Work in Progress

Women and Suicide: The Cry for Connection

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Work in Progress

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Women and Suicide: The Cry for Connection[1]

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Abstract

Suicide statistics reveal significant gender differences in patterns of completed suicide and suicide attempts. This paper examines these differences in the context of recent insights into the centrality of relational processes in women's development. Many women's suicide attempts reflect a reaching out to engage meaningfully with others and to repair relational disconnections, while completed suicide in women seems to reflect a conviction that there is and will be no hope for meaningful human connection. The quality of mutually empathic connection in the therapeutic relationship is emphasized in discussing the treatment of suicidal women.

This paper was presented at the Stone Center Colloquium on February 1, 1989.

This paper centers on a paradox — but one not unique to the topic of suicide. Virtually all discussions of suicide mention the most common statistical patterns in suicidal behavior, reported most often by sex, age, and race. They reveal the now familiar findings that three times as many men as women commit suicide, whereas women make three out of four suicide attempts. Black men commit suicide significantly less often than white men, while adolescent white males have the highest increase in rates of completed suicides. We will elaborate more on these and other such findings shortly. But what they suggest is that suicide is a *contextual phenomenon*, that patterns of suicidal behavior are rooted, in part, in dimensions of sex, race, class, and age. The meanings of an attempted or completed suicide to the individual involved, its likely precipitants, the life circumstances of the suicidal person, the ways the suicidal action is understood by others, all exist within a specific sociocultural context.

Yet, and herein lies the paradox, when *explanations* for suicidal action are made, they are typically presented in terms of noncontextualized, psychodynamically based, internalized phenomena. Few discussions of suicide refer to the relationship between the inner experience of the suicidal wish and the outer reality that shapes the expression of that experience. In much of the literature on suicide, the authors view race, class, sex, and cohort status as significant for explaining statistical patterns, but not the individual condition. By contrast, we hope to bring alive the contextual properties of suicidal action, focusing particularly on the impact of gender on suicide. Toward this end, we will build on the relational perspective of women's psychological development (Gilligan, 1982, 1990; Belenky, et al., 1986) and, specifically, on the Stone Center work as represented in working papers by Jordan, Kaplan, Miller, Stiver, Surrey, and others.

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[1] An earlier version of this talk was published in D. Jacobs and H. Brown (Eds.), 1989. *Suicide: Understanding and Responding.* Madison, Conn.: International Universities Press. Reprinted with permission of the editors.

These writers have proposed that women's psychological development evolves optimally through *action in connection*: the experience of actively contributing to mutually created and mutually-enhancing empathic processes. These ongoing experiences create a greater sense of zest, knowledge of self and other, capacity to act, greater sense of worth, and wish for more connection (Miller, 1986). As opposed to theories that postulate increased levels of psychological separation as the path toward maturity, Stone Center writers posit that the sense of one's capacity for participating in mutually generated and mutually-empowering, relational connections provides the groundwork for further psychological development and is the basic source of empowerment. Women, we believe, seek action in connection as the primary and necessary path of growth (Kaplan, 1988).

If a relational context is lacking — if a woman feels that her movement toward connection is met with avoidance, disdain, ridicule, or punishment — she will begin to constrict her relational world, and her sense of strength and integrity will diminish accordingly (Miller, 1988). Because of the centrality of connection in women's lives, we believe that the loss of hope in one's capacity to foster and maintain connection forms the core of women's suicidal ideation and action. For a woman, the decision to kill herself and thereby to abandon and destroy all relatedness stands in direct opposition to the core of her identity (Maltsberger & Buie, 1974).

The multiple meanings of suicide attempts

Only 5-10% of women who attempt suicide do eventually kill themselves (Simpson, 1976). Given the far greater number of suicidal attempts than completions by women, it becomes pivotal to understand the experience of the woman who attempts suicide as compared to the woman who completes suicide. Generally, the woman who attempts suicide is not of the same risk population as her sister who completes suicide. Nor is she similar to male attempters, as will be discussed shortly. The prototypical or modal woman who *attempts* suicide is a young, white, unmarried, heterosexual woman. She comes from a chaotic family with whom she is still living and has a history of chronic interpersonal conflicts and previous suicidal attempts. The prototypical person who *completes* suicide is an older, unemployed, married or widowed man, living alone. He is more likely to be alcoholic, to have made fewer suicidal attempts, to have more legal problems, and to have sought help less often. The precipitating event is often a humiliation sustained in the realm of employment or ill health (Hirschfeld & Blumenthal, 1986).

Striking in the above portrayal is the greater interpersonal embeddedness of the women who attempt suicide as compared to the men who complete suicide. The women are connected to others, albeit conflictively. The men are much more isolated. The women seem to be reaching out, the men to be pulling back. This distinction appears to be a function not so much of psychodynamic differences between *attempters* and *completers*, as they are described in the literature, but more of differing relational qualities between women and men. Men who attempt suicide, for example, tend to look much more like men who complete suicide than like women who attempt it. They tend to be living alone, to be socially isolated, and to link their suicide attempts to "loss of status" in the realm of paid employment. Generally, both male attempters and completers seem to have suffered an injury to their pride or sense of individual competence, while female attempters and completers seem to have suffered a major breach in their felt capacity for connection. For both the women and the men, there is a basic sense of utter worthlessness, but the *source* of that feeling differs markedly for each.

Consistent and compelling evidence in the literature demonstrates that young women's suicide attempts are embedded within relational disappointment or disruption. Many authors cite family quarrels, conflict, threatened loss or abandonment, or even a relational rupture on a hospital ward as common precipitants of women's suicide attempts (e.g., Weissman, 1974; Sifneos, 1978; Stephens, 1985). These attempts are often portrayed as expressions of wishes to manipulate, control, or fulfill unmet dependency needs generated by the women's inability to care for themselves. Such formulations are consistent with a developmental understanding of connection as need gratification; a suicidal attempt, in this framework, represents a desperate demand to receive that which is not forthcoming. However, if a clinician reflects back some version of that formulation to the client — implying that she is too needy, too demanding, too manipulative — this clinician risks reinforcing the client's worse fears about her relational failings.

By contrast, we would understand the motivation behind a suicide attempt as a desperate wish to be heard and recognized in an increasingly distant relational world. A therapist who understands the meaning of an attempt in terms of a last-ditch grasp at connection would likely center on helping the client value and trust her relational capacities and hold

on to the possibility of joining in a process of empathic connection.

Self-mutilation

Women who damage their bodies, most commonly by wrist-cutting, are often between the ages of 16 and 24. They show both similarities to and differences from women who attempt suicide. The most striking difference, in our experience, is that women who injure themselves are not so directly or overtly reaching out to repair relational disruption. Rather, they are making a desperate attempt to translate an unbearable sense of disconnection into a concrete, identifiable pain which they then can better comprehend and control. They tend to express their interpersonal pain more in terms of relational disengagement and to avoid the active relational conflict characteristic of women who attempt suicide.

Many women who mutilate their bodies are substance abusers or runaways with school problems. Many are in trouble with the law and/or have been sexually active from a relatively young age. A surprising number have been separated from their families in childhood due to hospitalization, foster placement, or parental death or divorce. They talk about "hating their own bodies and feeling forced into their fantasies and the acts of mutilation by their bodies" (Simpson, 1976). Typically, they fear abandonment, and at base, like their sisters who attempt suicide, are not committing an act of suicidal intent. These comparisons, however, are by no means absolute.

From a relational perspective, it is noticeable that the women who mutilate themselves often come from homes characterized by relational "foreclosure" and seem less able than the women who attempt suicide to sustain even an embattled connection. They are more prone to disengage or flee than to remain in a conflictful relationship. On the other hand, like the women who attempt suicide, they are engaging in an act (wrist-cutting) which is bound to draw them more closely into a relational world. There is a sense that the women who cut themselves are trying to address more an inner than a relational need — that they do not initiate their behavior out of a felt relational desire, but rather out of a need to get back in touch with their embodied selves as a preliminary step toward trusting the possibility of connection. Self-mutilation is "a form of reconnection with life," Simpson writes. "It is an act of anti-suicide to gain reintegration, repersonalization and empathic return to reality and life from a state of dead unreality" (1976, p. 292). It seems, in part, like a prelude to connection.

Literature on the etiology of wrist-cutting behavior is not too helpful in clarifying the relational history behind these women's sense of living in a dead reality of nonpersonalization. In general, it blames this problem on inadequate maternal parenting. It links daughters' difficulties to cold, distant mothers; maternal deprivation; or mothers who are dominant, hostile, critical, and involved in a pathological relationship with their daughters. Typically, it portrays fathers as timid, weak, and aloof, with minimal impact on their daughters' lives or self-destructive behavior.

Aside from the fact that clinicians hold mothers accountable for the majority of emotional difficulties in their children, the specific assumption here seems to be that the wrist-cutting daughters shun connection because of painful relational histories with their mothers. And yet, more recent research (e.g., Breyer, et al., 1987) has documented that women who attempt suicide and women who cut or otherwise hurt themselves do share some common history: the likelihood of being survivors of incest or sexual abuse. In some local hospitals nearly 100% of these women have an incest history. These women suffer traumatic relational wounds: they may feel alienated from their bodies, bear the shame of believing that they perpetrated the incest, associate connection with relational violation, or feel abandoned by their mothers because of the sexual abuse. Based on particulars of individual personality and family history, they may feel out of touch with their physical bodies or tempted to destroy them. Clearly, we do not yet understand all aspects of these self-destructive actions (Darche, 1990).

Women who mutilate their bodies may be acting more from a wish to understand and localize their pain than from a wish to die. This distinction became apparent in my work with a college student whom I was seeing as an administrator in conjunction with her ongoing therapy. At one point she began to cut her wrists; so we met to discuss the experience and to devise a contract which would protect her from further self-harm. After some discussion, we agreed to a contract that stated, "I promise that if I have a wish to hurt myself, I will immediately call the Infirmary and go there if requested to do so." We both signed, and I assumed that that would suffice, as such contracts usually do. Instead, several weeks later she again cut herself. When we met, she explained with great sincerity that she did not feel that she had broken our contract. Her actions had nothing to do with a wish to hurt herself — she only wanted the pain to go away. This distinction was essential for her

and generated a new contract, and an important piece of learning for me.

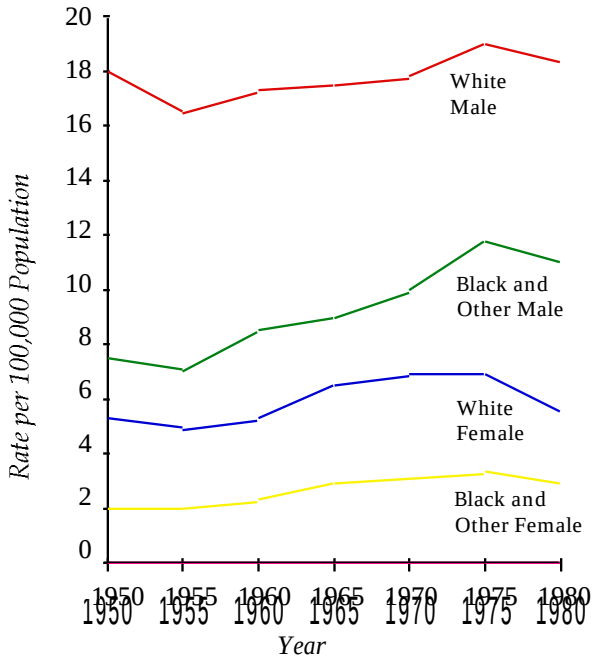
Statistical trends in completed suicide

Suicide statistics reflect dramatic patterns differentiated by gender (Centers for Disease Control, 1985, 1986; Kaplan & Klein, 1989). These important gender differences in suicide trends have not been sufficiently emphasized and studied so far. The need to do so is particularly important because in understanding them, we may gain a clearer understanding of how to prevent suicide by both women and men.

Not only is the suicide rate at least three times higher in men than in women — and this applies to all races — but the differential between male and female rates has been increasing steadily, as reflected in increasing male:female suicide ratios. As cited above, despite the reality that 70-80% of suicide attempts are made by women, women actually account for only a small percentage of completed suicides. Only 5-10% of the women who make suicide attempts will eventually complete suicide, while over 90% will go on to live out their lives (Clayton, 1983; Kaplan & Klein, 1989). These facts appear to indicate that women who complete suicide and women who make suicide attempts probably represent two overlapping but different groups — in relation to the *meaning* as well as the outcome of their behaviors.

The graphs in Figures l-4 demonstrate several important trends in completed suicides. Bear in mind, as you consider the information in the graphs, that important race-related suicide patterns are embedded within the data. They call for more intensive investigation and discussion than is possible in the context of this paper.

Figure 1
Age-Adjusted Suicide Rates by Race and Sex, United States, 1950 -- 1980



Source: Centers for Disease Control: Suicide Surveillance, 1970-1980, April, 1985, Figure 2, p. 24.

Age-adjusted suicide rates by race and sex

The graph in Figure 1 (this page) results from a breakdown for the period 1950-1980 of suicide rates per 100,000 population for white females, white males, black and other [sic] females, and black and other [sic] males. Several trends emerge from this method of looking at the data. First, not only are the male rates consistently higher than the female rates, but also the rates of suicide for white men and women are consistently higher than the rates for the black and other population. In fact, if we were to calculate the total combined white rate of suicide and compare this to the total combined black and other rate, we would find the white rate to be double that of the black and other rate. Furthermore, in looking at the curves over time, we can see that white males always have the highest rates, while black and other females always have the lowest. These suicide rates must be understood, however, in the context of recognizing the greater risk among black and other men of death due to other factors such as violence or the inadequate treatment of cardiovascular disease.

The rates of each of the four population groups peaked around the mid-1970s. They then declined for all groups through the remainder of the decade. However, more recent information reported by the National Center of Health Statistics indicates that if we were to plot out the data from 1980-1983 we would see the curves continuing to decline for the bottom three groups, while the curve for white male suicides would increase slightly (Kaplan & Klein, 1989, Table 14.1). It seems to be as true for suicide as it is for other aspects of modern life that the white male "is alone at the top."

Percent distribution of suicide by race and sex

The circle graph in Figure 2 (p. 5) emphasizes the magnitude of the suicide problem for white men in

comparison to other population groups. For the year 1980, white males carried out 70% of all suicides and white females 22%, while the remainder of the population accounted for less than 10%. These figures reinforce the need to understand suicide in the context of race as well as gender. We need to study and understand what it is about growing up black in this country that may contribute to the lower suicide rates.

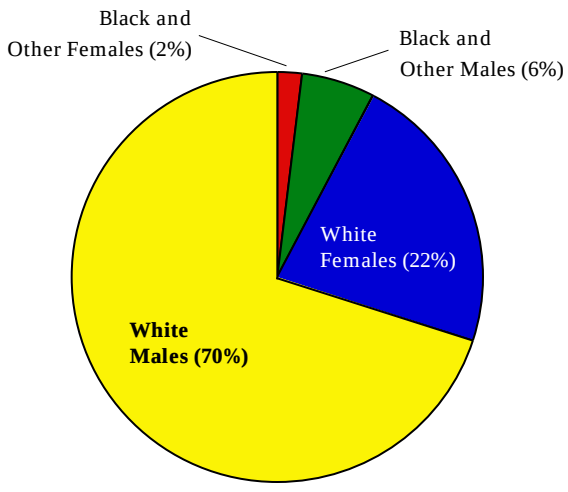
Percent change by age group and sex

Since the late 1970s both the lay press and professional literature have expressed much concern about what they call an epidemic of increasing suicide rates among young adults and late adolescents. However, the bar graph in Figure 3 (p. 6) demonstrates that the phenomenon of increasing suicide rates is not a generalized one. Rather, it is almost exclusively confined to late adolescent boys and young adult men. As shown, during the 1980s men below the age of 35 experienced an alarming increase in suicide rates: for males aged 15-24, a 50% increase, and for those aged 25-34, an almost 30% increase. Furthermore, if race had also been included as a variable, we would see that these increases represent primarily suicides in white males below age 35 (Centers for Disease Control, 1985).

By contrast, during the same decade, the only increase in female suicide rates was a 2% increase for 15-to-24-year-old women, while the rates decreased by 20-30% for women in all other age groups. Suicide statistics reveal other important age-related patterns. For example, age distribution curves for suicide and tables reporting suicide by race, age, and sex show that white women have their highest suicide rates in mid-life (age 40-55), while black and other women have their highest rates in young adulthood (Kaplan & Klein, 1989; Centers for Disease Control, 1985). However, even at their highest, the suicide rates for all women remain uniformly lower than those for men of any age or race.

Figure 2

Percent Distribution of Suicides by Race and Sex, United States, 1980



Source: Centers for Disease Control: Suicide Surveillance, 1970-1980, April, 1985, p. 26.

Comparison of labor force participation and suicide rates in women

Some suicide researchers have suggested that women will become more vulnerable to suicide as they enter the labor force in increasing numbers and thereby gain greater access to the educational and vocational opportunities and pressures previously reserved for men. These predictions foster a myth that female labor force participation correlates with increasing suicide rates in women. However, recent findings show that female employment correlates with decreased female vulnerability to a range of problems, including suicide, and that employment may, in fact, contribute to the prevention of suicide in women.

A comparison of the two graphs in Figure 4 (p. 7) reveals that the growth in the number of women in the labor force has not been accompanied by an increase in their rate of death by suicide. On the contrary, female employment seems to correlate with decreased female vulnerability to suicide. Although more study is warranted, the data suggests that increased female labor force participation may, in fact, help to prevent suicide in women.

The weight of the pervasive and consistent statistical differences between male and female suicide and suicide attempt rates raises many possible questions. One that is most pressing for our purposes is: Given that the incidence of depression is consistently at least twice as high in women as in men, and that depressive illness is the diagnosis most frequently associated with suicidal behavior, why is it that the rates of completed and attempted suicide in women are not higher? In a statistical sense, female

suicide rates are actually lower than would be expected. Ironically, the most intriguing question, especially in terms of effective prevention and treatment strategies, may be: What keeps women alive?

Key psychodynamic issues in women with and without suicidal intent

The Stone Center's concept of women's interactive sense of self clarifies that what women live for — what keeps us alive — are opportunities — (or at least the hope for opportunities) — to experience themselves as engaged in mutually responsive relationships (Kaplan & Klein, 1989). Moreover, we propose that the centrality of relational process in women's self-development provides women with a kind of internal *relational immunity* against suicide — a form of immunity that is less achievable within male development in this culture. In fact, if you think for a moment that a decision to kill yourself means willfully breaking all human connections and that to do so would be a direct violation of women's inner imperative to avoid hurting others (Gilligan, 1982), it is not so surprising that so few women kill themselves.

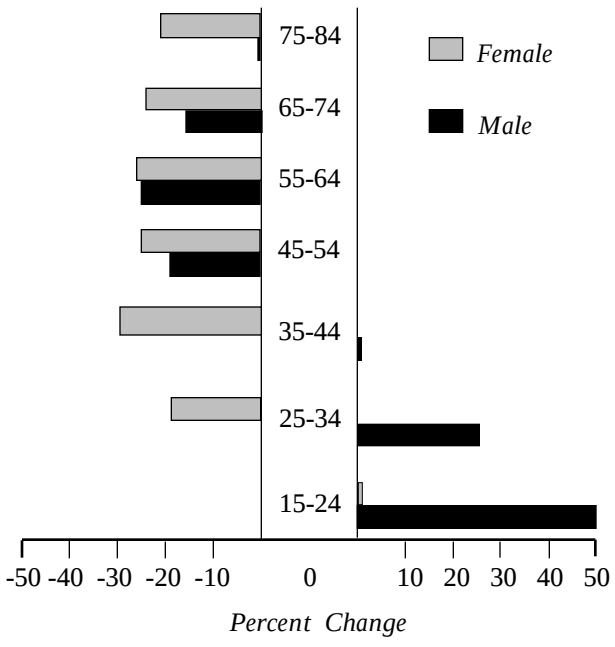
Now, given this notion of *relational immunity*, let us address the question: What then are the psychological and emotional forces that compel those women who do decide to kill themselves?

Our hypothesis is that the central dynamic in these women is a deeply felt, inner conviction or *reality conclusion* (Shein and Stone, 1969) that there is — and will be — no hope of engaging with others in the sort of relational exchange women need in order to maintain a sense of authenticity and meaning in life (Miller, 1984). In our clinical work with suicidal clients, we have found that a woman typically experiences such a perception of her personal reality as a total violation of her very being. It evokes within her intolerable feelings of annihilating aloneness or inescapable, eternal isolation, along with an overwhelming sense of self-loathing; the extreme painfulness of this experience tips the scales toward death.

Laura, a single white woman in her late 20s dramatically demonstrated a number of affective themes that we find to be characteristic of the inner psychological state of seriously suicidal women. These include: (1) relational disconnection, (2) intense aloneness, (3) extreme self-hate, and (4) overwhelming pain. These feeling states, which often take on a quality of urgency, are central in the dynamics underlying a suicidal crisis.

Figure 3

Percent Change in Suicide Rates by Age Group and Sex, United States, 1970 and 1980



Source: Centers for Disease Control: Suicide Surveillance, 1970-1980, April, 1985, Figure 6, p. 28.

Description:

For Laura, intense feelings of relational disconnection, aloneness, intensified self-loathing, and overwhelming pain occurred at a point in therapy in which she lost her sense of connection to her therapist. She became acutely and intently suicidal. It is important to clarify here that the loss Laura felt was not a loss of love or caring. She, in fact, believed that her therapist was working hard to understand her and help her. Rather, what was most salient was that Laura felt an acute inability to understand or empathize with her therapist's values and ideals.

This impasse was precipitated by Laura's misinterpretation of an aspect of the therapist's family life. This experience translated for Laura into feeling that her therapist (the one person with whom she had felt a truly meaningful connection) was really unknowable to her and, therefore, that Laura's own true essence must

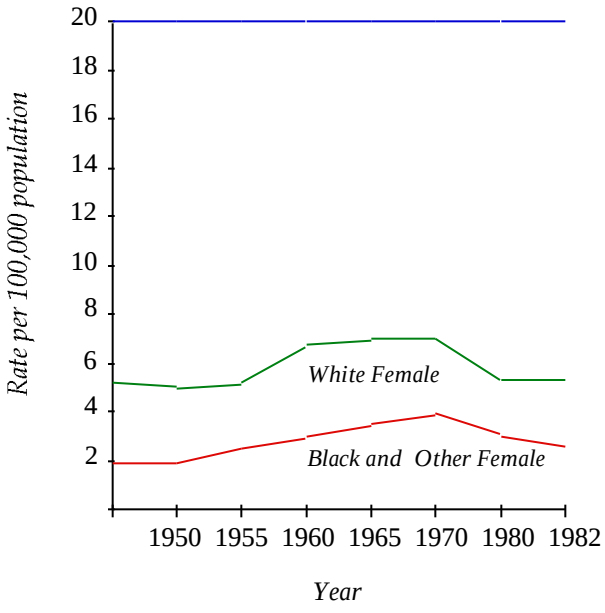
also be unknowable to her therapist. An expanding rift lay hidden between them over several sessions until the terror Laura was experiencing — of an unbreachable, unending void between her and her therapist — exploded in the form of an acute suicidal crisis. She could no longer see a reason to stay alive.

The disconnection within the therapy relationship intensified Laura's existing fears of being utterly ineffective in sharing her own subjective experience, and confirmed for her a growing inner conviction that she would never be able to express her innermost passions and values in a way that would allow others to truly know her. She would be condemned to stay adrift in a sea of unsharable pain and mandatory isolation. She said: "I am alone, so alone, like falling into an endless blackness:...no words are big enough to express the intensity of my life — so no one will ever be able to understand, and I'll be alone forever. All they will be able to see is a dirty, repulsive little girl. It's too much to bear....I feel trapped inside a dead, grey skin. It's like a walking death anyway!"

In seeking to understand the roots of suicide, recent theorists such as Buie and Maltsberger (1983) have stressed the role of developmental failures in the phase of separation. By contrast, we believe that the genesis of suicide in women evolves from problems in the development of relational connections. Recent findings in the field of infant research support our focus on the development of relationship rather than separation. The observations and formulations of Tronick and Gianino (1986) and of Daniel Stern (1985) indicate that babies engage in active relational processes from the earliest days of life; babies develop patterns of interacting and of coping with stressful interactions as early as three to six months of age. The nature of a baby's early interactions with its social

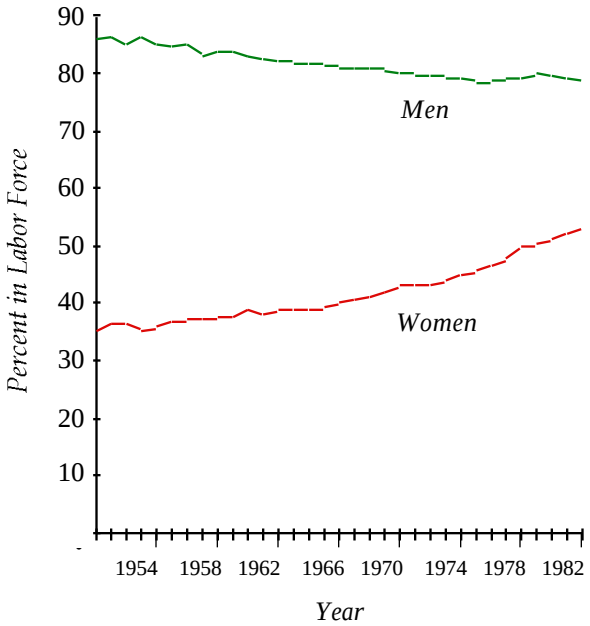
Figure 4

A. Age-adjusted Suicide Rates by Race and Sex, United States, 1950-1980



Source: National Centers for Health Statistics, Unpublished Data; and Centers for Disease Control, Suicide Surveillance, 1970-1980, April, 1985, Figure 2, p. 24.

B. Women's participation in the labor force has grown dramatically



Source: Chart 2, Labor force participation rates by sex, 1950-1982, Women at Work, A Chartbook, U.S. Dept. of Labor, April, 1983.

environment has important implications for the development of self-esteem, empathic abilities, and coping skills.

In speculating about the genesis of psychopathology, these investigators emphasize the contribution of internalized interactive patterns of — depending on whose jargon is used — faulty attunement (Stern, 1985), unrepaired mismatch (Tronick & Gianino, 1986), or what we would think of as relational disconnections (Miller, 1987; Stiver, 1989) — that is, relational exchanges characterized by a lack of mutual attention and responsiveness and decreased empowerment. To illustrate the experiences of relational disconnection that are prominent in the development of seriously suicidal women, we'd like to return to Laura and share with you some of her early history.

Laura's earliest experiences were colored by her vivid inner awareness of her family's pain and turmoil, which was centered around her hyperactive older brother and involved great hostility between Laura's parents. Laura's earliest relational experiences were mainly with her mother, Mrs. L., who, as the primary caretaker for her children, was subject to repeated, rageful criticisms from her husband. He held Mrs. L. responsible for their son's problems. According to Mrs. L., her own emotional state was usually one of consuming, impotent fury at her tyrannical husband and demanding son. She brought to her interactions with Laura an outward demeanor of cold, stoney, silent rage, and a consistent unavailability for entering into Laura's subjective experience. Laura felt the powerful influence of what she read as "the look of hate" in her mother's eyes, especially in the setting of her father's literal and emotional absence. By eight years of age, Laura began leaving her mother notes that indicated that Laura was spending a great deal of time worrying about her mother — wondering what she might have done to make her mother hate her and what she could do to make her mother "less tired and happier." At nine she wrote, "Mommy, I feel so sorry for you...every night I pray that you wouldn't have so much work and that I will help you....You don't understand how much I love you so I promise I will always be good." Subsequently, on several occasions, Laura purposefully picked lesions on her face to try to demonstrate concretely "that something was terribly wrong in our house."

Unfortunately, Laura's parents proved repeatedly unable to recognize her pain. Mrs. L. stated that she always thought of Laura as her "sunshine child" who "could never have any problems." As a result of her continued inability to gain her parents' accurate attention and understanding, Laura came to feel as if they "did not want me to have feelings....If I didn't even deserve to have feelings, then I must be truly bad and undeserving." Over time, Laura became increasingly blocked in her ability to act within relationship and hopeless about ever finding a way to relate to others on the basis of her own feelings and perceptions.

Like Laura, those women who come to a conviction of relational hopelessness such that they give up trying to connect to other people typically experience repeated, painful, and serious disconnections in their early and continued self-development. These destructive interactions constitute the individual's inner view of herself as a relational being, resulting in what Miller describes as distorted, "narrowly constructed" images of "what actually occurs in both self and others and in the relationship between them" (Miller, 1988). As seen in Laura, such a distortion of relational development promotes a fixed view of the self as relationally paralyzed or incompetent, intrinsically bad and undeserving, and sentenced to a state of endless isolation. Thus, the stage will be set for later vulnerability to suicidal states of hopelessness, aloneness, and self-hate, particularly when the internalized disconnections are re-experienced over time and reinforced within current relationships.

In framing therapeutic interventions, it will matter a great deal whether the therapist views the core arena for work as separation or connection. For example, the therapist could have interpreted Laura's wish to die to be a pathological, childhood wish to merge with an omnipotent, idealized parent. Another avenue — the one taken — was to frame Laura's need to understand her therapist as evidence of a current, healthy yearning to connect within a mutually-responsive relational process. Helping Laura to put aside her intense wish to die — in essence to take a risk on living — meant helping her gain a renewed sense of hope for herself as a relational being through her interactions with her therapist.

Therapeutic implications

A developmental emphasis on the growth-promoting qualities of active, relational engagement suggests a therapy relationship with suicidal women in which they can reclaim their potential capacity for connection at a time when it may seem all but lost to them. This perspective goes beyond the position of such writers as Havens (1965) and others who stress that the first priority in working with a suicidal client

is to form a relationship. For us, the relationship is not just the first, but the central and continuing priority, the vehicle through which change and growth occur.

Recent papers which emphasize the importance of the clinical relationship in work with potentially suicidal clients have identified three main relational functions: to serve as a reliable vehicle for monitoring suicidality and reaching contractual agreements; to create a supportive, life-affirming, patient-therapist connection; and to foster the client's connection to a sustaining support system. Often, the first two points are interwoven — the supportive, life-affirming treatment relationship is emphasized until the first monitoring function has been accomplished. But from that point on, the relational emphasis recedes; the function of the relationship shifts to fostering the therapist's understanding of the patient's condition and assessing threats to life. Connection is a means to a defined end, not a basic and sustaining process. It is created primarily to empower the therapist (though not necessarily the client) in her or his understanding of relevant processes.

Alternatively, within a relational model, the experience for both client and therapist of joining in an empathic process of discovery is the heart of therapy and the primary path toward change. For all clients, active involvement in a mutually-evolving process forms the core from which comfort in connection, deepening strength from relational engagement, and sense of vitality emerge. However, for the suicidal client who despairs of her capacity to maintain connection or fears her destructive impulses, safety lies within a process that awakens within her the possibility of her own capacity to facilitate rather than destroy connection.

When therapists respond to suicidal clients in ways that evoke feelings of relational distance or destruction, they risk tapping into the clients' deepest fears about their utter worthlessness. It is crucial that the therapist not imply, directly or indirectly, that the client is relationally inappropriate, e.g., not properly engaging the therapist, being "manipulative," being "resistant." Although the client may be responding in ways that reflect anger, rebellion, threats, or distance, comments which, in effect, blame the client contribute to fears of destructiveness and may increase suicidal impulses. Such blaming usually stems not from clinical wisdom, but from the therapist's need to protect her/himself from the power of the client's affect. As Simpson (1976) notes, clinicians who conceptualize a suicidal patient as manipulative or resistant view the patient in terms of her impact on them, holding the patient responsible for the therapists' feelings of diminished control. Such challenges to the client's relational worth, however, clearly increase her potential lethality.

Therapy with suicidal clients, then, builds on the evolution of a mutually created flow of empathic resonance. For many suicidal clients, this can be a lengthy, protracted, and ambivalent course. Feeling incapable of sustaining relationship, they may respond with rage or distance, fearing to begin that which they believe they may not be able to sustain. And yet, of course, the process of engagement has already begun. Anger, silence, deviations from standard procedures are all messages that can be understood within a relational frame. Engagement with the client's affect regardless of its particular content, staying with the expressed feeling as the client begins to work with it, makes it possible for an atmosphere of safety to emerge. The client will experience her part in the deepening process, knowing that she is neither reaching out in vain for others, nor needing to protect herself from hurtful, destructive messages. Rather, the sense of being deeply understood legitimates and validates the feelings she is trying to communicate and propels her toward further awareness of her relational potential and further confirmation of her right to life (Miller, 1986).

It is especially important that suicidal clients who are survivors of physical and/or sexual abuse be affirmed in the validity of their experience and its impact on them. These women may suffer profound confusion about their role in the incest experience, harbor a deep sense of shame from implications of their complicity, and experience themselves as relationally fraudulent. A therapist's failure to hear and support their reality can produce serious consequences. Such was the case in the work of a male therapist whom I was supervising. He was treating a young woman who had had an incestuous relationship with her father's favorite cousin. Burdened by her felt need for secrecy, she tentatively began to explore the possibility of revealing the incest to her father. The therapist ignored her hesitancy and the complexity of her request and quickly urged her to talk to her father, assuring her that the father would understand. But the client was not convinced. Torn between loyalty to the therapist and her fear of the father's reaction, she made a major suicide attempt.

Suicidal incest survivors often hold themselves responsible for the abuse, which colors all aspects of their experience of relationality. Longing to be understood and respected despite their shame, they simultaneously fear that any serious attempt at relational engagement or expression of their own

authenticity will reveal what they believe to be their real, destructive selves. Work with these women requires a capacity to bear their fears and their pain, and to promote a mutual flow of increasing relational engagement.

We are suggesting that patterns of suicidal intent and action have a strong gender base that needs to be incorporated into any understanding of suicide. In particular, our emphasis on women's relational development suggests the need for a clearer understanding of the historical and relational worlds that suicidal clients bring to treatment. Suicide is gendered, not so much by method as by intent and degree of relational embeddedness. We need to recognize these qualities as part of a broad relational frame, so that factors such as a history of abuse and the client's capacity for connection are taken into consideration in working with women toward healing and re-engagement in the world.

Discussion Summary

A discussion is held after each colloquium presentation. Selected portions of the discussion are summarized here. At this session, Drs. Robin Cook-Nobles, Judith Jordan, Irene Stiver, and Carolyn Swift joined Alexandra Kaplan and Rona Klein in leading the discussion.

Question: In the cases you discussed, a breach with the therapist seemed quite dangerous. Can you comment on the necessity of fostering connection in the therapeutic relationship and helping the client to develop other connections as well?

Klein: Fostering friendships and working together on what it means to have and make friends are primary forces in therapy always, whether or not the woman is suicidal. Any woman who is suicidal yearns for connection. However, a good therapist-client relationship is so powerful that when there is a breach, it can lead to a suicidal crisis in some clients.

Kaplan: The importance of the therapist-client relationship with a suicidal client may leave the therapist with a heavy responsibility, given that we are dealing with situations which must be taken with utmost seriousness. On the other hand, the breach in both cases we discussed was repaired, suggesting we have to consider the ways through and beyond the breaches, along with the potential harm from them. The breaches can become poignant turning points and confrontations with deeper experiences that lead to growth.

Jordan: Especially with chronically suicidal patients, it is important for the therapist to have other connections because the suicide of a client is so awful. With such responsibility, therapists can feel helpless and blame themselves. In feeling shame, they may feel they have to hide and bear it alone. Being involved with others around this experience is very important.

Stiver: With patients who are not able to have relationships when they begin therapy, the therapeutic relationship creates an extremely vulnerable situation where the person risks for the first time. Anything can be a breach because the client becomes more vulnerable. Repairing the breach is a process in which hope becomes a possibility for the first time. Knowing this helps all of us get through this as therapists.

Swift: There is research that indicates that adult incest survivors who have confidantes to whom they can talk have overcome those issues more than those who don't have confidantes.

Comment: I'm struck by your talking about clients' expectations that the therapy relationship will fail, because I think, concurrently, they expect that the relationship will be perfect. There is a burden on both client and therapist in surviving the perfect relationship together, given all the ebb and flow of therapy. Sometimes the breaches are healed over the imperfections on both sides. This creates an opportunity to experience a real relationship with all its flaws, and especially as it survives despite mutual anger.

Comment: I'm fascinated by the social differences, particularly the black women who have the lowest rate of suicide, and I'm wondering if that is because black women have been in the workforce for a much longer time, or whether that has to do with their having increased connections.

Cook-Nobles: There has been little research on black women having lower suicide rates, but there is an interaction between the two. Even though black women have been in the workforce, they do not find the same achievement-related expectations from the larger society impinging upon them. Also, the interconnectedness within the black community and the connectedness among black women may contribute to the lower rate. However, while black women do have lower suicide rates, I don't want us not to worry about them.

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