucasian	Psy.D	5 years	psychodynamic
3	male	49	Caucasian	Psy.D	4 years	psychodynamic
4	male	63	Hispanic	LMFT	29 years	psychodynamic
5	female	67	Multiracial	Ph.D	9 years	psychodynamic
6	female	38	Caucasian	Psy.D	9 years	psychodynamic
7	male	58	Caucasian	Ph.D	25 years	psychodynamic
8	male	62	Caucasian	Ph.D	34 years	psychodynamic

Patients' data

Among the cases that were presented by the participants, the mean age of the patients was 48.25, with a standard deviation of 15.97 and a range of 46. Five of the patients were females and three were

males. All patients were described as Caucasian. Four patients were described as having severe/chronic suicidality with no attempt but possible hospitalization(s), 3 patients were described as having severe/chronic suicidality with a history of attempt(s), and 1 patient was reported to have had completed suicide. Table 2 contains patients' data.

Table 2
Patients' Data

#	Gender	Age	Ethnicity	Time in Therapy	Suicidality Status
1	Female	71	Caucasian	10 months	attempted
2	Male	38	Caucasian	18 months	attempted
3	Female	68	Caucasian	5 months	attempted
4	Male	49	Caucasian	3 months	severe suicidality
5	Female	35	Caucasian	6 months	completed
6	Female	25	Caucasian	12 months	severe suicidality
7	Female	55	Caucasian	15 years	severe suicidality
8	Male	45	Caucasian	10 months	severe suicidality

Recruitment

Participants were recruited through the help of Lawrence Hedges, PhD, PsyD, ABPP, a senior psychoanalyst and suicidality expert, and the founder of the Newport Institute of Psychoanalysis. Dr. Lawrence Hedges agreed to assist the researcher with locating local psychodynamic psychotherapists to participate in the current study. Dr. MacMillin, a professor at The Chicago School of Professional Psychology at Irvine, also assisted the researcher during the recruiting process, by providing contacts of potential candidates. Moreover, the researcher utilized the California Psychological Association (CPA) and the Newport Institute of Psychoanalysis (NIP) to recruit participants. Both institutions gave the researcher permission to recruit participants through their institutions. An ad created by the author with the description of the study, the

inclusion criteria, and the researcher's contact information was sent to potential participants or posted on the CPA and the NIP listserv. Interested prospective participants contacted the author by email. After determining eligibility using a screening demographic questionnaire, the author set up meetings to conduct the individual interviews. Interviews were conducted via Skype, via phone, or in person, depending on the subject's preferences and availability. In circumstances in which the interview was conducted in person, the researcher met the participating psychotherapists at their private offices. Participants were informed that the interviews were to be audio recorded and transcribed for further examination. The clinicians were informed that all information will be kept confidential; any identifying information was de-identified and excluded during transcription to ensure confidentiality and to maintain the integrity

of the data. The author used a transcription service (TranscribeMe, 2019) for transcribing the interviews. TranscribeMe is fully compliant with Health Insurance Portability and Accountability Act of 1996 requirements for Medical Transcriptionists. To ensure inter-rater reliability, the transcripts were also reviewed by a second reader. The second reader was unaware of the study's aims and agreed to sign a confidentiality agreement. Upon completion of the semi-structured interview, a verbal and written debriefing statement was provided along with the researcher's contact information and any necessary referrals.

Measures

Demographic data for each of the participants were gathered prior to the interview via a questionnaire created by the researcher. This type of data included information on each of the

psychotherapist's age, gender, ethnicity/race, degree (i.e., MD, PhD, PsyD, LMFT), number of years of experience, and knowledge of psychodynamic theory as based on type of training. In light of the reviewed literature on the etiology of suicide, the researcher created a semi-structured interview instrument. The semi-structured interview was the principal method of data collection for this qualitative study. This interview consisted of 13 questions (Table 3). Clinicians were instructed to answer the questions as they apply to one particular case involving a suicidal patient. Questions focused on the nature of early relationships in suicidal individuals and their perceived separation-individuation disruption as experienced by their psychotherapists. More specifically, the researcher inquired about the quality of internalized object relations, the presence of a false self, the role of aggression and anger in the patient's suicidality, the

triggers of suicidal ideation and acts, and the transference and countertransference relationships. The researcher developed open-ended type of questions, allowing participants more spontaneity or freedom in their response styles.

Table 3
Interview Questions

Semi-Structured Interview Questions
1. Please provide a general description of your patient (i.e. age, gender, ethnicity).
2. Please provide a historical and present diagnostic picture of your patient (i.e. diagnosis, chief complaint, type of and reason for referral, history of mental illnesses, history of or current medical conditions).
3. Please describe the duration and type of treatment you provided.
4. Please describe the transference and countertransference relationship.
5. Please describe the patient's family of origin.
6. To what extent did early relationships play a role in the suicidality? (significantly low, somewhat significant, significantly high)
7. Please elaborate on the patient's object relations and attachment style focusing on the nature of his or her early relationships.
8. What were your patient's early childhood

experiences? (Did the patient experience emotional abandonment or misattunment either in the form of neglect, rejection, or engulfment?)

9. How was the patient's relationship with his or her early primary caregiver (i.e. mother, father, adoptive parents, grandparents) at the time of the suicide attempt?
10. Please describe your patient's adult object relations. How did/does the patient relate to others?
11. Please describe the patient's level of character development (i.e. neurotic, borderline, psychotic) both at "normal" functioning and when the patient was suicidal.
12. Are you familiar with the concept of false self by Winnicott? Were there issues of false self relevant to your patient? If yes, to what extent? Please elaborate.
13. Please describe the patient's suicidal history (i.e. number of suicide attempts, suicide completion if applicable, active and passive suicidal ideation, preferred methods, plans, triggers)

Data Analysis

Interview data was analyzed through interpretative phenomenological analysis (IPA), a type of qualitative study developed by Professor Jonathan Smith from the University of London (Smith, 2007). The IPA is a qualitative approach to

research that focuses on phenomenology, which is defined as the philosophical study of subjective experience. IPA aims to provide a detailed account of the participants' personal lived experiences and it is a useful approach for investigating complex, ambiguous, and emotionally-charged topics (Smith, 2007). IPA takes into account that different individuals experience and perceive the world in different ways. It attempts to understand the subjective meanings of experiences of each individual participant. While the subjective experience of the participants is paramount, IPA also recognizes the value of the investigator who has to make sense — or interpret — what the participant is sharing (Smith, 2007). The analytical part of an IPA study consists in a systematic search for themes arising in the transcripts.

In the present study, the researcher worked to identify specific themes or patterns within and

across interviews. Identifying data from the interview were omitted and numbers were assigned to transcripts to ensure anonymity and confidentiality. In order to ensure inter-rater reliability, second reader Dr. Lawrence Hedges, an analyst and psychologist with 50 years of experience, read the transcripts to assess for those same themes. The researcher briefly reported and explained the themes that were found to the second reader. Dr. Hedges was given an empty chart in which the themes were laid out and was asked to mark whether those themes were present within each individual participant's interview transcript. The investigator discarded themes that were not common and/or unsupported by the second reader. Eventually, for organization purposes, the author decided to group related themes together to form broader domains. At this point, the researcher was able to use the themes that arose to produce a theory

about, or explanation for, the phenomenon of suicide, drawing on examples from the participants' answers as evidence.

Chapter 4

Study Results

Themes and Reliability

Overall, the analysis revealed 8 specific themes that were grouped into 3 domains for organization purposes. The broad domains created were: the (a) Early Relationships Domain, the (b) Diagnostic Domain, and the (c) Later Relationships Domain. The two relationships domains (i.e., Early and Later) were comprised of two specific themes each, and the Diagnostic domain included four specific themes. The inter-rater reliability was calculated and revealed a 90% agreement between the two

raters. Table 4 lists the domains and the specific themes. Tables 5–11 provide additional quotes for each specific theme.

Table 4
Domains and Themes

Domain	Specific Themes
Early Relationships	Theme 1: Early relationships play a significantly high role in adult suicidality
	Theme 2: Emotional Misattunement
Diagnostic	Theme 3: Depressive features
	Theme 4: Anger
	Theme 5: False self
	Theme 6: Borderline features of functioning
Later Relationships	Theme 7: Relational triggers
	Theme 8: Resistance toward therapeutic relationship

Domain 1: Early relationships

Domain 1 concerned the quality of each case's early relationships with primary

caregivers. Below are the descriptions of the themes found in this domain.

Theme 1: Early Relationships Play a Significantly High Role in Adult Suicidality

The participants were asked one 3-point Likert scale question about the level of significance that early relationships played in their patient's adult suicidality. The options were (1) significantly high, (2) somewhat significant, and (3) significantly low. All participants except Participant #4 reported that early relationships, which refer to the parental or the primary caregiver's relationship, played a significant role in the suicidality of the patients. Participant #4 stated that early relationships were "somewhat significant" in regard to adult suicidality. However, the participant explained that the reason why he did not think the early

relationships played a significantly high role in his patient's adult suicidality, is because the therapist "[doesn't] think that [the patient] has internalized a secure object." The internalization of a secure object is the foundation for the development of a cohesive sense of self, which includes robust self-esteem in the face of disappointment (Kohut, 2009). A secure object is one that can be perceived omnipotent and attuned, a parental figure that the child can both admire and feel admired by. Thus, the internalization of the object is related to the quality of the object relationship itself (Kohut, 2009). In light of this answer, one could speculate that the inability of this patient to internalize a secure object is related to the lack of attunement in the early relationship. Therefore, even in this case it seems that early

relationships do play a notable role in the development of later pathology, including suicidality.

Table 5
Theme 1: Early Relationships Role Quotes

Participant	Quote
Participant #1	“I would say significantly high” “she had a very disengaged mother and felt rather insufficient in her worth in the eyes of her parents. And yet, it's natural to seek an attachment and to experience validation from those most important to you. And, by her report, that was not her experience. So that she would feel some closeness. And then, for example, her father would erupt in anger. And then, he was a frightening individual. And then, she would not be sure how much she could be close to and trust him, although he was the warmest, by her report, of the two parents. So I would guess her attachments were always tenuous and always guarded, although probably always with a sense of desperation for the attachment.”
Participant #2	“Significantly high. Obviously, he's molded by those relationships. But to back it up, I think, obviously, the dad attempted suicide. I think this lack of

	emotional support he got in the family. I think he tells his sister about feeling suicidal and she gives him all these things he needs to do to fix it. So I don't think there was much emotional warmth in the family. I don't think it was acceptable for the family to talk about emotions and to really support each other in that way. So I think he probably internalized a lot of it. And then this other thing too that I think was playing out with us of him not knowing how to depend on people and not knowing what's that like and how to do that. I think he developed this thing where he felt a lot of pressure in his life to perform. He felt a lot of pressure from the family to do things correctly and then he didn't know how to do it."
Participant #3	"Significantly high" "she was never given the basic capacity through many regulating activities of the caregivers to have that [self-soothing ability]… and kind of internalize that […] it's really that area for her is significantly weakened by those early experiences and potentially temperament from the beginning"
Participant #4	"I would say somewhat significant, and the reason being is that I don't think he's internalized a secure object."
Participant #5	"I would say significantly high" "the parents and the entire family suffered from alcoholism" "there was a lot of ambivalence and there was a lot of feelings of not being seen or heard or

	understood, and after her sister committed suicide the family sort of watched her like a hawk”
Participant #6	“Significantly high” “So there's a lot of just emotional dysregulation with her as an adult that I think has been a product of that not being properly identified and managed and contained early on in life.”
Participant #7	“Significantly high” “for most of her life I think the inner relationship in her mind and that she internalized from a mother who has emotional supplies she needs but they're withheld from her. And that fantasy doesn't really bear out. The mother just really doesn't have anything. There's nothing in the kitchen [laughter]. There's nothing to eat, so to speak. But she internalized a very kind of cruel, kind of uncaring mother image. And her father, again, is kind of like that exciting object who draws her into a lot of affection, but can't deliver. At the time that he was dying, she cared for him all throughout day and night, but he spent more time with the other sisters than her. And they were very close — I think I believe her — but it was almost like it was all for his gratification. And so I think she learned the inner object is one of, ‘I must be pleasing to get what I need, but I'll never get what I want.’”
Participant #8	“Significantly high.” “His father was reportedly a very highly regarded professional in his community. Extremely well-known. But was brutal

and violent towards his two children, [patient] being one of them, and [patient]'s mother. […] Domestic violence, physical abuse. […]very sadistic and tormenting psychological abuse as well."

Theme 2: Emotional Misattunement

All eight participants reported the presence of chronic emotional misattunment in their patients' early lives by the hand of their primary caregiver(s). Schore and Schore (2008) define misattunement as the inability of caregivers to anticipate or respond to child's needs appropriately. Although some misattunement is expected and inevitable, chronic misattunement without repair likely leads to long-term psychological damage (Schore & Schore, 2008). This emotional dismissal — or abandonment — was experienced in the form of either: (a) engulfment, (b) rejection, and/or (c) neglect. In

some cases, a hybrid of two or three different forms of misattunement was found. Two participants reported a purely engulfing primary caregiver (i.e. Participant #2 and Participant #5). Specifically, Participant #2 reported his patient's parents were controlling and overbearing and Participant #5 reported that the patient stated that the patient's family "hovered over her like a hawk." Participant #1 reported a purely rejecting object relation. Specifically, Participant #1 stated that her patient that had a "very disengaged mother," and an "angry, incompetent" father from whom the patient reportedly neither felt validation nor did she feel "sufficient in her worth in the eyes of her parents." One participant indicated a neglecting primary caregiver (i.e. Participant #8). Specifically, he reported that his patient's mother witnessed the

physical abuse perpetrated by the patient's father but did not attempt to stop it or protect her child in anyway. The other four participants reported a parental figure fluctuating between two or all of the dimensions of neglect, rejection, or engulfment. Participant #7 stated that his patient's mother was "highly narcissistic," and that his object relations fluctuated between the engulfing, rejecting, and neglecting dimensions. Participant #3 and Participant #6 described their patient's object relations as both engulfing and rejecting. Participant #3's patient was reportedly parentified and used as a mirroring object by the hand of his mother. Participant #6 shared that her patient's mother and religious community fostered both an engulfing and rejecting emotional climate. The patient, as per report, was unable to "be herself," and struggled with

the "contingencies" of her mother's love and acceptance. Participant #4 identified his patient's object relations as both engulfing and neglecting, and shared that his patient's mother often used him as a self-object. Moreover, the participant added, the patient maintained a "symbiotic relationship" with his mother that became "parasitic" and stunted the development of the "patient's true self." This latter description is describing a typical problematic "separation-individuation" presentation, in which the caregiver, whose needs are put before the child's, is unable to match the individual's developmental need of separation (Kramer & Akhtar, 1994; Mahler, 2000). The descriptions of the other caregivers as narcissistic, engulfing, rejecting, neglectful are also risk factors for problematic separation-individuation processes

(Kramer & Akhtar, 1994; Mahler, 2000). Table 6 provides additional quotes for this specific theme.

Table 6
Theme 2: Emotional Misattunement Quotes

Participant	Quote
Participant #1	"She had a very disengaged mother and felt rather insufficient in her worth in the eyes of her parents. And yet, it's natural to seek an attachment and to experience validation from those most important to you. And, by her report, that was not her experience." "For example, she, I think, was offered a college scholarship for her academic abilities. But she was told she could not accept that because her brother would feel badly because she would have outshone them. And so, her worth was recognized, and then, rejected."
Participant #2	"He probably felt like his parents were overbearing and a little controlling" "He describes relationships as being a lot of burdens."
Participant #3	"She's had abandonment in terms of unpredictability of the parental figures early on and then […] at the age of seven or eight, really took on a role of caregiving for her siblings." "But also by late childhood, [her mother] was

	also significantly involved, the mother would involve her in discussion about her own difficulties. Clearly, something that a mother wouldn't normally relate to a 9 or 10-year-old daughter in discussing. […] So definitely, the scripts were reversed."
Participant #4	"I think his mother used him as a self-object. It was reversed, he was the emotional reservoir for the his mom." "Whenever a child is used as a self-object, they've been abandoned, so it may not be the way we think of abandonment, but the child's true self was never really allowed to develop in a healthy way, and the symbiotic relationship that was created between the mother and the child is parasitic." "The abandonment of his father with the alcoholism and not being empathically attuned."
Participant #5	"She and the mother were pretty enmeshed" "There was a lot of ambivalence […] feelings of not being seen or heard, or understood, and after her sister committed suicide the family sort of watched her like a hawk, her mother especially, hovered over her like a hawk."
Participant #6	"In terms of her mother, I think that there was a lot of anxiety, guilt, and shame that was inadvertently put onto the patient early on and adopted by the patient that's actually her mothers. And her mother, having difficulty being able to withstand the patient being herself, expressing herself, individuating in her own way, that

	would incorporate anger, hate, sadness, resentment, irritability, kind of the uncomfortable, negative emotions that every single human has and, especially, every child has different individuation points and developmental milestones."
Participant #7	"The parents were pretty neglectful. I guess, in spite of having all these children, the mother never wanted to have children."
Participant #8	"Like the babies who are provided with adequate food and clothing and shelter, but don't receive sufficient love. I think it was probably something more like that. I think it was the absence of attachment, the absence of nurturing. There was an ab— that's how he described his childhood and that's how he presented as somebody who really could not see it in other people, transferentially."

Domain 2: Diagnostic Domain

Domain 2 concerned themes that more directly involve the clinician's judgment and observation, such as diagnostic impressions. Below are the descriptions of the themes found in this domain.

Theme 3: Depressive Features

One of the interview questions asked participants to share their DSM-5 diagnostic impressions of their patients (American Psychiatric Association, 2013). Four participants reported that their patients suffered from Major Depressive Disorder (Participant #3, #5, #6, #7). Participant #1 and Participant #4 reported diagnosing their patients with Persistent Depressive Disorder. Participant #2 reported that their patient had an unspecified depressive disorder (American Psychiatric Association, 2013). Participant #8 stated that his patient reported a history of pharmacological treatment of depression. However, the participant shared that he did not diagnose the patient with any disorder, as he reported not believing in the "diagnostic number culture." Overall, this theme

supported the notion that depression is linked to suicide (Bertolote & Fleischmann, 2002).

Table 7
Theme 3: Depressive Features Quotes

Participant	Quote
Participant #1	“She sought treatment for anxiety and depression”
Participant #2	“His chief complaint at that time was depression. And he was feeling suicidal.”
Participant #3	“So, a history of major depression. That is also the current diagnosis. It's major diagnosis in partial remission.”
Participant #4	“I gave axis 1 diagnosis of dysthymia, with concurrent major depressive episode.”
Participant #5	“Her diagnosis was alcohol abuse, severe. And she was in early recovery, and she also had a diagnosis, I believe, of generalized anxiety disorder, and major depressive disorder.”
Participant #6	“So presently she's diagnosed with major depressive disorder, recurrent.”
Participant #7	“this is a person who […] presented and they're still in therapy, 15 years ago with major depression. And then, throughout her treatment, it was revealed that there was sexual abuse

	and trauma and emotional neglect throughout childhood and a very abusive marriage. And so, two other diagnoses, I don't know if they're exclusive or whatever, but is post-traumatic stress disorder, kind of along the lines of a complex PTSD. And then as things progressed, it's become a dissociative disorder with features of dissociative identity.”
Participant #8	“Diagnosis, on admission, at sort of intake was really kind of deferred because I didn't think he, on the one hand, fit into any sort of discreet diagnostic categories but was generally miserable, angry and probably fits some broad version of a narcissistic character” “I generally don't use the diagnostic number culture. I don't find it helpful and doesn't move the treatment forward in any particular way. He was referred to me by a psychiatrist who also could not really diagnose him. And had probably I think - it's been quite a while but if memory serves me had put him on a anti-depressant.”

Theme 4: Anger

Although the original interview did not include a specific question about anger, it was a theme that was reliably found in all participants

except for Participant #2 by both the investigator and the second reader. The investigator believes that the theme might have appeared in more transcripts had a question been included in the interview. In all the seven cases, the aggression of the described anger seemed to have a self-directed quality. Participant #1, #3, #4, #7, and #8 clearly described it as anger "turned inward." Participant #5 and #6 explicitly reported that the patients' anger was triggered by their relationships with their parents. All seven participants reported that their patients seemed to have relational triggers to their anger. In these cases the anger seemed to be displaced from the object onto the self. Participant #7 described his patient's suicidal threats as an attempt to "attack the object." Participant #1's statement about the patient's experience was: "[My patient] want[s]

to kill [their spouse], but [she] would never do that, so [she] is thinking about killing [her]self." Participant #8 reported that anger was an important component of his patient's suicidal threats, as it felt like they were made to "torment the object," or "out of spite." Table 8 outlines more quotes for this specific theme.

This theme is congruent with the traditional view of suicide being the ultimate form of anger and aggression turned inward (Freud, 1922). It also supports the mechanism of displacement in suicide, in which the unbearable feelings of hatred for the object are directed toward the self, which has internalized the object (Menninger, 1933). The wish to kill the object or the wish for riddance of an enemy (Maltsberger & Buie, 1980; Menninger, 1933) is also apparent. Therefore, this theme supports the conjecture

that suicide can be conceptualized as an effort to get rid of intolerable hostile introjects, or to free oneself from the internalized parental object (i.e., the enemy) that one has pathologically identified with. This also supports the seventh step in Novick's (1984) suicide sequence, in which the individual experiences a loss of control over the rage at the object and is faced with a somewhat conscious choice between "killing their mother" and killing themselves. This theme is also in line with Richards' (1999) study, which deemed anger toward the object to be the most important motivation for suicide in 93% of their cases. The idea of wanting to kill the object that one feels internal can be linked to the wish for separateness and individuation. Anger is in fact, a common denominator in the development of pathology originating from

stunted individuation process (Kramer & Akhtar, 1994). This is also supported by Wade's (1987) study, which suggested that suicide as a resolution of the separation-individuation process. Overall, this theme confirms the idea that suicide might be the product of self-directed anger and aggression, resulting from faulty introjections of pathological early relationships, in which separation and individuation processes were stunted.

Table 8
Theme 4: Anger Quotes

Participant	Quote
Participant #1	"I saw lots of reasons why she was not a high suicide risk but that there were likely these moments when she would suddenly be at a highly elevated risk. That would be when she was really angry. And then it would be self-directed." "And I once said to her, 'Usually, when people are really unhappy in a marriage, they get a divorce,' […] 'And here you are.' […] 'you want to kill him, but you would

	never do that. And so now, you think about killing yourself.'"
Participant #3	"So she […] will quickly go from rejection first to anger, which promotes more problems communication-wise to find any common ground. So there's that piece, which goes to anger first. […] The anger then, when the person really is making an obvious separation, the emptiness comes and a significant sense of sadness, worthlessness, helplessness sets in, and under the relational stress and the separation of these important figures, she definitely drops into suicidal thinking and pretty readily." "So, the anger seems to be a prominent feature, and though it is expressed both towards others — but, yeah. I feel like is a depressive process. Ultimately, the anger is turned inward or when she finds a really breath sense of belonging, connection or stability, that really triggers the more depressive piece."
Participant #4	"This feels to me — his inability to access healthy aggression developmentally — you hear about depression's anger turned inward. I think for my patient, this one actually may be that, the components of it."
Participant #5	"She hated going home for family. They had family barbeques a lot. She hated going there because everyone would get drunk and fight with each other."

Participant #6	Right now she's actually living with her parents because she doesn't have a job. Which is creating a lot of anger and resentment within her. And can be triggering of her depression at various times because she does not want anything to do with them and she needs space from them.”
Participant #7	“When he spoke about suicidal behaviors it was always because he was angry. It was always like a fuck you kind of: ‘you can't do anything about this. You can't help me.’ But it wasn't a complaint. It was an attack. […] And what he was expressing — and this is why it always felt really hostile and really sadistic — was because it would be directed at me… because you have failed me or because you have said something stupid or because I think you just got irritated with me, I'm just going to kill myself. And there's nothing you can do about it.” “to torment the object” “So it's in his mind was going to be a sadistic attack on me if he were to kill himself because he thought that would be more torturous for me.”
Participant #8	“No matter how safe she feels with me, that there still remains parts of her that feels like no one ever got her, and she's enraged about that. And so there's an underlying hostility that no matter how — it doesn't matter how safe or nice she thinks I am, there is parts of her that remain unreached and very kind of hostile and protected against any connection. But it's sort of

	surfacing through the anger and almost like…these upsurges of anger" "That kind of interjected form of the hated other, and, suicide, they can't attack the other so they kill themselves instead of it." "I'm thinking of all these times where she tests me, as killing herself, 'I'm going to have to kill myself, if you continue to — if people continue to not get me, and including you.' And then I get her, the hostility is lessened"

Theme 6: Borderline Features of Functioning

All participants except for Participant #2 and #4 reported that their patients presented with borderline features of functioning. This refers to McWilliams' (2011) levels of character development, in which *borderline functioning* is associated with a fragmented sense of self, a mix of mature and immature defenses, relational problems at the dyadic level, and an oscillating fear on the spectrum of the engulfment and abandonment dimension. Participant #3, #7, and #5 described their patients as mainly functioning

at a borderline level, Participant #1 reported that her patient functioned neurotically but had borderline features, especially when in a suicidal crisis. Participant #6 and #8 reported that their patients fluctuated between a psychotic and borderline level of functioning. This theme supports the idea that a borderline organization is a risk factor for suicidality. Because it has been speculated that a borderline presentation stems from disruptions at the rapprochement subphase of the separation-individuation process of development (Mahler, 1971), the presence of this theme also suggests the potential role of stunted separation-individuation processes in suicidal individuals. This is also in line with Wade's (1987) findings, which suggested that suicidal adolescents had a history of disruptions

in the rapprochement phase of the separation-individuation phase of human development.

Table 9
Theme 6: Borderline Features of Functioning Quotes

Participant	Quote
Participant #1	“She would mostly operate at a neurotic level but brittle enough that she would drop into that characterological state of the black and white thinking and the blame. And then would not direct it outward, would direct it inward.”
Participant #3	“This patient has borderline features. Doesn't meet full diagnostic criteria, but borderline features. And that's not necessarily something that is a diagnosis that is sent to insurance, etc., but for my own kind of understanding conceptually.” “Her functioning, or character functioning, I would say, it would be at a borderline level. And particularly, she responds under stress and can take a dip into more significant borderline functioning or less function.”
Participant #5	“She might have been diagnosed as borderline personality at some point in time in the future. I didn't diagnose her with that, but it's — she wasn't easy to deal with. She was avoidant of relationships. And then when she'd

	get into relationships she'd be a little bit demanding."
Participant #6	"[Patient is] in between organizing and borderline."
Participant #7	"It would have to be closest to borderline, like a complex PTSD." "She did that kind of borderline thing where they kind of won't tell you enough, but you're not convinced they're not going to do it, so you end up having the police go to their house and check on them."
Participant #8	"Definitely of the borderline/psychotic continuum"

Domain 3: Later Relationships

The third domain concerns themes regarding later life relationships patterns of the suicidal individuals. These include their current relationships and the therapeutic relationship. Below are the descriptions of the themes found in this domain.

Theme 7: Relational Triggers

All participants reported that the triggers to the suicidal ideation, attempts, or completion appeared to be relational. In other words, a relational disappointment would usually precede the suicidality. For the majority of the patients, romantic relational disappointments seemed to be the most common trigger (Participant #1, #3, #4, #5, #6, #8). Friendships and familial relational disappointments also were present. Even in the case of Participant #7, in which the participant reported that some of the patient's superficial triggers may have been related to personal career failures, the therapist shared that it was the sense that the patient "could not face his family with his failure" that was the driving force of the patient's depressive mood and suicidality.

The relational disappointments that would trigger suicidality might be either real or imaginary. In other words, it seems that it is what the person feels more than what actually happens relationally that is responsible for the suicidal crisis. In fact, an individual might interpret situations based on their own object relations. A perceived rejection, or misattunement of any kind, even when "imaginary" can therefore activate old wounds from childhood. For example, Participant #8 stated that when his patient would have an experience with someone and it simply would not "go the way he'd hoped it would go," the patient would become suicidal and would say that he did not want to live anymore because "people [did not] care." Participant #6 explained that although the triggers might have been

current relational experiences, his patient's suicidality was related back to earlier trauma by the hands of people in his childhood. These cases clearly highlight the importance of individual object relations and their role in suicidality, as it seems to be the internal representations originating from early life experiences that get activated in the face of current disappointments. Participant #1 and #4's cases, in which clearly pathological adult relationships appeared to be the trigger for suicidality (i.e., abusive partners), also support the importance of object relations in the role of suicide, as they demonstrate the adhesiveness of bad object ties (Fairbairn, 1952). The latter refers to the way pathological relational patterns are sought and engaged in again and again by an individual because they are familiar and because

they are the way the individual is able to connect, which is what libido is seeking (Fairbairn, 1952). The individual, therefore, is not just a victim of early experiences, but a co-creator and perpetuator of conflictual relational patterns, which if not safe, are at least known (Mitchell, 1988).

Overall, this theme introduced the role of later relationships in suicidality, which can be linked to the inner conflict that originated from traumatic, inadequate early relationships. This theme is consistent with the idea that adult individuals who were unable to develop soothing introjects — or healthy object relations — will experience an ego loss when faced with real or imaginary object loss such as relational disappointments (Kaslow et al., 1997; Maltsberger & Buie, 1980). This theme is also in

line with the most up to date data on the reasons behind suicide, which appeared to be *relationship problems* (Stone et al., 2018). It also supports the main idea of the seminal theories of suicidality, which held that suicide is an interpersonal phenomenon, in which the individual experiences a sense of burdensomeness or of disconnection from his social world (Durkheim, 1897; Van Orden et al., 2010).

Table 10
Theme 7: Relational Triggers Quotes

Particpant	Quote
Participant #1	"She lacked fundamental trust in her relationships, so that she would seek connection and fear connection and seem to have some success in professional relationships, where there was no strong emotional intimacy required…" "Her stance was when things got really difficult, the only way out of that marriage was to kill herself."

Participant #2	“It would be easier to kill himself than to face the shame and disappointment” “he felt like he wanted to die because he couldn’t face his friends, his family.”
Participant #3	“All these relational triggers, and especially, when it comes to men, romance, and other significant female friendships, there seems to be a regular pattern of her getting overly attached or kind of immersing herself in the relationship, getting enmeshed and overly involved, and then finding that any sense of the person turning away, resisting, or rejection completely throws her off track.”
Participant #4	“So the triggers, for him, are life and not being in a collaborative marriage. He's been happily married a long time.”
Participant #5	“I think the domestic violence she had experienced must've been a bigger trigger than she could ever speak about. Because when we would talk about that, she'd immediately change the subject, and it was hard for her to stay with that topic. And also, the idea of her sister's suicide was a big trigger.”
Participant #6	“The things that are the most triggering for her are relational and the fear of attaching, the fear of her rejection and abandonment, and symbolically of her re-engaging with the world and with others” “That is a trigger. Either with her parents, with family, with people in general or with

	somebody that she might be dating or with me [...] so it's both directly and indirectly related to her parents. They are not necessarily always a trigger, but relationships are, which is directly related to her earlier attachments."
Participant #7	"That that would be the biggest focus of her rage of killing herself, would be to have her mother know how bad she made it for her. That she couldn't live."
Participant #8	"He would have an experience with someone, and it didn't go the way he'd hoped it would go. And he would just think, 'This is why I don't want to live because people are so stupid. And I'm never going to have a good relationship because, basically, people don't really care.' So I'd say interpersonal relationships [were the trigger], generally, not just with me."

Theme 8: Resistance Toward Therapeutic Relationship

One of the interview questions prompted participants to describe their transference and countertransference when working with their suicidal patients. Because of the design of the study, however, observation of the participants' countertransference was possible throughout the

whole interview process. The countertransference feelings differed in every case, ranging from excessive worry and wish to engulf and protect the patient to annoyance at the devaluation and resistance to the interventions. However, all therapists appeared to report a sense that the patients were particularly resistant to either specific treatment interventions or to the therapeutic bond.

Participant #1 and #3 reported that their patients were resistant to the treatment itself and to the therapist's specific interventions. The other participants reported that the resistance was more directed to the therapeutic relationship per se. In all cases, however, the patients seemed to struggle with issues involving the attachment to the therapist. The patients seemed to protect themselves from attaching by either putting up

barriers, not trusting "being dependent on the therapist," devaluing or idealizing the therapist, and fearing the expectations of the therapist.

Table 11 provides quotes from the transcripts related to this theme. It appeared that all the patients struggled with the fear of both engulfment and abandonment. On the one hand, they showed up to therapy sessions consistently and wanting to be helped. On the other hand, they did not trust that the therapists could help them without later disappointing them relationally (e.g., engulfing/rejecting/neglecting them), and thus they would not easily comply with the interventions or with the therapeutic process, which involved the therapeutic relationship.

This theme is in line with Richards' (2000) findings, which suggested that, although suicidal patients presented a strong need to be loved and valued, they seemed to experience "fear and hatred of the dependent relationship upon the therapist," as they perceived it as ending in rejection or engulfment, thus emotional misattunement. The engulfment/abandonment fear that was observed in these cases is characteristic not only of the borderline organization (McWilliams, 2011), but also of the rapprochement subphase of the separation-individuation process of development (Mahler, 1971). This theme reinforces the idea that, because suicidal individuals present with borderline features of functioning and with fear of engulfment and abandonment, they might have pathological early relationships, which

significantly hindered the process of separation-individuation.

Table 11
Theme 8: Resistance Toward the Therapeutic Relationship Quotes

Participant	Quote
Participant #1	“And when I would propose to her alternative approaches, saying that my way of doing psychotherapy was not the only way, and offered alternative avenues to begin to tackle this, I felt thwarted by all of those offers. She shot all of them down. Sometimes she would give a little verbal agreement, but no real follow-through. So really would put up barriers.” “So treatment ended because I was saying to her, ‘We can no longer talk around the suicide or ideation. That is what we have to talk about. And here's why we have to talk about it and if you don't want to talk about it with me, there are some other ways that you can approach your depression and your anxiety. And with everyone that I've proposed to you, you have told me how it's not going to work. So now we're in this tiny place. So we have to figure out where we can go in the therapy from here.’ And then she called and canceled the appointment.”

Participant #2	“But the picture I got was of a parental figure that the patient believed he couldn't depend on. And so what I think was developing between us was this transference where the patient didn't see me as someone that he either felt comfortable depending on or wanted to depend on or knew how to depend on. And so throughout the treatment, the patient pretty much monopolized the conversation. He would come in, he would start talking, and he noticed that I was going to say something he would try to beat me to the punch. Or if I were to offer something, he would either make a comment kind of erasing what I said or making it seem as though he had previously already had that thought. He'd be like, ‘Oh yeah, that's what I had thought too.’ And then he would sort of take it for himself.”
Participant #3	“She thought it would be helpful to have more structure, but she [would] resist the very structure that she had asked for at the beginning” “Whether there’s an aspect of wanting to feel in control so she is guiding the process and bringing in what she wants to talk about and forgetting about me”
Participant #4	“That was my countertransference to him, ‘I'm getting irritated. This guy is very resistant. I'm getting annoyed. What the hell?’” “I would say, again, more on the avoidance style and because of his, I think depressive predisposition, he— I mean, I also called him out. ‘Why didn’t you call me

	this weekend?' On more than one occasions, I've told him, 'You don't have to go through this alone.' So his predisposition is to go in, to withdraw, versus reach out."
Participant #5	"It sounds like you had the push to act on the engulfing mother countertransference?" (Researcher) "Exactly, exactly, part of me just wanted to get in my car and find her, and just say 'come on, let's get a cup of coffee.' (Participant 5) "Maybe the missed sessions or her resistance that you sometimes felt, have you ever thought of that in terms of her being afraid of being engulfed again?" (Researcher) "Oh definitely. Definitely. And I felt like I had to walk on eggshells a little bit when we talked after she missed a session."
Participant #6	"The more she attaches to me and the more I attach to her, the more she's going to want to pull away and kind of break that attachment. And so yeah, I think it absolutely comes and goes."
Participant #7	"She was so schizoid and depressed that she felt like disdainful to me. It felt like as I would try to connect with her that she was like rejecting of me. I felt so inadequate and so ineffective, and yet I would learn later that it was so helpful or— so I really kind of experienced the counter-transference feelings of just rejection and hostility. These were probably more her defenses in warding off anything, any attempts to connect."

Participant #8	“It was generally speaking sadistic and hostile and attacking and devaluing. He saw me as a withholding, disinterested figure whom he hated. And devalued and despised. I mean I was really looked down upon. I think any time I presented with any kind of maternal kind of concern or compassion, he would then look down on me as this weak and helpless mother who couldn't protect him and was useless. And anytime I thought I had an idea that was maybe something he hadn't thought of or a point of view that he didn't agree with, then I was the aloof, superior, smug paternal figure who also and in that way would pose a certain kind of danger to him.”

Chapter 5

Integration of Literature and Study Findings

Discussion

The present study was conducted in an attempt to integrate existing empirical evidence and theoretical assumptions, and in response to the demand for greater knowledge on the etiology of suicidality from a developmental and relational perspective. Specifically, the paucity of psychoanalytic studies on the phenomenon of adult suicidality was what propelled the researcher to conduct the present study. The aim was to provide a more in-depth analysis of the

relational lives of suicidal individuals, which included individuals who died by suicide and individuals with chronic suicidal ideation and/or history of attempts. Semi-structured interviews were conducted with eight clinicians and later analyzed qualitatively through an IPA. The interview questions targeted variables thought to be relevant in regard to the relational dimension. Although the majority of the questions focused on early relationships, participants were also asked to elaborate on their patients' current relationships, which included the therapeutic relationship. More specifically, the participants were inquired about the quality of their patient's internalized object relations, the presence of a false self, the role that aggression and anger play in the patient's suicidality, the triggers of

suicidal ideation and acts, and the transference and countertransference relationships.

First of all, the results supported the speculation that suicidal individuals have pathological internal object relations, which are associated with a history of misattuned early relationships and stunted separation-individuation developmental experiences. The review of literature that preceded the conduction of the present IPA indicated that severe chronic misattunement on the part of the parent or primary caregiver is the precursor to problematic separation-individuation experiences (Kramer & Akhtar, 1994; Mahler, 1971, 1974). Findings from the present study suggested that parental misattunement was a significant piece of the suicidal individuals' history (Theme #2) and the participants deemed their patients' early

relationships to have played a significantly high role in their suicidality (Theme #1). In fact, two participants reported a purely engulfing primary caregiver, one reported a purely rejecting primary caregiver, and one reported a neglecting primary caregiver. The other four participants reported a parental figure fluctuating between two or all of the dimensions of neglect, rejection, or engulfment.

The work of Kramer and Akthar (1994) also suggests that some of the indicators of disrupted or inadequate separation-individuation experiences are: (a) faulty introjection and identification, (b) the presence of false self, and (c) the presence of unprocessed anger and aggression (Kramer & Akhtar, 1994). The themes that emerged in the present analysis included issues related to the presence of a false

self conditions (Theme 5), anger and aggression (Theme 4), and pathological object relations (Theme 1, 2, 7, and 8). Thus, it appears that this study confirmed the initial conjecture regarding the state of separation-individuation process in suicidal individuals. Based on the results of these findings, it appears that problematic separation-individuation experiences are a risk factor for suicide.

Another important theme that was found concerned the therapeutic relationship (Theme 8). All eight participants showed some sort of resistance to the attachment to the therapist. This finding is consistent with Richards' (2000), whose study showed the complex nature of the transferential and countertransferential dynamics with suicidal patients. Richards (2000) noticed that the cases he analyzed all shared a common

fear that the therapeutic relationship could result in rejection or engulfment. Although this variable might not be unique to suicidal patients, it does carry a more specific meaning in the context of their object relations. In fact, in the present study, the resistance that was observed involved a "push and pull," or fear and desire kind of dynamic. The latter is typical of borderline functioning, which constituted another of the themes that were found (Theme 6). Six out of the eight participants verbally reported borderline functioning or borderline features in their patients. However, it should be noted that, according to the second reader, this theme appeared in all eight transcripts. In other words, the second reader found borderline features in the diagnostic presentation of all eight patients. The lit review conducted prior to

this analysis indicated that borderline functioning — and the borderline condition — is associated with disrupted separation-individuation processes (Mahler, 1971; Wade, 1987). Thus, this theme further supports the conjecture that stunted separation-individuation processes are risk factor for suicide.

The analysis revealed an additional theme that seems equally noteworthy, as it appears to be providing another lens through which the phenomenon of suicidality can be understood. Seven of the eight participants reported a depressive disorder diagnosis in their patients. The participant who did not, reported not using categorical diagnoses yet stated that his patient had reported a history of pharmacological treatment for depression. The association between suicide and depression is not a novel

concept (American Psychiatric Association, 2013; Bertolote & Fleischmann, 2002). However, from a psychodynamic perspective, this theme is relevant and adds to the rest of the findings. From a psychoanalytic perspective, depression is viewed as stemming from early loss, which could manifest in obvious forms such as death or physical abandonment, but could also reflect chronic emotional misattunement (McWilliams, 2011). Introjection is believed to be the core defense of depressed individuals. As defined earlier, introjection refers to internalization of the object's attributes. In the case of depression, it is the most hateful aspects of the object that become internalized and part of the self. The self-hatred of depression is therefore explained as the individual's displaced object anger toward

oneself. Introjection allows the depressive individual to discharge the anger at the object without actually directing it to the object — as it is targeting the self. This dynamic is similar to the one behind suicide, which has been conceptualized as the ultimate act of self-anger (Freud, 1922). Because the present findings support the idea that suicide reflects a displaced aggression that was originally felt toward the object, the presence of the theme of depression is meaningful.

Clinical Implications

Given that suicide is the tenth leading cause of death across all age groups in the United States, and the second most common cause of death among college students (CDC, 2018), a more comprehensive understanding of the

etiology of suicide is of imminent value as it carries implications for treatment. Increased awareness of the psychodynamics of suicide is likely to be conducive to improved treatment outcomes in this population. Although it is hard to pinpoint what exactly causes a person to attempt suicide, many interpersonal factors are linked to suicidality (Stone et al., 2018). In fact, the most recent data on suicide suggests that relationship problems are the most common contributing factor to suicide (Stone et al., 2018). Specifically, the present study sheds light on the impact that early relationships with caregiver figures have in the development of suicidal ideation, attempt, and completion. Although a history of disruption in the separation-individuation stage of development and poor object relations do not always lead to

suicidal feelings, the link seems to exist. Therefore, when screening for and treating suicidality, clinicians should inquire about the patient's early history, focusing on the nature of his or her relationship with their primary caregiver(s). More specific clinical implications are grouped by the domains that arose in the present studies and are outlined as follows.

Early Relationship Domain

Firstly, clinicians should focus on the patient's early relationships and the emotional misattunement that was experienced. It is believed that by exploring early primary caregiver relationships, whether by simply encouraging it or indirectly through the use of the transference and the intersubjective field of therapy, the patient might begin to gain affective awareness of his interpersonal trauma. In other

words, the patient might begin to understand where his or her pain is stemming from, which could lead to a decreased use of displacement of the object hate, thus diminished self-hatred and suicidality.

Diagnostic Domain

Secondly, clinicians should scan for the presence of certain characteristics that might have both diagnostic and prognostic power and can inform risk assessment and treatment. These hallmarks include the presence of a depressive disorder, of borderline features or borderline level of character development, of anger, and of a false self. It is believed that a conceptualization that takes into consideration these features might be conducive to increased empathy and more accurate reflections and interpretations by the therapist. These, in turn,

would likely lead to subsequent increased moments of meeting and insight opportunities for the patient. These two phenomena, increased awareness and heightened connection with the therapist, are believed to constitute change in contemporary psychoanalysis (Mitchell, 1988; Stern et al., 1998; Stolorow & Atwood, 1996). Moreover, considering some of these features might be helpful while conducting a risk assessment. In fact, more severe depression, more impulsive anger and aggression, and lower borderline functioning could indicate higher risk in suicidal individuals.

Later Relationships Domain

The third major consideration with the suicidal population should concern the individual's current — or later life — relationships domain. Contemporary

psychoanalytic theory emphasizes the role that current relational experiences play on pathology. According to the relational conflict model (Mitchell, 1988) it is not solely the deprivation of generic infantile needs themselves that causes pathology, but the individual's later use of early experiences, memories, and fantasies to establish and maintain ties to significant others and be part of a subjective experience which imparts a sense of familiarity, safety, and connectedness.

Since most suicidal triggers are relational, as revealed by this analysis, observing the patient's current relational functioning in the context of childhood pain is likely a helpful tool for increasing both self-compassion and mentalization capacity in the suicidal individuals. The therapeutic relationship — which include all types of transferential,

countertransferential, and intersubjective material — is part of this realm. Clinicians should encourage exploration of the dynamic of the therapeutic relationship because this is the vehicle for understanding past relational trauma and for laying the foundation for a new relational experience.

In conclusion, a comprehensive understanding of the etiology of suicide is of imminent value, as it contributes to the literature and carries important clinical implications. Based on the results of this analysis, clinicians should focus on three factors that could be informative for the treatment of the suicidal individuals. These factors include: early life relationships, diagnostic features that indicate relational difficulties, and later relationships

functioning, which include the therapeutic relationship.

The Organizing/Symbiotic Trauma and Suicide

The results of this study suggest that suicidality is linked to disruptions in the separation-individuation stage of development (Mahler, 1971). According to Mahler (1971), this stage ranges from 5 months of age to later childhood, and is comprised of several subphases.

Moreover, as suggested by the literature reviewed, disruptions in the aforementioned stage are often a precursor of the borderline condition. However, this does not mean that suicide is a strictly borderline phenomenon or that disruptions in earlier phases of development

are not associated to suicidality. For instance, Hedges (2018) hypothesizes that different levels of suicidality are present in all ranges of functioning, and that the developmental stage at which trauma occur might inform the severity of the suicidality.

Using a Relational Listening framework, Hedges (2018) hypothesizes suicide completions to be associated with disruptions that occurred during the *Organizing Experience*, a period in development that ranges from birth to age 4 months that roughly corresponds to Mahler's symbiotic stage. Hedges (2018) explains that the organizing experience is marked with the fear of being alone and the fear of connecting, which results from having learned in early infancy that connection is dangerous. Individuals with emotional wounds originating from this early

developmental stage, Hedges states (2018), may turn toward suicide, or "toward the Call of Darkness of safe retreat, of rest, of the peace to be found in the unconsciousness of sleep and death" (pp. 43-44).

On the other hand, Hedges (2018) states that trauma that occurs in the following developmental stage (e.g., 4 months to 24 months) is mostly associated with suicide attempts. This phase, which Hedges (2018) refers to as *Symbiotic Experience*, overlaps with Mahler's separation-individuation stage. This developmental period is characterized by a pull toward individuation, which is hindered by the fear of abandonment and self-assertion; in other words, the core conflict underlying the borderline condition. Hedges (2018) proposes that it is the often unconscious hope of

impacting others and insuring that one's symbiotic — or Mahler's separation-individuation — needs can be met that motivates suicide threats, gestures, and para-suicidal behaviors.

According to Hedges (2018), trauma in later developmental phases accounts for less severe suicidal ideation or behavior. During the *Self-Other Experience* (e.g., 24-36 months) the individual needs are those of primal narcissism and suicide is less frequent "so long as one is feeling adequately affirmed in life" (Hedges, 2018, p. 50). In the *Independence Experience* (e.g., 36 months through adolescence), which corresponds to a neurotic level of functioning and relating, suicidal ideation and behavior may occur but they are rarely severe in lethality,

seldom long-lasting, nor used instrumentally for ensuring one's needs are met.

Limitations

Although this analysis is of remarkable value due to its clinical implications, there are various limitations to this study that need to be addressed in evaluating the findings.

As compared to other previously discussed qualitative studies on suicidal individuals (Novick, 1984; Richards, 1999; Wade, 1987), this dissertation utilized the largest sample. However, because the sample is only comprised of eight clinicians, it should be noted that the generalizability of these results is limited. Moreover, all the cases that were discussed by the participants were reported to be Caucasian.

Although there is no speculation that suicidality might present differently in different races, this sample characteristic might affect generalizability even further.

Another limitation concerns the measure utilized for data collection. The semi-structured interview that was used had been specifically developed for the purpose of this study. Although the measure was constructed in collaboration with the dissertation chair and underwent several revisions, it was neither tested for content validity prior to its initial administration, nor was it reviewed by a focus group or by an objective expert group. Therefore, it is likely that some questions may have not adequately captured the investigator's intent. For example, even though anger turned out to be a significant theme and was anticipated

as a relevant factor in the phenomenon of suicidality, there were no questions targeting this topic in the initial interview.

One could speculate that a more direct question could have helped the participants to articulate this theme more accurately. Although a limitation, the vagueness of the questions was also intentional to avoid suggestibility. In fact, no question directly asked participants if they perceived a history of problematic separation-individuation processes in their patients.

Another issue regards the potential influence of personal biases or over-familiarity with the topic. The influence of personal biases or over-familiarity with the topic should be noted and are likely to have impacted the quality of the data interpretation. In fact, questions included

specific psychoanalytical topics that, although familiar to the researcher, might not have been understood by the participants in the same way. Although having received psychodynamic training was part of the inclusion criteria, psychoanalytic concepts are not clear-cut and may be interpreted differently by different therapists. For example, Participant #1 reported not being familiar with the concept of "false self," which was ultimately one of the specific themes that were found (Kohut, 2009). Moreover, the researcher's lack of experience conducting a semi-structured interview might have affected the quality of follow-up questions, as there was uncertainty regarding the flexibility of modifying the pre-existing schedule. However, the investigator's inquiry mode evolved over time as a function of increasing

experience. This, in turn, depicts another limitation that must be considered when evaluating the study's validity.

Lastly, because there was no control group, another potential issue with the present study concerns whether the findings are specific to the suicidal population. In fact, the literature reveals that a history of problematic early child-caregiver relationships is common to most pathologies (Chapman et al., 2007; Dube et al., 2001). However, the findings of this analysis seemed to support the analytical hypothesis that suicide is the ultimate act of aggression displaced on the self but unconsciously directed at the object.

Overall, it appears that the study in question presents with a few limitations. Although some

were more crucial in scope, as they related to the validity of the study, these limitations did not negate the relevance of the findings, as their implications are promising and their value for future research is pivotal.

Future Research

Despite the limitations, the present study has significant clinical implications and adds to the existing body of literature pertaining to early relationships in suicidal individuals. The scarcity of psychoanalytic studies on the phenomenon of adult suicidality was the impetus for the researcher to conduct the present study. The goal of this analysis was to shed light on the psychodynamic etiology of suicide in the hope of developing more questions to guide further

research. Areas in need of future investigation are outlined in the following paragraphs.

As previously discussed, the current study's design was qualitative and did not include the presence of a control group. Overall, the study's findings were in line with the theoretical idea that the act of suicide is the result of self-directed anger — and aggression — that was originally felt toward the object (Freud, 1922; Kaslow et al., 1997; Maltsberger & Buie, 1980; Novick, 1984; Wade, 1987). However, the extent to which the themes that were found are specific to the suicidal population is unknown. In other words, it is possible that a non-suicidal individual could have a similar relational history to a suicidal individual, including similar disruptions in the separation-individuation experience. The principal investigator does not

believe that this possibility negates the relevance of the findings, as they confirm the existing conceptualization of suicide and because they have valuable clinical implications. However, future research could compare the presence and the intensity of this study's themes in both suicidal and non-suicidal individuals. It is expected that suicidal individuals might present with more severe manifestations of these factors, including more pathological separation-individuation history.

This research targeted various forms of suicidality, including individuals suffering from chronic and severe suicidal ideation, attempters, and completers. Although the psychodynamic etiology of this phenomenon might stem from similar variables, different factors likely separate non-attempters from attempters, and attempters

from completers. It is possible that it is the level of intensity — or severity — of the pathological history of the individual that differentiate these categories of suicidal patients. In other words, the more severe the disruptions in separation-individuation processes, the more pathological the object relations, the more likely an individual might attempt or successfully die by suicide. However, it is also possible that other factors influence the individual's level of risk or of suicidality. Studies have shown that impulsivity has been linked to suicidal attempts or completion (Klonsky & May, 2015; McMahon et al., 2018). In light of the present findings, it is believed that anger, which yielded a relevant theme in this analysis, could also impact the risk level of suicidality. Future studies could investigate the role of anger in

individuals who are completers as compared to individuals with a history of non-lethal attempts, or to non-attempters. Specifically, the intensity of the externalization of anger, or aggression, should be investigated, as that might be indicative of risk level.

The above outlined implications for future research only depict a small sample of what can be derived from the results of this qualitative analysis. Nonetheless, they emphasize the value of the current analysis, as questions pertaining to the variables affecting the suicide risk level can be formulated, as well as questions about what might differentiate completers and attempters from the chronic suicidal individuals. In conclusion, this study shows how significant qualitative research is for the advancement of the field of psychology, allowing for the

exploration of complex concepts that cannot be measured quantitatively.

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