A Psychoanalytic Thematic Analysis of what Primary School-based Staff say about Suicide-Communication in Socially Disadvantaged Children.

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I confirm that all names and identifying information has been changed to protect confidentiality.

SG MacDonald

Signed...

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To the troubled children who were ignition, fuel, and engine, to this thesis.

In appreciation of the participants who agreed to bear thinking and feeling further about these children.

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Dr Janet Smithson, Professor Judith Trowell, and Professor Stephen Briggs.

To my husband and our children.

In dedication to my father, a lifelong, qualitative, researcher.

Abstract

The challenge of preventing suicide remains an on-going domestic and global concern. Early intervention is indicated although dedicated research regarding suicide-communication (S-C) in children of primary school-age is sparse.

The research found impetus in primary school-based clinical practice, with suicide-communicating children from socially disadvantaged backgrounds. Sixteen primary school-based staff, including teachers, teaching assistants, pastoral and safeguarding practitioners, counsellors and psychotherapists, from schools serving socially disadvantaged catchments, were interviewed in an effort to answer the research question: '*What do primary school-based staff say about suicide-communicating children*?' These interviews were then subject to a psychoanalytically informed thematic analysis where both semantic and latent content was interrogated.

It was found that what primary school-based staff say about socially disadvantaged children's suicide-communication conveys that they understand suicide-communication in terms of environmental circumstances. These can be seen as sequelae of social disadvantage and adverse childhood experiences (ACE). This was then identified by the researcher as 'social bruising,' which when diffracted through a Baradian intra-action within a psychoanalytic triangulation of Freud's (1920) 'protective shield,' Winnicott's

(1960) ‘holding’, and Khan’s (1963) ‘cumulative trauma’, finds a new agential reality.

Intra-acting what primary school staff say about suicide-communicating children with psychoanalysis and agential realism finds the following. Suicide-communication in children can be understood in terms of social disadvantage (the unfacilitating environment), and its sequelae. This diffracts through the family producing cumulative trauma, breach of protective shield and holding, resulting in ‘Familial Abruption.’ Familial abruption, in turn, diffracts through the child resulting in cumulative trauma and breach of protective shield, producing ‘Psymatic[1] Abruption.’ Psymatic abruption, in turn, diffracts through the social world of the child resulting in breach of protective shield and holding, producing ‘Social Abruption’. The diffractive product of these accumulative abruptions is ‘social bleeding,’ of which suicide-communication is one expression.

The findings, in collaboration with the existing suicide literature, offer an opportunity to build a socio-clinical, suicidological, material-discursive, risk assessment, suicide-prevention inventory.

Keywords: ACE. Agential Realism. Early Intervention. Primary Schools. Psychoanalysis. Social Disadvantage. Suicide-Communication. Suicide Prevention. Trauma. Young Children.

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[1] A neologism bringing the words psyche and soma together.

[2] Source: BBC News 6/11/2020.

[3] Further, Freud’s response to Ferenzci’s 1949 paper, *Confusion of Tongues,* which paid

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Chapter 1

Introduction:

Suicide-Communication in Children

Chapter Outline

This thesis seeks to advance understanding and knowledge of suicide-communication in socially disadvantaged primary school-age children. It also seeks to consider the interface between the external and internal worlds of suicide-communicating children in the hope of making a contribution to early intervention, risk assessment and, ultimately, suicide prevention efforts. In section 1.0 an outline of the structure and argument of the thesis is given. In section 1.1 briefly introduces the epistemological position of the thesis. In section 1.2 the impetus for the research is outlined. I discuss my experience of working in primary school counseling services, and my growing awareness of young children speaking and behaving in ways that could be considered in terms of suicide-communication (S-C). Section 1.3 looks at terminology and the choice of the term 'suicide-communication'. Section 1.4 discusses the coalescing territories of self-harm and suicide. Section 1.5 maps the complexities and politics of suicide statistics and finds sensitivity in relation to recording S-C in younger children. Section 1.6 explores the relationship between accident and suicide noting a lineage of debate in the literature where these two areas have often overlapped. Section 1.7 offers a

sociopolitical context within which the research was undertaken. Section 1.8 positions adverse childhood experience (ACE) studies. Section 1.9 looks at the biography of the early psychoanalytic literature and how this sits in a study of socially disadvantaged children. It suggests that Freud's (1920) 'protective shield', Winnicott's (1958) 'holding environment' and Khan's (1963) 'cumulative trauma' as a potential theoretical triangulation within which to try to understand the transaction of the external world of social disadvantage and the internal world. Section 1.10 considers the context for schools, in particular, the suicide prevention agenda for government, and the importance of early intervention.

1.0

Thesis Outline and Structure

Chapter 1 is outlined above.

In Chapter 2 the suicide literature is reviewed capturing the contribution from psychoanalysis across the lifespan with a specific focus on primary school-age children. Noted is the dominance of psychoanalytic literature pertaining to socially disadvantaged children from immigrant backgrounds from the 1930s through to the 1970s. An absence of UK publications exclusively devoted to suicide-communication in primary school-age children, is identified. In conjunction with the impetus for the study, a research question is then formulated; '*What do primary school-based staff say about suicide-communication in socially disadvantaged children*?'

In Chapter 3, there is further consolidation that the best potential source of gathering data in relation to socially disadvantaged suicide-communicating children is from primary school staff serving catchments of social disadvantage. The method of interview is identified as the most expedient approach to achieve data collection. Thematic Analysis (TA), making use of psychoanalytic practice skills with which to identify and cohere themes, is considered the most suitable method of data analysis. The steps taken to manage and process the data are given. Further, a Baradian onto-ethico-epistemology is chosen. Diffraction and Reflexivity are outlined and discussed as distinct and overlapping approaches. Qualitative reasearch is asserted as best suited to manage the fine grain sensibilities of the subject under investigation. The methodology chapter ends with an additional question and that is: ‘How can psychoanalysis, diffracted through a Baradian portal of intra-activity, make sense of what primary school-based staff say about suicide-communication in schoolchildren?

In Chapter 4 the steps taken to process the data via a psychoanalytically informed thematic analysis are made transparent. Analysis of the data finds there are three, intra-acting ways in which the participant researcher makes sense of the participants’ making sense of primary school children’s suicide-communication. This is then subject to diffraction. Social disadvantage and the unfacilitating environment, when diffracted through the family, result in holding failure and breach in protective shield, which results in familial abruption. When familial abruption is diffracted through the child this results in holding failure and breach in protective shield, which results in psymatic

abruption. When psymatic abruption diffracts through the social it results in holding failure and breach in protective shield, which results in social abruption. These then culminate in social bleeding, with suicide-communication being one of its expressions.

In Chapter 5 these three findings are considered further. The original research question is revisited with a view to establishing to what extent it has been answered. The literature is returned to and the themes are further analysed alongside relevant multidisciplinary literature. Death narratives embedded in cumulative trauma, so prevalent in adversity, are further considered in terms of the unfacilitating environment, failure of holding, protective shield, cumulative trauma and continuity-of-being in relationship to temporality and universality within Barad's intra-action. Reflection on method and data analysis choice is given. Limitations are considered and clinical implications of the research are outlined. The epistemological position is returned to and the relationship between Barad and psychoanalysis is, briefly, explored. Finally, taking the findings of the current research, alongside those from existing multi-disciplinary research endeavour, psychoanalytic contribution is woven through an inventory which has the potential to make a contribution to risk assessment and suicide prevention. Concluding remarks are made.

1.1

Epistemological Position

As I have adopted Karen Barad's ethico-onto-epistemology it shapes the thesis from the outset as knowledge-building practices begin with 'agential

cuts' where decisions are made about inclusion and exclusion. This epistemology is anchored in Barad's theory of Agential Realism. Here she brings quantum physics together with science and technology studies (STS) feminist studies, Marxism and post-colonial studies, to try to think about how the universe is in a perpetual state of entangled, intra-acting agency. Here, agency is understood as relational rather than possessive. Further, she asserts a diffractive methodology that creates space to move beyond reflection and reflexivity, offering opportunities for revolution and change.

Barad scopes a post-binary landscape where everything is connected and within, where discursive practices are not seen as distinct from material practices, where matter and meaning is both continuum and birth, where ontology, ethics and epistemology cannot be separated. She draws attention to what she refers to as 'agential cuts' where decisions about inclusion and exclusion in knowledge building practices are to be accounted for, and hold ethical weight. In trying to make use of this landscape Barad gives this study an opening to look at the longstanding problem of suicide, holding on to revolving insights from previous research, whilst optioning the possibility of knowledge being built upon new ways of seeing, thinking and being.

1.2

Impetus

Having worked in primary school counselling provision since 2009, in early 2013 I became increasingly aware of a steady number of accounts of children

who appeared to be talking about taking their own lives. I learned of a Year 2 boy who suddenly stopped reading his book and informed the teaching assistant (TA) that he wanted to jump from a high building. She told him, “Don’t be silly, you would hurt yourself”. He subsequently, unequivocally, articulated his desire to die, saying how much he hated his life. A few months later I heard of a Year 3 boy who had pulled a skipping rope tight around his neck saying he wanted to, “kill himself”. Staff struggled to unpick his fingers from the handles to release it. Later, again, a colleague spoke of a Year 4 girl who ran in front of a car shouting at the driver to, “run me over!” These children were not alone. I had heard similar communications prior to this, but over the following 2 years I began to encounter increasing numbers of what could be considered as suicide-communications.

My concern was such that, in the spring of 2015, I checked through the safeguarding file, with the Designated Safeguarding Lead (DSL) of one of the primary schools where I practiced, and we found forms pertaining to, what I had come to call, ‘suicide-communication’ (S-C) in 10 different children during the previous 18 months. These included children saying; “I want to die”, “I don’t want to live”, “when you come tomorrow I won’t be here”, “I’m going to kill myself”. As the school counsellor, I was surprised that not all of these communications had been brought to my attention, as I knew all the children concerned reasonably well. I began to wonder why this was. Perhaps the staff, somehow, thought these comments were unimportant, or was I precipitously categorising them to be ‘suicidal’? I also wondered if these communications were an indication of the increasing hardship families were

facing due to the impact of the government's policy of Austerity (Ridge, 2013). The dismantling of initiatives such as Surestart, the thinning of the infrastructure of early intervention itself, and social support more broadly appeared to be taking a particular toll on family life in the socially disadvantaged catchment communities I served.

Having become aware of Adverse Childhood Experience (ACE) (Felitti *et al,* 1998) studies, a longitudinal research study which is charting the health outcomes of some 17,000 participants based upon a survey of their childhood experience such as sexual abuse, parental separation etc, and in consultation with the DSL, I looked more closely at the adversities of these children. UK ACE studies (Bellis *et al*. 2014; Kelly-Irving *et al*, 2013) found that if 4+ childhood adversities were amassed suicide risk increased by 1220% compared to those with none and I was concerned. Whilst a suicide attempt is a significant risk factor for completed suicide (Bostwick *et al* 2016) the literature was more equivocal about whether or not expressed suicide ideation warranted particular concern. Together we built an adversity table comprised of the 10 most common safeguarding concerns, in keeping with Felitti *et al's* (1998) original most commonly expressed adversities in his patients, in an effort to establish the children's 'adversity load'. These were then compared with the adversity load of non-suicide-communicating, comparably vulnerable, children, known to the school counselling service. What was found that the non suicide-communicating children had a slightly higher adversity load. Whilst the idea that issuing a suicide-communication might act as a relative sign of help-seeking safety, and the non suicide-communicating children

might prove to be a greater future risk, these tertiary 'findings', alongside my feeling that there was something prohibited, pointed to the possibility that psychoanalysis, with its dedication to the repressed, might be able to shed some light on the issue.

Terminology

1.3

Suicide-Communication

The term, 'suicide-communication' was selected for use in this research in acknowledgement of the 'receiving other'. The term holds a paradox in that 'suicide' equates to a pull toward death and 'communication' is a desire (for a reply) and this holds a pull toward life. Although it appears as yet another term to add to the ranks of suicide terminology, it has been used before, albeit in passing. Robins *et al* (1959) and Kobler and Stotland (1964) were the first of several authors who have used the phrase, 'suicide communication', and the notion of suicide behaviours being communicative has been widely accepted by those working and researching in the field. Whilst there is very little written on young children's suicide expression as communication, there is a sustained body of literature looking at the communicative element of adolescent and adult suicide expression. Stengel (1956) observed that:

> There is a social element in most suicidal attempts. Once we look for it we find it without difficulty. There is a tendency to give warning of the impending attempt and to give others a chance to intervene. Those who attempt suicide tend, in the suicidal act, to remain within or to move

> toward a social group. In most suicidal attempts, irrespective of the mental state in which they are made, we can discern an appeal to other human beings. This appeal also acts as a powerful threat. We regard the appeal character of the suicidal attempt, which is usually unconscious, as one of its essential features. (1956 p.117)

Stengel argues that those people who are suicide communicating are looking for someone to intervene, to prevent them from carrying out the threat to end their lives. Whilst Stengel notes the threat therein, Jensen and Petty (1958) found that most individuals who attempted suicide had a fantasy of being rescued. Robins *et al* (1959) identified that 68% of the people with a diagnosis of manic depression, who completed suicide, had communicated suicidal ideas beforehand, with 38% specifically stating they intended to kill themselves. Their study also found that these communications were spread across a number of recipients and were issued in the month preceding the death.

Dorpat and Ripley (1960) looked at 113 cases of completed suicides, one third of whom who had previously made a suicide attempt, and two thirds communicated their intent to others. Schneidman and Farberow (1961) called their seminal book on suicide, *Cry for Help,* and opened with the observation that their use of this title was intentionally, “meant to convey our feelings…about the messages of suffering and anguish and the pleas for response that are expressed by and contained within suicidal behaviours.”
(p. xi).

Wolk and Wasserman (1986) in their study of 40 suicidal patients found that 37 reported they had communicated their intent prior to attempt. A later study, Wasserman *et al* (2008) looked at 19 suicide attempters and found that 13 had communicated their intent, but importantly 6 had not. Kõlves and De Leo (2015), using the Queensland Suicide Register, examined 850 youth suicides, 43 of which were aged 10-14 years. They found that 41.9% had expressed a suicide-communication previously and that 34.9% of these had been in the last 12 months. However, those left behind after a suicide might not be the most reliable source to confirm suicide-communication prior to death for a whole host of reasons and it might be that the figure is higher.

Today there may be a greater tendency for young people to communicate suicide feelings on-line (Cheng *et al* 2015). Appleby *et al* (2016) confirmed that 57% of those 20 years and younger who had completed suicide had expressed a suicide-communication previously and 32% had expressed this in the week leading up to their death, including communicating on-line. Unfortunately, both studies do not pay specific attention to young children. However, Childline is now recording S-C in those less than 12 years and the task is to collect more data in relation to the earliest of suicide-communications. As for children identified as 12 years and younger Anderson *et al* (2016) argue that in these children, a suicide-communication is not an expression of a desire to die but rather it is intended to access empathy and responsiveness from key stakeholders in the child's life. This would certainly be a reassuring conclusion.

The term, ‘suicide-communication’ is also only a slight modification of Owen *et al* (2012), who used the term, ‘suicide communication event’ which they articulated as,

> A set of circumstances in which a person expresses suicidal feelings, thoughts, intentions or plans, either directly or indirectly, in interaction with other people in their social environment. (ibid p.1).

Whilst Owen and colleagues did not address the issue of children specifically and, for the purposes of this research, ‘event’ has been dropped, as it seemed surplus, the term is helpful as it acknowledges suicide ‘in relation to another’. Further, the term ‘suicide-communication’ contains a seeming desire for both an end and a beginning, where hope and despair meet. This captures ambivalence which psychoanalysis finds in most relational exchange with Freud’s (1917) formulation on the loss of the ambivalently held object, both loved and hated in melancholia, offering a foundational example of this.

Significantly, the term ‘suicide-communication’ allows for a consideration of verbal expression. The verbal expression of suicide is often the first clearly articulated suicide statement by young children as behaviours can often be misconstrued and assigned to accident and acting out. Finally, as the target research cohort would likely be suicide-communication recipients, the term suicide-communication served as a convening point between them and the children. All things considered, this study employs the term ‘suicide-

communication' encompassing ideation, verbal articulation, behaviours, attempts and completion. Further, the study uses the abbreviation 'S-C' for the term suicide-communication and the term 'suicide-communicating'.

1.4

Self-Harm and Suicide

There are longstanding debates, and overlapping territories, between the terms self-harm and suicide. Any study attempting to extrapolate one from another, inevitably, encounters challenges. The National Institute for Clinical Excellence (NICE), the body which draws up guidelines for health professionals for recommended treatments, defines self-harm as, '*self-poisoning or self-injury, irrespective of the apparent purpose of the act*' (Self-harm. National Clinical Practice Guideline. Number 16. p.16 (2004/2013 reviewed 2017). 'Non-suicidal' or 'Suicidal' are now, typically, used as prefixes for self-harm although the generic term, 'self-harm', is often used as a coverall. Again, there are disputes regarding whether non-suicidal self-injury (NSSI) should have its own category and others who see self-harm on a spectrum of which suicide is one end (see Cipriano, Cella & Cotrufo, 2017 for a review). Neeleman, (2001), in a systematic review of 14 cohorts (*n* = 21,385), estimated that individuals with a history of self-harm were 25 times more likely to die by suicide than the general population. However, Hawton and Harriss (2008) looking at 12-14-year-olds admitted to hospital for self-harm between 1978-2003 found that at follow-up the long-term risk for suicide was relatively low and that self-harm was an expression in and of itself. The most current UK research undertaken by Hawton *et al* (2015),

looking at psychosocial interventions, confirmed that self-harm had strong links with suicide. There is further debate regarding where self-harm ends, and suicidality begins (Whitlock *et al* 2007; Klonsky *et al* 2014; Grandclerc *et al* 2016). Childline (2014) state that 29% of children who were counselled about suicide also mention self-harm, although a clear definition is not given. Therefore, a further 71% did not mention self-harm in relation to their suicidal state, but, again, there are so many variables as depending on the expertise of the Childline counsellor this may have remained unexplored. Broadly, though, there is consensus that self-harm and suicidality can be distinct entities and continuum behaviours. Of note, though, is that NICE include suicide attempts under self-harm. Whilst this research did not expressly seek to interrogate self-harm there was a recognition that participants might well discuss aspects of self-harm alongside suicide expression.

1.5

Prevalence and Suicide Statistics

All of the researchers who were part of a first wave of collecting empirical suicide data (Moore, 1790; Peuchet, 1838; Winslow Forbes, 1840; Morselli, 1881) bemoaned the unreliability of statistics. There have been controversies regarding validity of suicide data ever since with concerns raised over the last fifty years (Douglas, 1967; Taylor, 1982; O'Carroll, 1989; Samaritans, 2017). There has been a historical lean towards an acknowledgement that underreporting is endemic in suicide statistics. Having said this, Tøllefsen *et al* (2015) argued that underreporting is not significant and early suicidologists such as Farberow and Shneidman (1965), and Stengel (1964), applied what

Taylor (1982) later referred to as limited acceptance of the data, arguing that the impossibility of exactness does not preclude the fact that suicide statistics have broad utility. The idea that official figures are sufficient for the purposes of comparison is echoed by more contemporary researchers, (Speechley & Stavraky 1991; Goldney 2010). More recent efforts to clarify the reliability of suicide statistics, such as Värnik *et al* (2012), confirm a variability in reporting across countries in Europe with some meeting the '2-20' benchmark. The '2-20 benchmark' is where the primary indicator is 2.0 undetermined intent (UD) cases per 100 000 and the secondary indicator is the proportion of UD to suicides 0.20 (20%).

When it comes to suicide statistics, the question of recording suicide in children under the age of ten has rarely been subject to debate. Currently, in England and Wales, coroners are directed not to find a suicide verdict in those under 10 years of age due to an uncertainty that a child younger than 10 is capable of intentional suicide. This position is reflected in the data collected by the Office of National Statistic (ONS). Their data on child suicide begins with age category 10-14. At the outset of this study I made a telephone enquiry to the ONS as to why this was. The operative said it was too distressing for parents to have a verdict of suicide returned, and that there were anonymity issues as there were so few suicides in this age group. It would seem there is something of an anomaly here, which is that suicide in young children is acknowledged but not recorded. Further, I interviewed a coroner who was a fellow member of a university-led stakeholder research group looking into school age suicides. He told me that the verdict for young

children who appeared to have completed suicide was something that had to be brokered between coroner and parent.

The ONS calculates the overall number of suicides between the ages of 10-14 years per 100,000 of the population across the United Kingdom. However, from a more detailed reading of Serious Case Reviews (SCR) the vast majority of these were in the 12-14-year age range. Further, as this is a study set in England the focus is on the statistics specifically pertaining to England. In 2017 it was 0.3 per 100,000. Another source of statistics about suicide is held in data collected by NHS Digital, the national provider of information, data and IT systems for commissioners, analysts and clinicians in health and social care. I asked NHS Digital for data pertaining to suicide and suicide attempts in children up to the age of 14. I was directed to the following data set for 2017-2018 (see Table 1 below).

Table 1: NHS Digital, Hospital Episode Statistics for England. Admitted Patient Care Statistics, 2017-18.

		Age 0	Age 1-4	Age 5-9	Age 10-14
X60	Intentional self-poisoning by and exposure to non-opioid analgesics, antipyretics and anti-rheumatics	1	19	15	3,291
X61	Intentional self-poisoning by and exposure to antiepileptic, sedative-hypnotic, anti-parkinsonism	2	9	8	699

	and psychotropic drugs, not elsewhere classified				
X62	Intentional self-poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], not elsewhere classified	3	2	1	252
X63	Intentional self-poisoning by and exposure to other drugs acting on the autonomic nervous system	0	0	2	82
X64	Intentional self-poisoning by and exposure to other and unspecified drugs, medicaments and biological substances	2	16	5	557
X65	Intentional self-poisoning by and exposure to alcohol	0	0	2	36
X66	Intentional self-poisoning by and exposure to organic solvents and halogenated hydrocarbons and their vapours	0	5	0	12
X67	Intentional self-poisoning by and exposure to other gases and vapours	0	0	0	2
X68	Intentional self-poisoning by and exposure to pesticides	0	0	0	4
X69	Intentional self-poisoning by and exposure to other and unspecified chemicals and noxious substances	0	3	2	155
X70	Intentional self-harm by hanging, strangulation and suffocation	0	0	9	117
X71	Intentional self-harm by drowning and submersion	0	1	1	4
X7	Intentional self-harm by handgun discharge	0	0	1	2

2					
X73	Intentional self-harm by rifle, shotgun and larger firearm discharge	0	0	0	1
X74	Intentional self-harm by other and unspecified firearm discharge	0	0	0	0
X75	Intentional self-harm by explosive material	0	0	0	0
X76	Intentional self-harm by smoke, fire and flames	0	0	0	4
X77	Intentional self-harm by steam, hot vapours and hot objects	0	0	1	4
X78	Intentional self-harm by sharp object	0	1	12	1,317
X79	Intentional self-harm by blunt object	0	0	0	28
X80	Intentional self-harm by jumping from a high place	0	0	1	23
X81	Intentional self-harm by jumping or lying before moving object	0	0	0	2
X82	Intentional self-harm by crashing of motor vehicle	0	0	0	0
X83	Intentional self-harm by other specified means	0	3	11	80
X84	Intentional self-harm by unspecified means	0	3	5	108

What does this table tell us? It tells us that 8 children aged 0-1, 62 children aged 1-4, 76 aged 5-9 and 6,780 aged 10-14 had a hospital episode due to intentional self-harm. However, it is to be noted that the first ten categories include *exposure* to various drugs and substances. The category of self-harm does not necessarily mean that these acts were suicide attempts, but NHS Digital themselves point to these statistics in relation to suicide. Although our major national statistics gatherers do not overtly acknowledge suicide before the age of 10, there is a body of research which points to children talking about suicide before the age of 10. For example, Pfeffer (1990) interviewed 101 young, randomly selected children between 6-12-years-old and found that 12% expressed suicidal ideas or acts. Notably, the National Institute for Clinical Excellence (NICE) do talk about attempted suicide in children younger than 10 but they classify it as self-harm. NICE offer the following vignette to illustrate self-harm in their Clinical Practice Guideline (2004),

> An 8-year-old boy, who was conceived when his mother was raped, was brought up by his mother and a stepfather whom the mother quickly married to avoid the shame of an illegitimate child. The boy was nevertheless called 'the bastard' by the stepfather, who also repeatedly sexually abused the boy from when he was about 4 years old. The mother was subject to frequent episodes of domestic violence at the hands of the pathologically jealous stepfather who attacked her for having a child by another man. The mother became depressed and began drinking heavily to 'escape' the beatings. When very drunk, the

mother told the boy that her life was a misery and it was all because he had been born. In desperation the boy drank bottle of bleach believing this would kill him and save his mother. He survived and was diagnosed as being depressed. (Number 16, p. 17)

In the above example NICE do not refer to the word suicide but do describe a case where a young boy tries to kill himself. There does appear to be something of a reluctance to credit S-C in younger children. For example, 'Childline', a telephone helpline and counselling service for children run by the National Society for the Protection of Cruelty to Children (NSPCC), produced a report; *Under Pressure* (February 2015), which only collected data about S-C for children age 12 and above, registering over 6000 calls in 2013/14 in relation to suicide. Childline deal with children of all ages, so are we to understand from this report that children under the age of 12 do not talk about suicide?

The 2016 Childline Report, *It Turned Out Someone Did Care* (2015/2016) confirmed a 10% increase in suicidal feelings amongst children, but it still did not register any children under the age of 12 years. However, there was a note of contradiction in the report insofar as the first testimonial was from a 29-year-old woman who talked of contacting Childline when she was 11 and spoke about feeling suicidal at this age. The 2017 Childline Accounts Report confirmed a further 15% rise with more than 60 children calling each day with suicidal thoughts with the youngest child actively planning suicide aged 12 years. Finally, the most recent report, *The Courage to Talk,* (2017/2018)

conveyed a change in policy and confirmed that 2% (595) of calls about suicide ideation were from children aged 11 years and younger. Whilst this suggests a shift, the report lacked clarity with unspecific data pertaining to age, but it offered an age category that allows for a differentiation between primary school age and secondary school-age children. The ONS persist with the 10-14 age category which traverses both.

1.6

Accident and Suicide

On a related point, regarding what constitutes a suicide-communication, the grey area between suicide and accidental death in children needs to be considered. One of my first encounters with a S-C young child was a case brought to me of a 9-year-old boy who had climbed on to a roof at school and threatened to jump. Coaxed to safety he was heard to say that he would run in front of a bus instead. The following summer holiday he was run over by a bus and killed. The verdict was 'accident'. Perhaps his death was an accident, but I wondered if the finding of 'accident' by the coroner was avoiding something important that merited closer investigation.

Children are, typically, more accident-prone than adults with 2 million in the UK, under the age of 15 years, being taken to Accident and Emergency departments for treatment, of which 40% were under 5 years (Royal Society for the Prevention of Accidents. 2018). Looking back over the children who 'spring-boarded' this study 2 ran into traffic and a further 3 were prevented from doing so. According to the Department for Transport (ONS, 2015) the

average road casualty rate in 2013, for seriously injured children under the age of 15 years, every week tallies at 52 deaths and 1,924 serious injuries. Child pedestrians accounted for 69% of the casualties with 39% being between the ages of 4-10 years. According to witness accounts, of the 69% of children in road accidents, 78% failed to look properly, 38% were reported to be careless, reckless or in a hurry, and 9% were described as being involved in a dangerous activity on the carriageway. It would seem indicated that some of these children might have actively sought serious injury and death.

Further, the relationship between accident and suicide was acknowledged Freud's (1901) *The Psychopathology of Everyday Life,* where he draws a line between accident and suicide after observing the activities of his eleven-year-old son.

> One of my boys, whose vivacious temperament was wont to put difficulties in the management of nursing him in his illness, had a fit of anger one morning because he was ordered to remain in bed during the forenoon, and threatened to kill himself: a way out suggested to him by the newspapers. In the evening, he showed me a swelling on the side of his chest which was the result of bumping against the doorknob. To my ironical question why he did it, and what he meant by it, the eleven-year-old child explained, "That was my attempt at suicide which I threatened this morning." However, I do not believe that my views on self-inflicted wounds were accessible to my children at that time." (p.201). Freud went

on to talk of, “semi-intentional self-inflicted injury” with unconscious intent, “which is capable of aptly utilizing a threat against life and masking it as a casual mishap.” (Ibid. p. 202).

Further, in *Psychoanalysis of Children* (1932), Klein stated; “Analysis of children has convinced me that such recurrent minor accidents-and sometimes more serious ones-are substitutes for self-inflicted injuries of a graver kind and often represents attempts at suicide with insufficient means.” (ibid, p.98). Menninger (1938) pointed towards the idea of a purposive accident reflecting that people accept what is referred to in the phrase “accidently on purpose”. Bender (1947) identified that children with head injuries were accident-prone and more often than not came from families with high levels of disturbance. Krall’s (1953) study confirmed accident–prone children’s levels of aggression were greater compared to those who were accident free. Krall also postulated that these children had higher levels of anxiety around expressing their hostility toward others. Bakwin (1957) suggested the concealment of child suicide under the auspices of accidental death was to protect the parents from the shame of a child where death was self-inflicted. Schecter (1957) saw the young child’s inability to exact a murderous attack on those responsible for not loving him enough resulted in accidents which were unconscious expressions of the child’s disturbance. Jacobnizer (1960) also wrote of accidents in children as being concealed suicide attempts.

Perhaps the most important investigation in the relationship between childhood accidents and suicide was conducted by McIntire and Angle (1973). They undertook a 'psychological biopsy' assessing 50 subjects aged 6-18 treated at a poison control center in the United States. They found that the hospital diagnosis showed 42% identified as accidents and 58% identified as suicide attempts. After further assessment, which involved review of case notes and patient history, the figures were modified as follows; 4% were considered accidents, 70% suicide gestures, 2% suicide attempts, 22% intoxication and 2% were deemed to be as a result of attempted homicide. Renshaw (1974) wrote about the collusion of staff in finding accident instead of suicide and similarly Tischler (1980) looked at intentional self-destructive behaviour in children under 10 years noting that often professionals identified the behavior as an accident when in reality the child had made a suicide attempt. Freuchen *et al* (2012) looked at the differences between children and adolescents who completed suicide and those who had experienced significant accidents and found that 60% of the parents of those who completed suicide reported a stressful life event prior to the suicide whereas only 12% of the parents of those who had experienced an accident reported a stressful life event.

What might we say in conclusion about the challenge of encountering the statistics in relation to suicide in young children, and also the data pertaining to accidents? According to the statistics, suicide in children before the age of 12 is, thankfully, a rare event. There may be some degree of under-recording, and there may be some data about children who have accidents

camouflaging the true figure. But can we be reassured that we are within the range of a broad utility of data that allows us to draw empirical conclusions (Goldney 2010; Speechley & Stavraky 1991)? The answer is probably ‘no’. Certainly, my conversations with the coroner with whom I worked in a research group, confirmed an average of 2 children, aged 12 years and younger, completing suicide every year in one county alone, suggesting a significant under reporting. There seems to be an anxiety about talking about suicide and recording suicide in young children before the age of 10, and yet there is no clear research evidence as to why this should be the case. The account of the officer at the Office of National Statistics (with whom I spoke) was that a verdict of suicide in a child before the age of 10 is too upsetting for the parents. Perhaps, also it is too upsetting for society to acknowledge that some young children live such desperate lives that they seek to find a way out of them.

1.7

Sociopolitical Context

To consider the social context of suicide-communication routes right back to the beginning of sociology itself with Durkheim’s landmark study of 1897. Durkheim suggested that suicide could be explained either by lack of integration into society or lack of, what we might refer to as emotional regulation by society. He proposed there were 4 different types of suicide, 1. Egoistic suicide, where a sense of sustained unbelonging, and excessive individualism are seen as source. 2. Altruistic suicide, where the individual feels a sense of being engulfed and experiences a loss of individuality. 3.

Anomic suicide, where a sense of disrupted or confused belonging prevails. This is often rooted in economic disregulation, where movement up or down a social category is found to be displacing. 4. Fatalistic suicide, where an individual's future is thoroughly thwarted. The society in which they live is so oppressive that they would rather die. Whilst Durkheim thought the latter was more theoretical than reality, it might be worth holding onto this category as we review some of the following literature.

Gjertsen (2000) cautions against intercultural comparisons of suicide but within the UK there are known suicide variables with 4.6 per 100,000 of the population between regional rates in England alone (Samaritans 2017). Further, we know there is a higher incidence of child suicide in Northern Ireland compared to England, in all likelihood related to the turmoil of the 'troubles' (Tomlinson 2012). Take also the phenomenon of 23 youth suicides in Bridgend in Wales between 2007-2009 (Jones *et al* 2013) and though there have been other suicide spikes, there is an argument that the suicides in Bridgend were located in a region suffering from economic depression from the loss of its mining industry in a post-Thatcher era, which led to a spike in depression, with one of the UK's highest anti-depressant prescribing rates; 70 rising to 80.4 million prescriptions between 2009-2017 (Welsh Government Statistics. 2018), which in turn saw an upturn in the rate of suicide.

Watkins *et al* (2017) concluded that the impact of austerity since 2010 has associations with an estimated 45,368 additional deaths. The reason for the impact according to the research was the result of the constraints on Public

Expenditure on Healthcare (PEH) and Public Expenditure on Social Care (PES). Whilst the focus was not on suicide, Watkins *et al* (2017) implicated government in the mortality rates of its citizens. Although these links are difficult to be emphatic about Shaw *et al* (2002) holds that suicide is higher under ‘right-wing’ governments and that there were an additional 35,000 suicides over a century when the Conservative Party were in power in the UK. Värnick *et al* (2003) also conclude that suicide and homicide are affected by socio-political and economic conditions.

It is well established that poverty brings with it a number of unwelcome side effects such as mental and physical health inequities. Shuey and Leventhal (2017) confirm a link between the deficit of resources in lower socio-economic areas and their link with more aggressive parenting, and aggressive parenting has been implicated in the scenario of the suicidal child (Kairys *et al* 2002.). Sun and Yang (2016) confirm that the; “unemployment rate, inflation rate, and divorce rate are all significantly and positively related to the national suicide rates.” (p.345), and likewise, Barnes *et al* (2016) show a positive link between rates of self-harm and economic hardship. Those who have experienced childhood abuse have a proven graded increased risk of suicide in later life (Felitti *et al* 1998). Shneider *et al* (2017) found that, “the Great Recession was associated with increased risk of child abuse.” (p.71) and we know that, in turn, child abuse is a causal factor in increased suicide (Bahk *et al*. 2017). The weave between society, economics and suicide is important to consider.

Government figures (Department for Work and Pensions. 2019) confirm that 4.1 million children lived in relative poverty in 2018 in the UK. The figure was 2.1 million in 2010, the year the coalition government took over from Labour. The figure is expected to rise to 5.2 million by 2022 (Institute of Fiscal Studies. 2019). Research has found that the Universal Credit system with its 2-child limit will plunge a further 300,00 children into poverty by 2023 (Child Poverty Action Group. 2019). Research has found that children living in the most deprived neighbourhoods are at an increased risk of being on a child protection plan or being taken into care than children in the least deprived areas (Harker *et al* 2014). Further, Looked After Children (LAC) have an increased suicide risk (Katz *et al* 2011). Feinstein and Sabates (2006) observe that;

> By age 5 it is possible to identify over one third of those who will experience multiple deprivation 25 years later in adulthood. By age 10 it is possible to identify between 44% and 87% of those who will experience multiple deprivation as adults...the true picture is likely to be around 70%, that is roughly 70% of individuals who will experience multiple deprivation at age 30 can be identified at age 10. (ibid, p.20-21)

By age 16, there is a 28% gap between children receiving free school meals and their wealthier peers in terms of the number achieving at least 5 A*-C GCSE grades (Department for Education. 2015). We know low level of educational attainment increases an individual's risk of suicide (Samaritans. 2017). ONS (2017) tell us that males working in the lowest-skilled occupations

have a 44% higher risk of suicide than the male national average. The risk among males in skilled trades stands at 35% higher. Men in the lowest social class, living in the most deprived areas, are up to ten times more at risk of suicide than those in the highest social class, living in the most affluent areas. We do not know how many of these men started life in lower social class households in areas of social disadvantage, but we do know that 35% of sons born in 1970 from the poorest homes remained in the poorest incomes as adults (Machin & Major 2018). We also know that, "since the 1980s social mobility appears to have stalled or deteriorated in terms of social class and income measures respectively" (The Sutton Trust. 2017. p2).

Collins *et al* (2011) talk of the impact of the neoliberal "political attack" on the working classes whilst Parkinson *et al* (2016) identify Generation X (those born between 1964 and 1980) as Thatcher's children and link this 'parentage' with the current swell of suicide statistics within this cohort, particularly middle-aged men. They claim that Thatcher's policies increased income inequality and contributed to the "erosion of hope" the impact of which is still being realised today. Arguments like this may go some way to reframing transgenerational (and genetic?) aspects of suicide in terms of political cohorts reared within particular ideologies expressing a 'suicide profile'.

A 2017 inquiry into child protection services by an All-Party Parliamentary Group (APPG) led by Tim Loughton, the Conservative MP and former Children's Minister, reported that services were on the brink of collapse, with nine out of 10 councils struggling to meet their legal duties. The report also

confirmed that spending by English councils on children's services has dropped by at least 9% since 2010, over a period when numbers of children identified as in need rose by 5% and thousands more children were being Looked After or made subject to a child protection plan (CPP). There were 394,400 children assessed as in need of services or protection in 2015-16, compared with 375,900 in 2009-10. The APPG report intimated councils were raising thresholds to reduce the number of children they had to take responsibility for, leaving the possibility of a number of vulnerable children being left in unsatisfactory and unsafe home environments. Further, the Local Government Association (LGA) (May. 2017) stated that funding shortfalls are estimated to reach £2bn by the end of the decade. By 2020 central government will not contribute any money at all to Councils for services to vulnerable children with the withdrawal of the Formula Grant (ChildrenEngland. May. 2017.)

And whilst the COVID crisis has brought significant changes to how central government disseminates funds, with a redrafting of what it means to be state dependent, this all adds to a worrying picture for vulnerable children and their future trajectories in England. We know that rates of domestic abuse have increased during this time (Kofman & Garfin 2020). Further, there are reports such as that of Ofsted's chief inspector, Amanda Spielman, confirming a 20% increase in infants being killed or harmed in the period March 2020-October 2020. Spielman attributes this to a 'toxic mix' of poverty, isolation and mental illness[2]. Further, there are growing concerns as to how COVID-19 will impact

[2] Source: BBC News 6/11/2020.

suicide during and after the crisis (Sher, 2020). In continuing to work in schools through COVID a mixed picture emerges, with debates around providing food for vulnerable children generating schisms and controversies, set against an impressive responsiveness from schools to increasing community need.

1.8

ACE, Social Disadvantage and Suicide

Irrespective of a global pandemic, we know from existing ACE literature (Felitti *et al* 1998) that accumulated adversities in childhood increase subsequent suicide risk. Although ACE has its critics around its lack of nuance and measurement error (Kelly-Irving & Delpierre, 2019) it has to be remembered that when Felitti delivered his findings to a group of psychiatrists it was reported by Felitti to not have been warmly received. We might consider critiques, justified or not, within the field of competition for research monies and resources. I would argue, however, that ACE, certainly in its original focus pays insufficient attention to the culpability of the broader social environment contributing to adverse experiences. Particularly as social disadvantage increases prevalence of physical and sexual abuse, and these are indicted in suicide scenarios (Bruffaerts *et al.* 2010) with sexual abuse standing out for particular attention (Bahk et al, 2017). As both ACE and psychoanalysis are trajectory literatures this study seeks to take the model of gathering childhood adversities as understood by psychoanalysis, in effect, ‘unconscious and inter-personal adversities’ which could be seen to arise from the intra-action of the internal and external, and build an inventory of adversity as a contribution

to future suicdological risk assessment. When piloted post-doctorally this could offer an infrastructure with which to continue to build a picture of what distinguishes those who experience suicidal ideation from those who will go onto make a high lethality attempt, which may or may not result in completion. This is the long-term goal of this research and, as such, data collection needs to take place where young children have either already experienced adversity, or are most likely to.

1.9

Psychoanalysis, Social Disadvantage and Children

Psychoanalysis is one of the probes this study uses to try to interrogate suicide-communication in relation to social disadvantage and children. Yet if we were to focus upon its beginnings, Freud's contribution in relation to the latter two we would be left wanting and more. Whilst general psychoanalytic contribution to suicide will be explored more fully in the literature review, I will take a moment here to qualify its use in a study such as this. It has been well documented how Freud's 'Seduction Theory' (1896), built upon his hysterical patients (12 women and 6 men) seen in the late 1800's, was subsequently abandoned by Freud. This was partly in response to the freeze Freud received from his medical colleagues upon delivery of his treatment findings, and the potential of psychoanalysis following suit (Schimek, 1987; Masson, 1984; Israëls & Schatzman, 1993).

Freud had proposed that their disturbance was a response to childhood sexual abuse (CSA). He suggested that because it was not possible to

assimilate these experiences they returned in the form of psychological disturbance. However, Freud subsequently retracted this and, instead, incestuous desire was then reconstituted within the Oedipus Complex (1900/1910). Here, perverse adult sexuality was now disappeared in the child's possessive, but asexual desire for the opposite sex parent. Whilst this led to fruitful theoretical and clinical yield its origins, arguably, remain a conversion symptom which causes psychoanalysis problems to this day. Also as Freud described some of these patients finding 'life impossible' (1898. p. 208), and the only acknowledged suicide of one of Freud's patients is likely to have come from this cohort (Hamilton, 2002)[3], this is the biography knitted into the unseen fabric of the origins of psychoanalytic suicide theory.

Further, Freud did not work with those from socially disadvantaged backgrounds therefore the foundations of psychoanalytic suicide theory are built upon clinical practice with middle class adults. Both Freud's burying of children's experience, which Ferenzci (1932) was the first to acknowledge as a trauma in and of itself, and the socio-economic skew of his foundational suicide theory need acknowledgement. However, Freud has given us invaluable theory with which to understand specific suicidal transactions, that have stood the test of time. Further, he has furnished us with an inchoate theory of trauma which might go some way to understanding the interface between social disadvantage and its sequelae.

[3] Further, Freud's response to Ferenzci's 1949 paper, *Confusion of Tongues,* which paid attention to child sexual abuse was to ask him to retract it (Dupont, 1995). Several other psychoanalytic luminaries also moved away from its conclusions relating trauma to childhood sexual abuse (Masson, 1984. p.151).

Freud's (1920) early contribution to thinking about trauma and 'protective shield', the latter of which when in receipt of too much stimuli, in the form of stress, either internal or external, can be breached leading to the ego becoming overwhelmed, is worth holding onto. Whilst it was in the first place proposed as a biological concept it has adaptive socio-bio-psychological utility beyond this. It also makes a contribution to understanding temporality, which I will return to in the closing chapters. Further, as a precursor to ACE studies, Khan's (1963) idea of cumulative trauma contributes to an extension of this theory. This study can take Khan's lead and take the protective shield that is mother and extend it into the social and physical world. For example, how does society act as an auxiliary ego to the socially disadvantaged family and how this, in turn, impacts upon the child? Also how breaches in protective shield, of which social disadvantage is a significant breach, how they shape ego/self in the child. These can then both be considered within a socially extended version of Winnicott's idea of facilitating environment and holding. Here, Winnicott (1958, 1960, 1965) finds that at its worst, failure of holding risks disintegration of self. This could be seen as due to a breach of the protective barrier that is mother. However, in this study, we might posit that there is no such thing as a nursing couple there is only the nursing matrix, an important part of which is the government, their policies, their designated educational institutions and their agents, of which primary school staff are amongst the first.

Bringing Winnicott, Freud and Khan together we might better understand how an unfacilitating environment, which produces the impingement of social

disadvantage and its sequelae, might breach protective shield, and the socially disadvantaged suicide-communicating child could be considered a product of this as the ego/self struggles to remain intact in the face of traumatic experiences and their continuity-of-being is interrupted with each incursion into their carrying on being.

1.10

Early Intervention, Schools and Suicide Prevention Policy

In July 1999 the White Paper, *Saving Lives: Our Healthier Nation*, highlighted four areas of action, one of which was Mental Health, with an ambition to reduce death by suicide and undetermined injury by at least a fifth. In April 2002 the government published its first consultation document in relation to a national suicide prevention strategy for England. This was regarded as an ongoing document to be shaped by experts in the field with an evolving evidence base. In 2012 the Department of Health produced best practice guidance: *Preventing Suicide in England: A cross-government outcomes strategy to save lives*. This document superseded the, National Suicide Prevention Strategy for England. Its aim, since 2017 has been to reduce suicide rates by 10% by 2021. However, as I complete this thesis in late 2020 with pre-Covid-19 suicide rates in children and young people climbing (ONS. 2019) with an increase of 83% in completed suicide in girls aged 10 to 24 years, and a 25% increase in boys of this age in 2018, we are in unchartered territory in terms of the nation’s psychological wellbeing. However, schools are expected to have suicide prevention measures in place. As such they have been pushed to the front in terms of early suicide prevention and

intervention. We might ask if they are sufficiently resourced to shoulder such a responsibility, particularly as they are currently in a state of depletion containing families and communities in the throes of a health pandemic and and ensuing mental health crisis?

Accountability within the English school system derived from the Education Reform Act (1988) that led to the creation of the Office for Standards in Education (Ofsted), published league tables and national testing. In an effort to raise standards an institutionalised system of naming and shaming by the government began in earnest. Since then the parent has the power of the purchaser but catchment is still dictated to by real economics where rich and poor remain divided. Every child is expected to progress at the same rate irrespective of home circumstances. Further, Ofsted grades remain strongly related to the proportion of disadvantaged pupils in a school (Hutchings. 2016). Strand (2014) argued that Ofsted failed to take into account the socioeconomics of school's catchment. In addition, there is no credited inspection of emotional support and mental health provision. If, as the research above shows, social disadvantage increases the likelihood of mental health problems and emotional distress, then this oversight does not offer a fair playing field by any measure.

So, where do primary schools fit in this suicide prevention strategy? Galton and MacBeath (2015) flagged up the reluctance in schools for taking on children who might lower their test scores. The report, *The Impact of*

Accountability Measures on Children and Young People, (Hutchings, 2016), surmised that the study exposed;

> the reduction in the quality of teacher-pupil interaction; the loss of flexibility and lack of time for teachers to respond to children as individuals… and that accountability measures… threaten children's self-esteem, confidence and mental health. (ibid. p.2)

Donaldson's (2015) study suggested that there was, "a diminution of responsiveness to children" (ibid. p.10) as so much of teacher's time was taken up with the implementation of external expectations, namely those driven by Ofsted. This might find a wayward justification if the system was producing generations of bright, intelligent contributing members of society but Hutchings (2016) found that, *"…*while accountability measures may increase attainment as measured in tests, they do not increase underlying levels of understanding and skill." (p.68) The British Humanist Association (2017) published a report looking at how Personal Social and Health Education (PSHE) and Sex and Relationship Education (SRE) are inspected in English schools. Findings from analyses of more than 2,000 primary and secondary school inspection reports for 2015/16 show that: SRE was mentioned by inspectors in less than 1% of reports; PSHE was mentioned in 14% of reports. There does not appear to be a great deal of incentive, or opportunity, for primary school teachers to spend time talking with children about their emotional lives.

One of the earliest studies encompassing children and suicide, Serin (1927) concluded that many of the completed suicides were sourced in faulty upbringings and could have been avoided if the necessary support had been invested earlier. Anna Freud (1969) affirmed that traumatic separations in early life can have lasting effects whilst many psychoanalytic thinkers have flagged the importance of difficulties in the rapprochement phase (Mahler, 1985) which, typically, takes place between 15-25 months, are responsible for crises further down the road. Shneidman (1996), toward the end of a dedicated career confirmed that, "the pains that drive suicide relate primarily, not to the precipitous absence of equanimity or absence in adult life but to the haunting losses of childhood's special joys." (p.164). Arguably, we need to look to S-C much earlier in life with the focus of suicide prevention research sitting in early childhood before venturing beyond it to draw conclusions.

My experience, and this is exclusively based upon one city, is of S-C children routinely being turned away by Child and Adolescent Mental Health Services (CAMHS)[4] as their problems are seen to be 'environmental', with the accompanying assumption that environment and mental health are distinct entities. It is not unusual for neglected children not to come to the attention of CAMHS, nor is it unfamiliar that children who have the most chaotic family situations also do not receive a CAMHS intervention as therapists favour a stable base from which to work. A recent study (British Journal of School Nursing, 2018) found that in 2017 over 55,000 children were refused treatment by CYPMHS and that 1 in 4 of these were self-harming or had

[4] More recently Childrens and Young People's Mental Health Services (CYPMHS)

experienced abuse. However, almost all children attend primary school. To this effect the research concentrates upon those who are potentially exposed to the greatest number of S-C young children and that is those who work with them day in and day out, school staff.

It is primary school staff that best know these children. They know if they have free school meals, they know what is in their packed lunch, how they smell, and whether their toenails are clean or dirty. They know if other children like them. They know if their parents help them with their homework, read to them at night or can read at all. Some teaching staff have taught the children's siblings, aunts, uncles, cousins, even parents. They are great gatherers of community intelligence, for example whose houses were screaming the night before, who had the police round, whose children are hanging out on street corners, who are the gang leaders, and who are vulnerable to 'county lines'[5] threat. It is they who have insight into the communities the children live in and some live in the community themselves. They were the people to go to and so the research sought them out to see what they knew about S-C children in their care. Arguably, early S-Cs, and how they are responded to, are foundational to suicide trajectories. Further, research tells us that perceptions of social support (D'Attillio *et al* 1992; Rigby & Slee 1999; Thompson *et al* 2002; Miller *et al* 2015.), particularly in schools, are recognised as prophylactic against suicide. Further, as there is often a sharp hike in suicide figures after the age of 12, whilst there has been this emphasis upon the revolution that is puberty, there has been considerably less focus upon the

[5] County lines is where drug dealers recruit children in drug running, dispersing drugs from cities to rural communites, as they are below the age of criminal responsibility.

significant external change that is the move from primary to secondary school. This study offers a rare insight into what could be termed as the first mandatory, statutory social space and how children, who are delivering their suicide-communications into its representatives, are received and understood in this first port of call outside of the family.

However, perhaps, the most persuasive argument for early intervention is best left with the words of a mother who lost her 12-year-old daughter to suicide. Talking of how people had assumed that the day her daughter killed herself must have been the worst day of her life she said, “No, the day before…the day before.”[6] It is hoped that this research contributes to the day before the day that never comes.

Chapter Summary

In this chapter I have outlined the argument and structure of the thesis. I have outlined the ethico-onto-epistemological position of Barad’s agential realism. The impetus for the research is examined in terms of its anchor in my work in areas of social deprivation. I have discussed the nosological debate and overlapping territories of self-harm and suicide. I have examined the scene in regard to the various strains and controversies in relation to identifying and recording S-C in younger children, and the shared and diverging territories between suicide and and accidents. The socio-political context of the research, particularly in relation to social disadvantage, is explored, favouring an inspection beginning at home and the necessity for cultural precision. ACE

[6] Molly Russell: Did Her Death Change Social Media? BBC News Channel. Aired on BBC 3/11/2019.

studies have been introduced. Psychoanalysis is discussed in terms of its early history, Freud's original 'seduction theory' and his work with middle class patients being foundational to psychoanalytic suicide theory. Posited is the possibility of a 'socio-adaptation' his idea of protective shield, Winnicott's idea of holding and Khan's idea of cumulative trauma. Finally, the necessity of early intervention is discussed.

Chapter 2

Literature Review

Chapter Outline

In section 2.0 the literature review opens with a question. This is followed by a brief clarification of what constitutes psychoanalytic literature. Section 2.1 lays out a justification for a psychoanalytic focus. Section 2.2 outlines the two psychoanalytic literatures which will be garnered. Section 2.3 oulines the search terms. Section 2.4 gives the yield of the search for the generic suicide literature excluding young children. Section 2.5 briefly discusses the place of psychoanalysis in the discipline of suicidology. Section 2.6 explores the literature from the first search from 1885-1959. Section 2.7 summarises this epoch of generic literature. Section 2.8 explores the generic literature from 1960-2020. Section 2.9 summarises this literature. Section 2.10 outlines the psychoanalytic child literature search terms and yield. A prisma flowchart is used to present this. Section 2.11 outlines the demographics of the children discussed in the literature. Section 2.12 explores the child literature. Section 2.13 summarises the child literature. Section 2.14 offers a reflection across both literatures. Section 2.15 identifies the gaps in the literature which the research hopes to fill. Section 2.16 identifies the research question to take into the data collection phase of the research.

2.0

Literature Review Question and Clarification

In an effort to help steer the literature review the following question is posed, 'What has psychoanalysis contributed to the understanding of the socially disadvantaged suicide-communicating child, and how might it help us understand the phenomena now?' In order to answer this question literature that is clearly influenced by, or makes use of, psychoanalytic ideas in relation to suicide will be captured and considered. There will, inevitably, be disciplinary overlap as some psychiatrists and clinical psychologists are also psychoanalytic practitioners. Further, there are also psychiatrists, such as Cynthia Pfeffer, for example, who are not psychoanalytic practitioners but have made use of psychoanalytic ideas. All will be included in the literature.

In summary, two psychoanalytic literatures will be searched.

1. Generic, adolescent and adult psychoanalytic suicide literature. Contributions considered to be most relevant to suicide-communication in socially disadvantaged children will be summarised.
2. Psychoanalytic suicide literature expressly devoted to primary school-age children.

Finally, as this study has chosen a Baradian ethico-onto-epistemological position (this has been outlined in the previous chapter and will be explained further in the following chapter) part of the critique of the literature will be a knit of the external and internal, that is the biography and ethics of the literature might be touched upon briefly. Applegate (2000) asserts the

postmodern view of theory as story in relation to social work. Here, I share this perspective whilst placing it in a Baradian context. It is often the exclusion and inclusion criteria of the literature where disciplinary politics begin. Research voice, which, in the case of suicide, can translate into clinical administration, therapeutic delivery and suicide risk protocols, is where onto-ethico-epistemological agential cuts are made. This will be attended to when felt to be pertinent. Further, as suicidology advocates multidisciplinarity, or in Barad's terms 'entanglement' and 'intra-action', my hope is to single out the contribution from psychoanalysis with a view to then knitting it through wisdoms gleaned from ACE, psychiatry, and psychology, with the building of a multi-disciplinary, unconscious-informed, inventory which could offer an early intervention suicide risk tool to inform future studies and, potentially, pilot post-doctorally.

2.1

Why Psychoanalysis?

Whilst I have made use of biographical detail in qualifying the use of Freud's contribution when undertaking a study into the socially disadvantaged suicide-communicating child in chapter 1, before embarking upon the literature review in earnest I would like to take a moment to outline why the focus is psychoanalytically informed literature. Whilst a study that makes use of probes from psychiatry or psychology would unlikely start with justifying their model of enquiry, the current silo position of psychoanalysis seems to invite such a justification, perhaps unnecessarily, but nevertheless.

Ridge Anderson (2016) informs us that, “there are no evidence-based treatments for suicidality in children under 12” (p.3). Glenn *et al* (2015) tell us that suicide risk assessment is equal to the flick of a coin and that, “there are currently no well-established treatments for suicidal or non-suicidal self-injurious behaviours in youth” (p.26). Franklin *et al* (2016) confirm no improvement in suicide risk assessment capabilities in the last 50 years. This, and rising youth suicide rates (ONS, 2019), suggests that whatever we are doing now, under the auspices of psychology, could be improved upon.

Psychiatry is struggling. Apter (2004) finds that psychiatric diagnosis alone is insufficient to adjudicate suicide risk. Further, we have understood for some time now that although depression can be an indicator of suicide risk, it is perfectly possible to be depressed and not suicidal, and suicidal and not depressed. The giant that is ‘hard science’, the stature of which psychoanalysis can only dream of, is encountering its own battles. Anti-depressant use in those under the age of 25 increases (Stone *et al* 2009) or doubles (Sharma *et al* 2016) their risk of suicidal behaviour. Further, we have at least two generations where numbers of children have been reared from gestation by mothers taking anti-depressants (Liu *et al* 2017). The impact of the chemical dissociation of feeling states and medicated mind-to-mind transfusion has yet to be realised, but in my clinical experience there are clear warning signs of children being reflected back in the glazed, empty eyes of mothers who have taken their pain to the GP and returned with a prescription, which whilst it might estrange them from their pain, at the same time estranges them from their children.

As my preliminary reading of the multidisciplinary literature on suicide identified a receding voice of psychoanalysis over the last 40 years, that is to say, psychiatry and psychology have been less inclined to draw on psychoanalysis to understand suicide. Perhaps it is time to thread through some of the wisdoms gleaned from psychoanalysis into current approaches. This is not just because what we have is not working, clinical psychoanalysis justifies its place in a study of suicide-communication for a number of reasons. It is a NICE endorsed treatment for depression, which has a weighted relationship to suicide. It achieves comparable, if not better, broader outcomes than its therapeutic peers (Abbas *et al* 2006; de Maat *et al* 2006; Shedler 2015; Steinhert 2017; Leuzinger-Bohleber *et al* 2018). Also, there is now evidence (Briggs *et al* 2019) that supports the effectiveness of psychoanalytic psychotherapy for suicide and self-harm reduction.

Further, psychoanalysis is the only talking therapy that has the ‘sleeper effect’, meaning that not only at the close of treatment does the patient feel better but 6 months and a year later improvement continues (Shedler, 2010). This stands in sharp contrast to psychology’s adopted offspring, Cognitive Behavioural Therapy (CBT) which the NHS has embraced due to its economically expedient, quick fix promise. Studies demonstrate its failing efficacy in relation to depression (Johnsen & Friborg, 2015) compared to psychoanalytic treatment with almost twice as many patients achieving their goal of structural change after three years (Leuzinger-Bohleber *et al* 2018).

It would appear the further CBT moves away from its psychoanalytic origins the more it struggles. In fact, Shedler (2010) suggests that the success of other therapeutic treatments is due to practitioners employing psychoanalytic techniques and insights. Research suggests, though, that it is not the model of therapy that matters, it is the practitioner who delivers it. The rigour of psychoanalytic trainings, with their focus upon practitioner development, is incomparable. There is a positive relationship between time invested in any endeavour and competency achieved, with skilled experts in the field also investing in this process, we might conclude that an intensive training has the greatest potential to yield a practitioner who can make a sustained difference to quality of life. It is this clinical acumen that can be brought to bear.

Further, it is not just what clinical psychoanalysis has to offer a study of suicide. Applied psychoanalysis, in terms of the psychosocial approach, has a longstanding tradition of extending our understanding of culture, and the social and political domain. In *Civilization and its Discontents* (1930) Freud devotes a section entitled, '*The Sociological Interest of Psycho-Analysis,'* where he attests,

> What is today an act of internal restraint was once an external one…what is now brought to bear upon every growing individual as an external demand of civilization may some day become an internal disposition to repression. (p.189).

Here, Freud confirms that socio-cultural history becomes psyche. Law becomes internal regulation. The social becomes the individual. This stretches the idea of the individual as a hermetically sealed unit. It introduces the idea of porosity and suggests the individual is shaped by a tangle of forces that exist beyond the dyadic and familial. This is in keeping with a Baradian perspective where notions of self and other, and inside and outside, collapse into a soup of intra-activity that enfolds the past in the present and the present in the past. In relation to suicide Hendin (1964, 1969, 1975, 1981/96) has made the most significant psychosocial contribution. However, his attention sat with parenting, race and students, not young children. Here, there is a dearth of literature expressly attending to the relationship beyond the family and the suicide-communicating young child, and it is here where this study situates itself.

2.2

Why look at Generic Suicide Literature in a Study of Young Children?

As the unconscious is continuum, in the first place it seemed helpful to start with a summative and chronological trawl through psychoanalytic literature attending to suicide-communication in adolescents and adults. Authors in the field of child suicide-communication, Pfeffer (1986); Orbach (1988); Patros and Shamoo (1990); Berthod *et al* (2013), all advocate the utility of literature across the lifespan being brought to bear in the understanding of S-C in young children. It is intended that this study will not just be of use to work with young children as the reverse is also true. One of the founding fathers of

'suicidology', the dedicated multi-disciplinary study of suicide and suicide prevention, Shneidman (1996), wrote:

> Perhaps every person who commits suicide at any age has been a victim of a vandalized childhood in which the preadolescent child has been psychologically mugged or sacked, and has had psychological needs, important to that child, trampled on and frustrated by malicious preoccupied adults, or obtuse adults (Ibid. p.164).

Although Shneidman notes this, he did not choose to redirect his focus to children who were experiencing the vandalised childhood.[7] Typically, the focus is upon adolescence. Adolescence, the testing ground for moving away from. Adolescence, is the transitional space between childhood and adulthood. However, the literature often hones in on puberty, sexual development, the role of body. As this study's focus is young children, I will only make the occasional detour into adolescent literature when it feels relevant to do so. I am keen to separate out the two in an effort to ascertain a distinct picture of suicide-communication in the primary school-age child.

Having made a case for delineation in the literature, as the adolescent and adult literature mainly refers to intra-psychic transactions that have taken place in infancy and early childhood there is much shared territory. As the young child suicide literature comes chronologically later and often makes reference to early theory culled from adult work it is necessary to attend to this

[7] Shneidman would have been in the twilight of his career at this point.

literature first. Further, as the adolescent and adult literature reaches back over one hundred years, and is sizeable, attention will primarily be paid to psychoanalytic authors who have demonstrated a dedicated interest to the subject, or are seen to have provided a theoretical underpinning with which might be used to understand suicide-communication in the socially disadvantaged S-C child.

2.3

The Search

Even though this was the first search it was secondary to the psychoanalytic child suicide literature, as it was necessary to ground the child literature within the already existing theoretical infrastructure on suicide. The following engines were searched: PsychLIT, PEP Archive, Web of Science, ERIC, Science Direct, PsychINFO, Google Scholar using the terms ‘suicide’ and ‘suicidal’. I also scoured various textbooks for further references. I had a totally inclusive remit. If it was psychoanalytic and had suicide/suicidal in the title, or I knew it to concern suicide, such as Freud’s (1917) *Mourning and melancholia,* then it was captured. Only, after a more detailed reading of the literature did I hone it for relevance to young child suicide-communication.

2.4

The Yield of the Generic Literature (excluding young children)

The literature spanned from 1895-2020.

Books	19
Papers & Chapters	290

2.5

What the Yield tells us about the place of Psychoanalysis in Suicidology

Before going on to deliver a more detailed summary of the literature, as multidisciplinarity sits at the heart of suicidology, what is notable from the literature is that across the journals exclusively dedicated to suicide, *CRISIS*, *Suicide & Life-Threatening Behavior* and *Archives of Suicide Research*, in terms of psychoanalytic papers, Maltsberger (1988, 1993, 2003a, 2003b, 2004, 2006) and five other authors, Richman (1978), who hails from a family therapy background, Hendin (1978, 1987, 2004), who focuses upon the psychosocial, Briggs *et al* (2006), who comes from a social work background and is the only author from the UK, Ronningstam (2010) (co-authored with Maltsberger) and De Kernier (2012), both clinical psychologists, have been published within them. Further, the more recent multidisciplinary tomes, such as Hawton & van Heeringen (2000), and O'Connor and Pirkis (2016), either make cursory mention or exclude psychoanalytic contribution altogether. However, Wasserman and Wasserman's updated, *Oxford Textbook of Suicidology and Suicide Prevention,* (2020), includes psychoanalytic contribution. Whilst five of these chapters are reprinted from the first edition in 2009, there are more recent contributions. As such, over the last 10 years there have only been two psychoanalytic papers published in the generic suicide journals, and a thin representation in the multidisciplinary suicide textbooks. If we compare this to earlier multi-disciplinary works such as Farberow and Sneidman's (1961) *Cry for Help* there appeared to be a more balanced inclusivity. As this is a study that hopes, ultimately, to contribute to an integrated approach to suicide prevention, this matters.

2.6

Generic literature identified as relevant to young children: 1885-1959

In an effort to manage the literature, I thought it best to divide it into two, relatively arbitrarily delineated, ‘epochs’, 1885-1959 and 1960-2020. With both epochs I ask, ‘what is the literature telling us that might be made use of when trying to understand suicide communication in young children?’ Most publications make mention of Freud’s seminal contribution to suicide’s theoretical build, beginning with *Mourning and Melancholia* (1917). However, in terms of the earliest inchoate theoretical underpinnings, these came in 1910, at a gathering of the Vienna Psychoanalytic Society, convened to discuss suicide in the young. Although Litman (1970) contends Freud arrived at the meeting already assured of 7 clinical features of suicide: 1) Guilt in relation to death wishes, typically toward parents, 2) Identification with a suicidal parent, 3) Loss, 4) Revenge, 5) Escape from humiliation, 6) As a communication, 7) A link between sex and death.

Opening this meeting Sadger asserted that unrequited parental love was its source (Friedman 1967. p.79). Stekel later announced; “No one kills himself who has never wanted to kill another, or at least wished the death of another.” (ibid p.87). Further, Stekel argued that suicide for a child was talion because the child;

> …wants to rob his parents of their greatest and most precious possession: his own life. The child knows that thereby he will inflict the greatest pain. Thus, the punishment the child imposes upon himself is

> simultaneously a punishment he imposes on the instigators of his suffering. (ibid. p.87.)

Suicidal talion was not a new idea and developed a train of thought that Freud (1901) had outlined in relation to accidents being unconscious events of suicidal intent with revenge as a key (discussed in chapter 1). Freud was reported to be unusually reserved during the meeting (Friedman. 1967) and concluded by remarking that they had not yet been able to answer the question as to how the, “extraordinarily powerful life instinct (can) be overcome” in suicide (Friedman 1967. p.140), acknowledging that greater attention needed to be paid to the issue of melancholia. However, before outlining this, a brief detour into Jones’ (1911 and 1912) papers is required. Jones asserted that the unconscious cannot encounter death and almost immediately transforms it into rebirth. Here, he was more interested in a link between suicide and narcissism rather than sadism.

Jones concluded that many saw death as a journey into a more peaceful existence accompanied by a belief in a world beyond. He argued that this belief might become more enhanced when life was full with disappointment and sorrow. Jones quoted Sadger (1910) who had concluded that the wish to die together with someone else was the same as the wish to sleep and lie together, the origins of this being to lie with the mother. Thus a longing for the grave was an equivalent of the mother’s bed. However, Jones took Sadger’s statement and interpreted it as, not a return to mother’s bed, but to mother’s womb, a return to a narcissistic state where self/ego and object were merged

and undifferentiated. Jones also wrote of the desire to be rescued in suicidal fantasy which has already been touched upon the suicide as communication section in chapter 1. This also feeds into the later literature concerning ambivalence in the suicide-state.

Five years after the meeting convened to discuss youth suicide Freud was still pursuing how ‘the ego is overwhelmed by the object.’ (1915b. p.252). His answer was fully elaborated in *Mourning and Melancholia* (Freud 1917) where he found that patients suffering from melancholia held deeply ambivalent feelings toward the lost object. In this situation processes of identification and resultant ego splitting found that, ‘the shadow of the object fell upon the ego and the latter would henceforth be judged by a special agency.’ (Freud 1917 p. 249).

> It is this sadism alone that solves the riddle of the tendency to suicide which makes melancholia so interesting and so dangerous. Now the analysis of melancholia teaches us that the ego can only kill itself when it is able to treat itself as an object because of the return of object-investment, if it is able to direct the hostility that applies to the object back against itself and represents the original reaction of the ego against objects in the outside world…. Thus, in the regression of the narcissistic object-choice the object may have been abolished, but it has proved more potent than the ego itself. (Freud 1917 p.211-212)

Freud's reference to a 'special agency' was later to become identified as the superego which proves to be a key stakeholder:

> If we turn to melancholia first, we find that the excessively strong superego which has obtained a hold upon consciousness rages against the ego with merciless violence…It is remarkable that the more man checks his aggressiveness toward the exterior the more severe - that is aggressive - he becomes in his ego ideal. (Freud, 1923. p.53).

What Freud tells us is that in depression, aggression is externally muted and internally amplified, and it is the superego that is holding the loudspeaker. This formulation was responded to by other psychoanalytic thinkers, and there is literature attending to Freud's (1920) idea of the death instinct, but the most relevant for this study was that of Ferenczi's (1929) in his paper, 'The Unwelcome Child and his Death Instinct'. Here, he discussed the impact of early childhood upon his death-seeking adult patients. Ferenczi suggested that the unconscious and conscious maternal intolerance of their offspring's existence was to blame for their suicidality, concluding; "I only wish to point to the probability that children who are received in a harsh and disagreeable way die easily and willingly." (ibid. p.126).

Menninger (1933 & 1938) then extended the idea of suicide across three motives; i) the wish to be killed, ii) the wish to kill and iii) the wish to die. However, unlike Freud, he suggested that all three were present in every suicide. This opened up a more nuanced understanding of suicide and moved

it to extend the repertoire beyond aggression. Klein (1935) then extended this further by suggesting,

> phantasies underlying suicide aim at preserving the internalized good object and that part of the ego that is identified with good objects, and also at destroying the other part of the ego which is identified with the bad objects and the id. Thus, the ego is able to be reunited with its good objects. (p.276)

What Klein brings to the early suicide theoretising is suicide as an act of preservation offering a counter to the focus upon murderousness within Freudian thinking. Although Klein did not write much more, specifically, in relation to suicide she does offer a way to understand psychic processes which contribute to suicide states such as projective identification, splitting and failure to achieve depressive position (see Bell, 2008, for a further explanation). Subsequently, Smideberg (1936) and Hendrick (1940) make a formulation for suicide being an escape from aggression rather than an enactment of it. Finally, Moss and Hamilton (1956) bring the idea of hope and hopelessness, whereby they conclude that there were three coexisting unconscious or partly conscious determinants involved in the act of suicide, (1) A hope of greater future satisfaction. This took the form of a permanent reunion in death with a lost loved one…(2) hostility or rage directed against another, now turned against the self …(3) a relinquishing of any hope of receiving satisfaction from current living situation. And whilst there are other

papers in this period of merit and interest the above have been identified as holding the greatest potential relevance to young children.

2.7

Summary of the Generic Literature (excluding young children): 1885-1959

In brief there are some reoccurring themes that point to what might be described as a provisional psychoanalytic suicide lexicon up until 1959. After Freud's move away from his hysterical patients in the late 1800s, one of whom completed suicide, there is a great emphasis on internalised aggression, and its sequelae. With Freud's suicide formulation focusing upon the depressed patient. Latterly, there is an emphasis on the preservation of the good and an avoidance of aggression, moving from wanting to kill and be killed in a sadomasochistic inversion, and into wanting to die in an attempt to return to an oceanic oneness with mother.

Conceptualisation focus on the following domains. 1) Love's absence. 2) Melancholia. 3) Loss, real and symbolic. 4) Aggression turned back against the self. 5) A ferocious, vindictive superego 6) Self/Ego object con(fusion). 7) Revenge. 8) The desire to be rescued. 9) The desire to kill, be killed, or die. 10) The preservation of the good objects. 11) Regression. 12) Flight from aggression. 13) Narcissism and the desire to return to the womb. 14) A defusion of the life and death instinct. 15) Reconciliation with a lost loved one. 16) Rebirth. 17) Sadism/masochism. 18) Atonement. 19) Identification with

the dead. 20) Abandonment. 21) Escape from suffering. 22) Guilt. 23) Hope for an afterlife, hopelessness in the life lived.

2.8

Generic Psychoanalytic Literature (excluding young children) 1960-2020

From the 1960's through to 2020 many of the above features have been refined and extended. Here, the relevant literature can broadly be divided into the following areas: 1) Relationship to therapist/receiving other. 2) Further elaboration upon internal phenomenology of the relationship between ego and superego, splitting, projective identification, depressive and paranoid schizoid position, regression. 3) Mother/separation individuation. 4) Death and the Afterlife. 5) Body and Pain. 6) Father. 7) Narcissism. 8) Trauma. 9) Shame. 10) Risk Assessment and Prevention. 11) Gender & Sexuality. 12) Hope. 13) Ambivalence. 14) Fantasy

Whilst I would wish to explore all of the above I am going to select those that seem most relevant to trying to think about socially disadvantaged children.

Relationship to the Therapist/ Receiving Other

Whilst I have been clear that this is not a study of the receiving other, I wish to briefly address this literature. Both these literatures will be considered together for two reasons. First, they both address something about the broader context within which clinical work takes place, with a particular focus upon the practitioner working in the public sector, vulnerable to both litigation and reputational damage (Gabbard, 2005). For those who work closely with

death can easily become contaminated, becoming both executioner and executed (Asch, 1980). Second, these literatures mark the only distinct departure from the first epoch of literature as all the other literatures are a continuation. This would appear to reflect the changing culture of health care provision over time. It would seem that the suicidal patient, more than any other, allows for a more far-reaching analysis of the context of the work.

The literature attests to the demands of working with the suicidal patients, and its relevance to socially disadvantaged young children lies in the way this literature draws in the external environment, and how it shapes the therapeutic encounter. Further, the literature looks to developing risk assessment and suicide prevention tools. Both have a dual purpose of patient and practitioner protection. This particular literature, captures something about society, how society manages, and takes responsibility, or not, for its suicidal members. For example, Kobler and Stotland (1965) wrote about the impact of policy change in a mental hospital upon the suicidal patients. Bell (2008) writes about how a change in policy, which then diverted staff's energies from patient care, was felt to have resulted in a patient's suicide. I pay brief attention to this literature here to confirm that suicide does not take place in a vacuum and that broader social structures are pulled into play.

Mother/Separation/Individuation and Father

Whilst the early literature flags murderous mothers and deficits in maternal love, the next epoch of literature offers two maternal positions. Following on from Ferenzci (1928) murderous mothers are again confirmed (Bettleheim,

1967; Sabbath 1968; Pfeffer, 1986; Orbach's 1988). Glasser (1979) writes of the fear of an engulfing or abandoning mother which echoes the merger and loss dynamic of Freud's formulations. Campbell (1999) writes of the 'mothering object' experienced as dangerous and untrustworthy. Separation and individuation are not felt to be possible and instead a regression to a merged state with an idealised mother is sought. Schacter (1999) focuses upon the struggle of the suicidal male who is unable to negotiate a sense of separateness from mother. Orbach's (2007) work, '*From Abandonment to Symbiosis*' argues there is a developmental reversal whereby a lack of maternal care in early life then results in a symbiotic functioning whereby the adolescent is not allowed to move away from the family as the adolescent is the receptacle for all their ill and unresolved feelings. As suicide could be seen as the ultimate separation individuation this literature is important, particularly for young children who are still heavily dependent upon mother.

However, particularly from the 1990s to 2020 the absence of father is a discernable theme within the adolescent and adult literature. Campbell (1999 and 2008), and subsequently Campbell and Hale (2017), write of the role of the uninvolved father as part of the pre-suicidal state. "In normal development, both pre-Oedipal parents represent to the child the world outside the exclusivity of the mother-infant relationship, e.g. the realities of time and place and object." In a good-enough father he manages his envy and exclusion from the mother-infant dyad and then over time, and with mother's help, father shapes up to offer a more phallic authority whereby he reclaims mother and

facilitates the child moving away from an exclusive relationship with mother and out into the social world.

This is highly relevant to children who come from areas of social disadvantage where relationship breakdown is higher and there are a number of lone mothers rearing their children. We also need to consider culture as absent Caribbean fathers, for example, are three times more prevalent (Hunt, 2009) than absent White fathers. Whether this can be considered as a consequence of the castrating assault of slavery to male Caribbean identity and its transgenerational consequences requires consideration within a postcolonial psychoanalytic frame. The geospatial nature of slavery and how this has contributed to these fathers moving away from, yet another port of call. However, again, the ethnocultural aspects of absent fathers need to be considered alongside a socio-economic analysis.

However, perhaps Campbell and Hale pay insufficient attention to present fathers, and their role in the pre-suicide state. The impact of fathers who are threatening and violent to mother, and its castrating dynamic, particularly upon sons who have to bear witness to, but are impotent in the face of, domestic violence and rape, requires exploration. Further, the impact of the violent father, present or absent, on older, violent brothers who then become the threatening male figure in the household. Also, the ambivalent place fathers hold, where they offer internal danger and external safety would also be something of particular relevance to some children living in areas of social disadvantage. However, there is no doubt, that the father's role as

representative of an external world beyond the fused world of mother and child, alongside protection from a dangerous mother holds relevance to this study.

Death, the Afterlife, Ambivalence and Hope

I have chosen these themes because the literature attending to them encounters the idea of the universe harbouring places that are elsewhere in time and space. This is in keeping with a Baradian study and also because this literature is relevant to young children who often have a greater elasticity in relation to the possibilities the world holds. Again, this was touched upon in the earlier literature. Studies by Pfeffer (1977) and Orbach (1978) found that S-C children had a different perception of their own death and that it involved both a transformation and an 'ongoingness.' Maltsberger and Buie (1980) confirm this in suicidal adults, in keeping with continuation of consciousness and post-death there is a surviving self. Ronningstam *et al* (2018) write about the glorification of death, dying and afterlife in the narcissistic suicidal patient.

Further, this literature ties into the literature concerning hope and hopelessness, which has limited exploration in relation to young children (Nock & Kazdin, 2002; Vinas *et al*, 2002) although it is confirmed as a risk factor. Hopelessness, which, itself, supplanted depression as a key indicator of suicide (Bedrosian & Beck, 1979; Beck, 1986), is now increasingly being called into question in non-psychoanalytic literature (Qui, 2017). There has been intermittent interest in hope in the psychoanalytic literature, perhaps, because it has more of an external expression, and has drawn greater focus

from psychology, although Winnicott (1955) wrote of regression as an act of hope. In this way, perhaps all defence mechanism hold some measure of hope. But it is the relationship between hope and hopelessness to one of the most consistently maintained wisdoms in the psychoanalytic literature, that is the state of ambivalence in all relational exchange, including the suicide scenario which is of interest here. Shneidman, of whom Leenars wrote (1999), captures the prototypical portrait of the individual in a suicidal crisis as one who both wants, and does not want, to die. It is this ambivalence which needs to be considered alongside hope and, arguably, any suicide-communication holds the hope that someone will receive and intervene.

More recently, Sharma and Fowler (2018) and Goldblatt (2017) write of the psychodynamics of hope. Goldblatt finds three pathways which install hope via the therapeutic endeavour, i) relational coping, ii) symptom management and iii) recognition of core identity. Goldblatt finds that the practitioner working with the suicidal is to survive their annihilatory attacks, support them in processing intense negative affect, and hold onto hope when the patient themselves cannot, and to do this whilst not denying their pessimism. Unlike previous literature on hope the focus moves from patient to practitioner. Whilst Goldblatt references, Boris (1976), which finds that the therapist should not try to infuse hope into the patient, and Lemma & Levy (2004) where hope is seen as the activation of a good object, he does not write about whether the hope is projected into the therapist by the patient, whether it is co-created or whether the hope belongs to the therapist alone.

The literature review question asks what is the contribution psychoanalysis has made to understanding suicide-communication in socially disadvantaged children and, as such, we might wonder about the place of hope within a social system which evacuates hopelessness and despair into particular social groups. Holding a Baradian frame, co-constitution of phenomena, including child suicide-communication, the psychoanalytic practitioner, along with everyone else, is called to account. If we apply Barad's perspective then the 'healer' of the socially disadvantaged suicide-communicating child is also the 'dealer' of the pain that, arguably, precipitates the suicide-communication in the first place. By this I mean, until the therapeutic encounter, the largely, white, middle class psychoanalytic practitioner[8] profits from a social system whereby social disadvantage is happening to others. In this way the practioner enters into the therapeutic transaction from a position of de-identification and, arguably, insufficient empathy. In all likelihood they are, on some level, relieved that it is not they who suffer from social disadvantage, and the deficits in hope that can come with this. As mentioned in the introduction, the hope that might once have come from the prospect of social mobility is less now than it was thirty years ago.

Alvarez's (1971) comment that he was too much of a pessimist to kill himself is one that has stayed with me from the adult suicide literature. Is it possible to be too depressed and hopeless to kill oneself? Is it the optimist who is most likely to attempt suicide? Is the suicide-communicating child less vulnerable than the non-suicide communicating child, for at least they are able to give

However, more recently, the Tavistock Clinic has made available bursaries for those of BAME background, and those in economically straightened circumstances.

voice to their despair? The issue is of locating where the hope and hopelessness lie. As those who believe in a transformative afterlife often project their hope into imaginary space depriving real life of hope's sustaining presence. Again, a sense of ambivalence prevails but what is unambivalent is that in the psychoanalytic literature on hope there is insufficient consideration of the theft of hope outside of the family.

Ego, Psychic Pain, Body and Gender

Hope and the afterlife weave in with the body and pain literature, as discussed previously, consciousness and biological bodily death are often seen as separate in the suicidal. It is the body that is identified as the site of pain when the ego is under stress due to psychic pain. In relation to Barad, it is the materiality of the body that is of interest, for whilst the body can be dispensed of in terms of biological death, in agential realism, effectively, there is no biological death as the body materially exists in reconfigured form. In this way both the body *and* consciousness continues.

Freud (1917) wrote about mental pain as the child's yearning for the return of mother. Decades later, Shneidman (1993) concluded that 'psychache' was at the heart of suicide. Whilst it could be argued that 'psychagony' might be more apt in my experience both Freud and Shneidman's idea have real resonance in the suicide-communicating children I have encountered. Freud wrote that the ego is first and foremost a body ego (1923), and as such psche and soma is a false binary. Campbell's work on the pre-suicide state (1999) where, "the body is treated as an object and concretely identified with the lost

loved and hated person" and that in the suicidal patient, "a split in the ego has resulted in a critical and punitive superego perceiving the body as a separate, bad or dangerous object" (p.76), highlights this well. Maltsberger (2004) writes of the ego in freefall, disintegrating and falling apart in the sucide scenario. Where the body is sacrificed to the preservation of the mind. Hale (2008) also writes of suicide being an attempt to kill the self's body. However, working with young children offers an additional reading of this literature in relation to the literature that focuses on regression to pre-oedipal or rapprochement phase in the suicidal. When young children draw topographical representations of themselves, typically, those under 30 months do not separate out body and head (Brownwell *et al,* (2010). I wonder that it is less about the body becoming jettisoned from the psyche and more that there is a return to a pre-binary state of oneness. Here, psychoanalysis would need to pay closer attention to method in suicide as hanging, gunshot to the head, and drug overdose, for example, hold very different psymatic narratives.

Further, the body has a biological sex, and a sociological gender, and this is less often addressed in the literature. The primary school, as a source of socialisation, is one of the first institutions to inculcate gender expression. However, biological sex is primarily, expressed bodily. That the female body begins with processes of identification and the male body by processes of de-identification is worth noting, particularly as there is a stark differential between the male and female completed suicide rates. Gerisch (2008) acknowledges that,

> "there is probably no other symptom comparable with suicide that, if looked at closely, reveals the reflexive interplay of nature, culture, sex and gender, both inwardly and outwardly" (p.128)

She writes with a particular focus on the female body where both fear of separateness and intimacy govern the suicide scenario. This finds alignment with the other literature concerning symbiosis and abandonment, losing and fusing (Lewin & Schulz, 1992). However, we might posit that it is the female body's ability to carry self and other, in a state of temporary fusion that holds significance in trying to understand the suicide gender differential. Whilst things are changing, we send males to war and females to the delivery suite. Birth and death are unevenly distributed and sociobiologically defined. Social disadvantage outlines different trajectories for the body with greater physical ill health, disability, and shorter life expectancy, but also higher teenage pregnancy rates and higher pregnancy rates generally. For example, we might wonder about the reduction in teenage pregnancy rates and the increase in young female suicide rates. Perhaps. It is that the gendered internality of female, and externality of male, reproductive organs, might also go some way to explaining different individuation/separation (inside/outside) trajectories for each, of which suicide is one.

Trauma

Although the definition of trauma is loosening to become something of a coverall for any difficult experience, it feels important to hold its distinction as being related to death and its threat. Whilst Khan did not write specifically

about suicide I want to take a moment to elaborate his idea of cumulative trauma, which was mentioned, briefly, in chapter 1 and will be made use of in chapters 4 and 5. Khan's (1963) idea of cumulative trauma sought to identify early trauma in the preverbal stage of development and its subsequent expression in the, 'bias of ego and psychosexual development' (p.302). First, he took Freud's model for protective shield,

> Protection against stimuli is an almost more important function for the living organism than reception of stimuli. The protective shield is supplied with its own store of energy and must above all endeavour to preserve the special modes of transformation of energy operating in it against the effects threatened by the enormous energies at work in the external world. (Freud. 1920. p.27)

and trauma,

> excitations from outside which are powerful enough to break through the protective shield…There is no longer any possibility of preventing the mental apparatus from being flooded with large amounts of stimulus…(ibid)

Within Khan's theory, the mother becomes 'protective shield' and the infant becomes Freud's, 'undifferentiated vesicle of a substance that is receptive to stimulation' (Freud, 1920. p.28). Khan then looked at cumulative trauma in terms of the breaches in mother's protective shield, or what Winnicott would

call ‘impingements.’ Impingements interrupt what Winnicott (1960) referred to as ‘continuity-of-being’, which forms the basis of a secure ‘true self’. Here mother’s role is identified as an auxiliary ego to the child’s fledgling one. As such the child amasses the incremental stresses from his anaclitic needs relying upon the vagaries of maternal protective shield. Khan emphasised that these breaches were different from gross intrusions from a pathological mother, he was interested in the strain they placed upon the ego. However, the above ideas could be made use of when thinking about how the external world impacts ego and self in the socially disadvantaged, adversity experiencing child.

Garland (2002, 2004) writes about trauma in relation to both threats to ego stability and attacks on linking and thinking, which, in turn, undermines capacity to articulate affective states coherently. This, in turn, impacts the body and how it can be experienced concretely as something to attack and rid. In this study we might wonder how the body of the socially disadvantaged child is treated, not just by the child and her family, but by society at large, as it could be considered as being jettisoned from consciousness, care and concern. The ACE literature attests that those who experience social disadvantage are more likely to acquire greater levels of trauma and that these have bodily consequences in terms of health outcomes (Nurius, Logan-Greene & Green, 2012). In this way the emerging psychoanalytic literature on trauma might hold the greatest utility for socially disadvantaged suicide-communicating children as there is a greater acknowledgement of the external and how it shapes the internal world. This might be because DSM

diagnosis of trauma related conditions such as PTSD and Complex PTSD are the only diagnoses that are seen to have an external event trigger.

More recently, Briggs *et al* (2012) consider the relationship between trauma in relation to childhood trauma and subsequent suicide trajectory. Here they acknowledge how a series of external events triggered flooding affect in relation to childhood traumatic experience. However, Maltsberger *et al* (2011) find that it is,

> the overwhelming events that lead to posttraumatic stress disorders and similar states are commonly understood to arise from noxious external events. It is however the unmasterable subjective experiences such events provoke that injure the mind and ultimately the brain…*and that* traumatic over-arousal may arise from inner affective deluge with minimal external stimulation.' (p.671)

and it is notable that the title is, 'Traumatic subjective experiences invite suicide.' It would seem that one of Maltsberger's last papers was to prioritise subjective experience over objective realities in the suicide scenario. Malstberger *et al* (2017) suggest that all those who survive a suicide attempt are subject to a trauma because they have been subject to a murder attempt, albeit by their own hand. This might offer an additional perspective to the increased risk after a suicide attempt. After his lifetime's commitment to understanding suicide we would not wish to lose this, however Maltsberger, as Freud before him, extrapolated his theories from his work with adult

patients, not young children. Adult patients, with their distance from childhood and their intersubjective build, will inevitably skew the practitioners perspective, along with the disciplinary allegiance to the unconscious. The following literature will offer a point of comparison. Further, as this is a study of the socially disadvantaged, there will be a necessary focus upon how, 'noxious external events' of an unfacilitating environment'can invite objective experiences and how these, in turn, shape subjective experience and suicide-communication.

2.9

Summary of the Generic Psychoanalytic Literature

The literature was separated into two halves 1885-1959 and 1960-2020, in part, to see what the last sixty years have added to psychoanalytic understanding of suicide, in keeping with the biographical dimension of the literature review. The first half establishes the structural underpinning of what follows. Here, there is Freud's mapping out of how the ego can consent to its own destruction in relation to depression. The emphasis being on aggressive drives turned against the self and the ego having to split to manage ambivalent identification with the lost object. There is also literature attending to the preservation of the good object and avoidance of aggression. The desire to return to the womb and an oceanic, narcissitic oneness is also a feature of the early literature. Of note, what follows does not deviate a great deal from the early literature, more it adds and refines. There is a greater emphasis upon mother and father, with a particular focus upon how thwarted separation leads to object subject confusion. As such the suicidal can kill the

self while either attempting to kill a part of themselves or another with whom they have become con(fused). There is further exploration of internal phenomenology, and the plight of the ego under assault from the persecutory attacks from the superego. The repertoire of suicide is extended from depression to encounter states such as ecstasy, psychosis and narcissism. However, the distinct new literature is the receiving other of suicide and the build of risk assessment and suicide prevention. This moves the literature out into external reality whilst still maintaining its focus upon subjectivity.

2.10

Searching for Literature: S-C in Primary School-Age Children

In the first place my aim was to gather together all literature specifically focusing on S-C in those age 12 years and younger and then extrapolate out the psychoanalytic literature in an effort to compare its relative contribution. The following search engines were employed: PsychLIT, PEP Archive, Web of Science, ERIC, Science Direct, PsychINFO, Google Scholar.

The search terms were applied as follows:

'suicide' + 'children', + 'young children', + 'pre-adolescent children', + 'latency age children', + 'pre-pubescent children', + 'primary school children', + 'elementary school-age children', + 'in children 12/11/10 years and younger', + 'pre-school children'. These terms were also prefixed with, 'suicidal', 'suicide attempt', 'suicidal ideation', 'suicide-communication'.

Literature Yield & Organisation

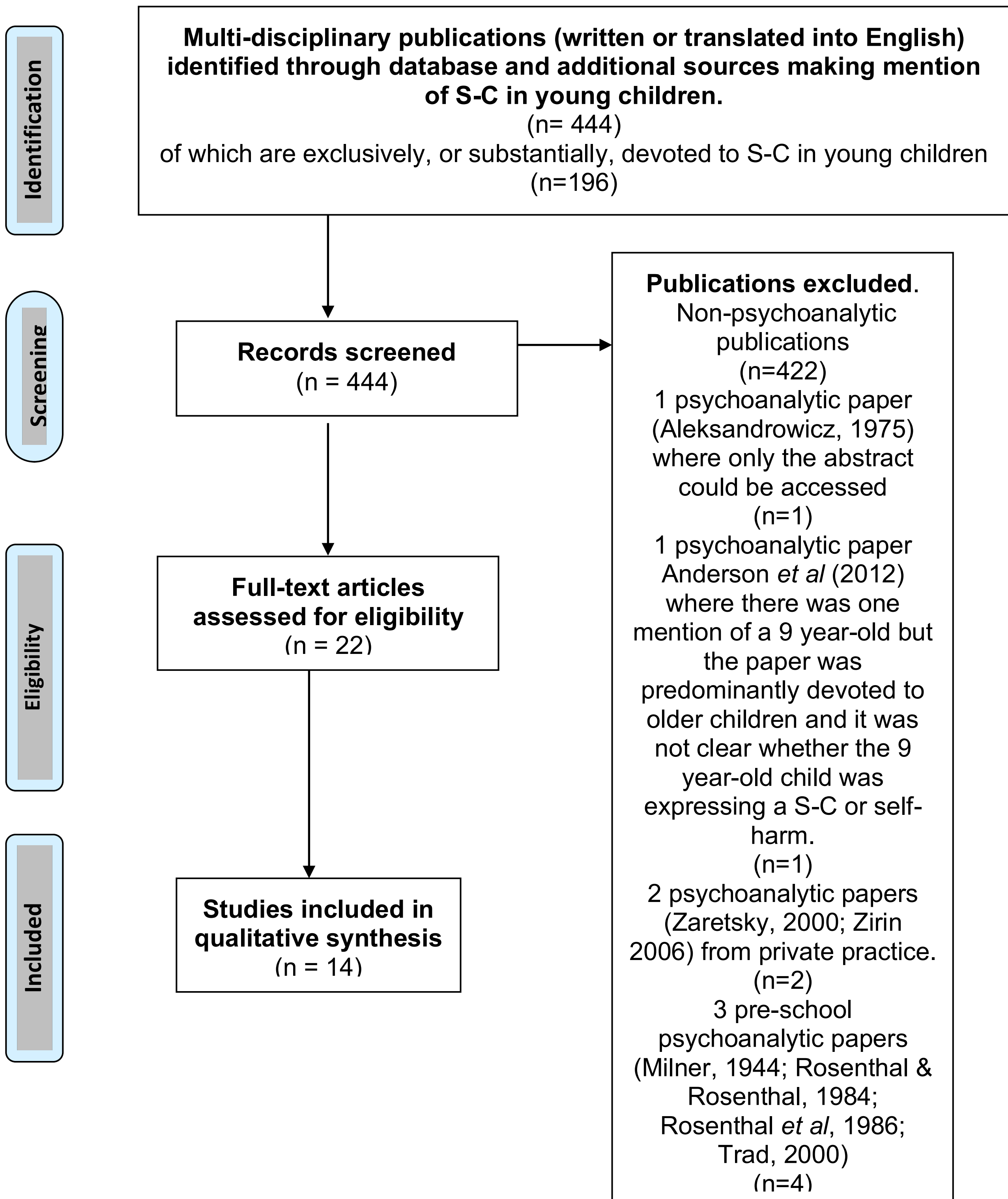
The search identified 444 publications between 1834-2020 making reference to S-C in children aged 12 years and younger. Twenty-two of the papers in the search were found to be defined as clearly psychoanalytically informed. Three focused on suicide in pre-school children. Eleven papers were devoted either exclusively or substantially to those of primary school age (4-12 years). Two of these were from private practice and as the study wished to look at social disadvantage they were removed. There were 5 further papers, where young children of primary school age were discussed alongside older adolescents, however one of these was insufficiently clear to progress with. This left 14 relevant publications. Of the remaining publications, 196 did focus exclusively or substantively upon primary school age children and S-C but emerged mostly from the field of psychiatry and psychology. A number of these are discussed in the later chapters where they are pertinent to my research findings, and some have been mentioned in the introduction. A further 236 publications made some reference to children under the age of 12, with a mixed focus, often substantially loaded toward adolescence and, occasionally adults. The theoretical orientation of the majority of these papers was, again, mostly in the field of psychiatry and psychology.

Below is a Prisma flowchart which documents the yield of the search.

Figure 2.1

Multidisciplinary Literature Search

Suicide-Communication in Primary School Children



2.11

Demographics of S-C

As this research intends to be noticing of socio-economic status, gender and race the following table offers the numbers of this collective cohort of S-C children upon which theory was built.

Table 2. 1: Cohort Demographics

Author	**No of Cohort**	**Age Years**	**Ethnicity/ Back ground**	**Gender**	**Socio-Economic (S-E)**
Bender & Schilder (1937)	15	5-12	Immigrant	Male & Female	Bellevue State Hospital[9]
Bender (1953)	15 [10]	“	“	“	“
Schecter (1957)	7	4-12	Not stated	Male	Mixed From state hospital & private Practice.
Schneer, H.I., Kay, P., Brozovsky, M. (1961)	1	12	Not stated	Male	Suggest Lower S-E

[9] Bender & Silver. (1951) wrote of the children who attended Bellevue that, ‘these children came from poor, immigrant families and children’s agencies.’
[10] Same cohort as 1937 paper with some additions.

Toolan, 1962	18	5-12		Male & Female	Bellevue
Winn & Halla (1966)	11	7-12	'largely Negro or Puerto Rican' (p.289)	42% girls 58% boys[11]	'largely, from the lowest socio-economic group." (p. 289).
Ackerly, 1967	24	12&u	Makes mention of 2 Jewish and 1 Catholic cjild	22 boys 9 girls	"Lower middle to low s-e" (p.
Toolan, 1975	18 [12]	5-12	Not Stated	Male & Female	Bellevue
Green 1978	20[13]	5-13	70% Black 30% Hispanic/ White[14]	2/3 Boys 1/3 Girls	Lower S-E
Pfeffer (1978)	Not stated But 3	6-12		1 Female 2 Males	Low S-E

[11] Of original cohort of 70 disturbed children
[12] Same cohort as 1962 paper.
[13] Not all were S-C, some were self-mutilating.
[14] What is not clear is if they were Irish immigrants

	cases studies given				
Pfeffer *et al* (1979)	58	6-12		4:1 Boys to girls	Low S-E
Pfeffer *et al* (1980)	39	6-12		4:1 Boys to girls	Low S-E
Friedman & Corn (1985)	1	7		Male	State Hospital US
Pfeffer (1985b)	3			1 Male 2 Female	Low middle and low S-E
Cohen (1993)	3	8-12	Israeli	Male	Lower S-E

If we exclude Green's work as it is not clear about the numbers who were S-C different primary school-age children 183 children have been written of in the psychoanalytic/psychodynamic literature over a 56 year period. Largely, these were children who passed through public hospitals in Brooklyn and the Bronx in downtown New York, most notably, Bellevue, particularly between 1933-1936 and 1960. Pfeffer's (1978, 1979, 1980, 1985b,) work brings in much bigger numbers, largely from data from the 1970s and 1980s.

2.12

Exploration of Literature Attending to S-C in Primary School Children.

The following literature is presented as a chronology, and also with some attention to the context to the work. The first work is that of paediatric neuropsychiatrist, Loretta Bender, and psychoanalyst and psychiatrist, Paul Schilder (1937). In the paper they concluded that suicidal children wanted to free themselves from unbearable situations where there were deficits of love, and feelings of hostility that were turned in against the self. While this perspective followed an orthodox Freudian view of suicide, they argued against the idea that aggression, hostility and anxiety were primordial responses equated with the death instinct, an idea that Schilder would develop in his later work. They also explored the talion issue of revenge, which they referred to as ‘spite’, concluding that a child’s suicide attempt was a desperate effort to solicit a parent’s love, and they noted that across the cases, withholding and/or aggressive parent, or parents,

> Great stress, however, should be placed on living situations and emotional problems of childhood life, as these are continually modifying the developmental process. The development of the child is seen in accordance with the general principle of psychoanalysis as an emotional interdependence between the parents, the surroundings of the child and the child himself…. (ibid. p.iii)

A decade or so later, Bender (1953) returned to re-examine the same cohort of children that had been the focus of the 1937 paper, this time elaborating

with the addition of follow-up information. Her re-appraisal drew closer attention to the family circumstances of the children, and she emphasized the fact that the children had commonly been subject to beatings, abuse and/or abandonment. Bender offered twelve case studies with only one child where she was unable to source the child's suicidality in family circumstances. She also noted that in the follow-up family conflict and illness appeared to have increased:

> …in all the preadolescent children in this study, with the possible exception of Paul, the (external) situation seemed serious enough and even more so after our follow up studies indicated that serious degenerative diseases or psychoses followed in the family pattern in nearly half the group. (ibid. p.86)

Sexual problems in the parents were referred to, but it is not clear whether or not Bender is referring to CSA as she did not elaborate further. Lack of parental love is re-asserted and linked to an increased aggression in the children. Bender found that aggressive parents and aggressive older siblings appeared to beget an aggressive suicidal child. She talked of processes of identification where, "one punishes the aggressor by acts directed towards oneself, when one identifies oneself with the aggressor." (ibid. p.88). Further, death as an escape, a kind of pardoning for the child's aggression was posited, and this seemed to be in keeping with Schmideberg's (1936) earlier theory of suicide as an avoidance of aggression. Finally, as this was, in part, a

follow up study Bender reported that none of the children discussed in the original paper had completed suicide.

Schecter (1957) turned to Freud's (1917) theory of melancholia, and the formulation of suicidality as hostility against a once loved object which is then turned against the self,

> "It is in this psychoanalytic framework-the attack of the introjected object and the attempts to recover it as a love object-that we can best understand some of the suicides or suicidal equivalents of children…turning hostility against and destroying the introjects within himself is too painful and too frightening. But another important factor is that the child's size and ego militate against the specific instruments of destruction." (p.132).

Schecter argued that militating defence mechanisms against disturbing affective states could break down in the face of excessive stress, leading to suicidality. This could be seen to find alignment with Freud's idea of a 'protective shield' (1920) which, when subject to too much stimuli, in the form of trauma can break the barrier (see section on Trauma above).

Schneer, Kay and Brozovsky (1961) looked at 84 suicidal adolescence, aged 12-16, and focused upon conscious ideation. Again, the hospital was in downtown New York, Brooklyn. They note the absence of father across the whole cohort and loss. The study is particularly interested in differentiating

between suicidal ideation and attempt. They found that, “The biological father, while usually the object actually lost to the child or adolescent in one way or another, had a secondary role and one based on frustration caused by the mother.’ (p 514).

They presented one case study of a 12 year-old boy admitted to the hospital after a drug overdose, partly in response to the prospect of meeting his third step-father. He desperate to hold onto a rejecting and abandoning mother and had placed in various foster homes. He held concerns around his masculinity and penis size, and a fear of being sexually attacked by boys. The authors concluded female envy and a desire to be reunited in eternal fusion with mother. Across the entire cohort they evidenced psychodynamic features of aggression turned against the self, killing the internalised hated object and joining the lost object. They gave a gendered reading

> The genital awareness and the continuing confrontation with the oedipal struggle at adolescence led to a revival of old frustrations; and through loss or rejection at the hands of the parents, interference with realization of the self as male or female. (p.514)

In 1962 the psychiatrist and psychoanalyst, James Toolan, published the first of 4 papers devoted to child and adolescent S-C. He looked at 102 children presenting suicidal thoughts and actions, 18 of whom were children under 12 years. He noted depression as significant and that in the very young they are less able to critique parents and therefore they assume the burden of the

difficulty themselves. They are then filled with despair for being a horrible person for hating the lost parent. Toolan also acknowledged the issue of revenge in the young S-C child who wishes to make the parent suffer in the way they have.

Winn and Halla's (1966) research focused on 70 children, 15 years and younger, who threatened to kill themselves. Again, disturbed relationship with the father is noted. They also noted the relationship between internalised and externalized aggression finding that there were high levels of expressed murderousness in the cohort. Of the 40 of the boys in the study 60% had threatened to kill another and of the 30 girls, 50% had threatened to kill another. The authors suggested that most acting out behaviours were due to underlying depression, noting that the children who had most reason to be depressed were the least likely to look depressed.

They also noted that 45% of the girls had sex with an adult which, translated into contemporary sensibilities, would find that 45% of the girls were victims of CSA. Further, 90% had demonstrated challenging behaviours in school with 10% making their suicidal threat whilst at school with a 3 year 'retardation' in academic performance. Sixty-five per cent of the entire cohort were preoccupied with death on admission and 90% experienced dreams where they were threatened with death or injury. Further, 50% had experienced a hallucinatory command instructing them to attempt suicide. Finally, Winn and Halla wrote about the losses the children had experienced.

Ackerly (1967), the only contributor to the American literature not working in New York, found that suicidal children were the product of severe emotional disturbance brought about by disturbance in the relationship within family. Twenty-four of the children had "threatened" (ibid. p.242) to kill themselves and 7 (4 boys and 3 girls) "attempted to" (p.242). Ackerly hypothecated that,

> "…the latency-age child who threatens to kill himself is giving expression to a complex interplay of psychic forces resulting from the vicissitudes of his aggressive drives and his narcissistic orientation to life…When a child has attempted to kill himself, there appears to be a major break with reality, a massive disruption of adaptive mechanisms and withdrawal of libido from the world. A psychotic state prevails." (p.242)

Ackerly located the source of S-C arising from; 1) aggressive drives, namely, primary oral sadism; 2) narcissistic expectations; 3) archaic superego; 4) his withdrawal of libido from objects (transient or prolonged); 5) the alteration of his ego by identification (usually with a suicidal mother); 6) his disappointment of not being able to achieve the aspirations of his ego-ideal; 7) his loss of a sense of well-being or ideal self; 8) his struggle with early emerging conceptions with death; 9) his attempt to overcome his state of helplessness, and; 10) his wish for rebirth or reunion with the all-giving mother (state of primary narcissism or the phoenix motif).

> In those children who attempt to kill themselves we see further a major break in reality intensified despair, hopelessness, and overwhelming

> aggressive response to frustration and disappointment. They were unable earlier to develop a firm basic trust and have no hopes for a better future. They regress to a psychotic state. My hypothesis is that a widespread regression in ego functioning and a rupture in total ego integrity differentiate those children who make a serious actual attempt at self-destruction. (ibid. p. 256)

Ackerly cited Menninger's (1933) suicide triad (to kill, to be killed to die), focusing on the child's aggression, hate and annihilatory rage, born from his primary oral sadism, desire for revenge and the wish to kill, masochism in the wish to be killed, and the finding of a better place in the wish to die alongside hopelessness and despair. He wrote of the wish to return to a lost Shangri-la of early childhood with the all-giving mother.

Further, Ackerly outlines what he considers to the formula for the most effective treatment approach for working with the S-C child with the following aims of treatment: 1) To offer a new object relationship and facilitate the internalization of a more benign object configuration. 2) To treat mother and father, their aggression toward the child, and their death wishes. 3) To help alter the child's overly harsh superego which is a product of his murderousness. 4) To help the child withdraw cathexis from the ideal self.

Toolan's later paper (1975), like Schecter earlier, found that at the core of the suicidal child is the real or imagined loss of a loved one. Toolan (1975) talked about 'masked depression' where depression is defended against and instead

express acting out behaviours, particularly the case with boys and he discussed countertransference issues (the therapists unconscious reactions to the patient) and the anxiety generated in the therapist who fears that the patient will kill themselves. Toolan asserted that there were 5 key aspects of child suicide communication; 1) anger, 2) reconciliation with a dead loved one, 3) manipulation of others, 4) a need to convey distress, 5) an indicator of inner disintegration. Toolan charted what happened when disturbance occurred at different developmental stages where maturation was impaired by neglect or abuse, suggesting that the development of the ego and all attempts at relationships thereafter would be compromised.

Green (1978a, 1978b), another psychiatrist working in a state hospital in New York, noted that the vast majority of the children had been subjected to recurrent abuse in their first 2 years of life. Less than one-third of the children were from intact families, while almost one-half had been removed from home for at least one period in their lives. Green noted how many exhibited an excessive use of primitive defences such as denial, projection, introjection;

> They were unable to integrate the loving and hostile aspects of their parents and others. This accounted for the baffling tendency of some of these children to support completely their parents' transparent denials and rationalizations concerning inflicted injuries…While this need to suppress knowledge of parental wrongdoing was occasionally motivated by fear of additional punishment, it also represented the child's need to protect himself from the awareness of the actual and internalized

> destructive parent and to safeguard the parent from his own murderous rage. The image of the “bad parent” was subjected to denial and was projected onto some other person, allowing the child to maintain the fantasy of having a “good parent.” Splitting mechanisms were more frequently observed in those children who were abused by the parent who provided most of their nurturing. Their acknowledgment of the destructiveness and malevolence of the primary caretaker, usually the mother, would have placed their tenuous dependent relationship in jeopardy. (Green 1978a p.97-98).

Green’s (1978a) first paper was concerned with the phenomena of attachment and he developed a line of inquiry that Bowlby (1973) had pointed to earlier. Green noted that the children had significant separation anxiety and how intensely fearful they were of object loss. He wrote of their struggles to behave well in school, quoting limited attention span, hyperactivity, learning difficulties, aggression and poor impulse control. He also noted that parents were frequently called to come into school. In response Green emphasized the necessity of securing a safe living environment for the children. He found that these children’s masochistic behaviours were acting out their treatment at the hands of their parents, inviting cruelty and punishment from others. Further, Green (1978b) found;

> Self-destructive behaviour represented the child’s compliance with parental wishes for his destruction and/or disappearance. The self-destructive behaviour of the abused child may also be conceived as the

> end result of the transformation of feelings of low self-esteem and self-hatred into action. (Ibid. p.92).

Green recognized that there were disturbances in their object relationships which he considered as pathological:

> Early and pervasive exposure to parental rejection, assault, and de-privation had an adverse effect on the development of subsequent object relationships. Potential new objects were regarded with fear and apprehension. The abused children were not able to achieve Erikson's (1950) stage of basic trust. They expected similar frustration and maltreatment from other adults on the basis of previous experience. Violence and rejection were regarded as the major ingredients of human encounters. These children were involved in a perpetual search for "good" objects to protect them from the "bad" ones. (p. 96)

Cynthia Pfeffer's (1979; 1980; 1981a, 1981b; 1985a; 1985b; 1986, 1990a; 1990b; 2003) was yet another psychiatrists working in New York with children from lower socio-economic and mixed ethnocultural background. The most relevant contribution in terms of this literature review is her chapter, '*Observations of Ego Functioning of Suicidal latency-Age Children*' (Pfeffer, 1985b) which offered an overview of her practice and encounters with young suicidal children. Pfeffer talked of her previous studies into ego functioning in S-C children where the findings indicated;

> that among psychiatrically disturbed children there was no difference in such aspects of ego functioning as intelligence, impulse control, reality testing, and defence mechanisms between children who have no suicidal behaviour and children who have suicide threats, attempts and behaviours. (Ibid, p.40)

However, Pfeffer went on to notice distinct observable effects of S-C children's ego functioning positing that these children see death as pleasant and temporary. Although they can grasp its permanence when not in crisis. Further, Pfeffer found that they are preoccupied that their relatives might die and concluded that their preoccupation with their own death might be a mechanism to avoid frustration as they have a belief that in death they will be taken care of by a nurturing parent. She noted that the suicidal child often was involved in a symbiotic relationship with mother but unable to tolerate frustration leading to aggressive outbursts and a state of regression to an infantile state.

Pfeffer was interested in the ego development in early infancy and she quoted Anna Freud (1963) that, "Depressive moods of the mother during the first two years after birth can create in the child a tendency to depression (although this may not manifest itself to many years later." (Pfeffer, 1985.b, p.43). She concluded that; "regression of depressed children may be an important mechanism leading to suicidal actions." (ibid. p.42). Pfeffer also referred to the ego splitting (Klein) in the S-C child, and that this splitting led to a particular vulnerability in children with suicidal ideas where the child would tend towards

identification with mother, the consequence being a confusion of feelings towards others. This state of confused identity, self-other blurred, compounded by ego regression she saw as the necessary focus for therapeutic work. Later Pfeffer's *et al's* (1995) follow up study found that,

> Specific ego functions, such as impulsivity, poor reality testing, and ego mechanisms of defence such as projection, regression, compensation, and reaction formation were positively associated with suicide attempts. Repression was a protective factor to prevent suicide attempts in the follow-up period. (p. 1318)

Pfeffer's attention to the child's external environment is significant as she asserts that before any scrutiny of the internal landscape, the external landscape needs stabilising and made safe.

> "An implication for treatment is that it is not only important to recognize the external warning signs of suicidal tendencies of children but also to offer the child immediate external ego support to bolster the child's failing intrapsychic mechanisms of coping. Only after external support and protection from harm are provided can the clinician begin the longer process of evaluating and treating the child's basic intrapsychic and environmental difficulties." (Ibid. p.47)

This paper marks a shift in the relationship between welfare and therapeutic services. In the earlier publications it would appear that welfare services

preceed the psychiatric/psychological services whereas here it would appear that it is the assessment process which might result in a referral into welfare services. I suppose what Pfeffer is saying here also chimes with Maslow's (1943) hierarchy of needs where, first, basic needs, such as safety, need to be met.

Friedman and Corn (1985) looked at 101 adolescents and found only one had made a pre-adolescent suicide attempt at 7 years. The boy was diagnosed with a primary affective disorder and hospitalised at 12.5 years. Again, his suicide attempt was understood within the context of his family dynamics and the authors emphasised the importance of actual life events as opposed to fantasy. They also underlined the importance of stressful events taking place at a phase-specific time of vulnerability and these enhanced the child's risk of suicide at the time of his attempt.

Cohen's (1993) paper begins with reference to Pfeffer's book, and states an intention to, "demonstrate those suicidal acts that may belong to Pfeffer's category, children with deficits in ego functioning and extreme parental psychopathology." (ibid. p.406). She goes on to offer three cases studies, a 12 year-old boy, and two 8 year-old boys, all treated at the Jerusalem Treatment Centre for Severely Emotionally Disturbed Children, Israel. All had either receded fathers, and had been doubly abandoned by both parents. Significantly, all endured beatings and the hatred of their mothers. I think this paper tries to look at the impact of the family environment, and transgenerational trauma, upon the ego but, it is clear from these terrible case

studies that anyone might be broken by such circumstances and question whether life was worth living.

Again, this paper inculcates that psychoanalysis is a method of making sense of what doesn't appear, at first, to make sense. However the suicidal communications from the children in this study do make sense. Whilst some might counter that a number of children experience adversity and do not become suicidal, ACE literature helps us understand that accumulative adversity, without any countervailing protective factors, will take its toll upon resilience and tenacity to stay alive. As ACE becomes more nuanced we might better understand risk. However if we bring this together with the depth or meta psychology of psychoanalysis then this might shape up into something more helpful.

2.13

Summary of the Psychoanalytic Child S-C Literature.

In summary, the focus of psychoanalytic literature on S-C in young children seems to point to a cluster of themes such as unsatisfactory, damaging, and abusive family environments, parental mental ill-health and Oedipal anxieties. There is less of a focus upon aggression thwarted and turned against self, than in the adult literature, with a greater balance of focus upon physical and sexual abuse, physical ill health in child and family members and traumatic loss. However, what starts to become clear in the child literature is that it is not just the loss, but the kind of loss, relationship prior, and those after, that might lie at the heart of child suicide-communication. The child is left

assuaged by guilt for any ill feeling toward those who have gone and to those who have stayed, particularly if those relationships have been violent and withholding. In this way it would appear it takes two parents to make a suicidal child, typically, with the combination of the loss of one and the hate of the other, a model of absence and intrusion, where loss cannot be mourned as hate intervenes and devours sad.

There is attention paid to damaged and damaging object relations, processes of identification, ego splitting and merger. Pfeffer (1985) pays close attention to the ego and finds that regression is an indicator of suicide risk, although she finds that risk in this age group needs to also take account of depression (whilst recognising that this is not the diagnostic panacea), however, the attention to the intra-psychic is set against the conscious cognition around hopelessness, worthlessness, wishes to die, preoccupation with death, a belief that death is temporary and painless. Further, there are the objective realities of suicidal parents, paternal absence, murderous and symbiotic mothers, lack of generational hold and the idea of transgenerational transmission.

The murderous mother who continues unabated without the ameliorating presence of father is the lethal combination with the child moving between death wishes and indifference, where existing is impossible. The minimal attention paid to siblings, might be both a continuation of this lack of life-affirming objects. Or it could be that psychoanalytic focus largely moves between the primary dyad of mother and child, then the triad of father. Any

sociality beyond this seems to fade from grasp. There is some attention paid to transgenerational transmission, and by omission in the immigrant group it could be the loss of the grandparent's generation left behind as their offspring built a new life and family that could be contributory to suicide states as rupture and lack of holding seem to feature in the literature.

In terms of social disadvantage there is an implied relationship between immigration, poverty and child suicide-communication but this is not detailed clearly in terms of its relationship to how the family functions or not. As outlined most publications make reference to the number of immigrant children in their cohort and, as such they are working with displacement, attachment, separation, transition, transgenerational disjunctures in continuity and experience of prejudice and racism, but this is not explicitly made sense of in terms of the child's suicide-communication. We now know that immigrant groups demonstrate higher suicide rates than indigenous residents (Merril & Owens, 1988; Raleigh & Balaran, 1992). This also echoes Durkheim's (1897) findings in relation to what we might refer to as 'social estrangement'.

Apart from Cohen's paper, where there is mention of the Holocaust, the broader socio-political schema is not pulled in for consideration in the child literature. Even Cohen, only touches upon it lightly. And the children we are left with in our laps, at the end of all these painful studies are those that, unlike adults, have no agency, and no place to go other than to attack and threaten themselves. Bender's (1956) was the only follow up study and she found none of the original cohort had completed suicide. What also emerges

from the literature is that those who are unable to articulate a need for help are often most vulnerable to suicide (Apter, 2004; Ronningstam, 2010). It was their articulation that these children found the minds of those who wrote them into a future. And it is the then and now intra-action of the entangled matrix of the suicide-communicating child, welfare and psychological services, who bring this agential reality to bear in this study.

2.14

Reflection Across the Literature

A review of the psychoanalytic suicide literature tells a story about how psychoanalysis has engaged with the external world whilst trying to elaborate internal phenomenology, and in so doing maintain its unique contribution as a metapsychology and cartographer of the unconscious. It also tells a story of of the ebb and flow of psychoanalysis itself. As a study looking to find a way of understanding the intra-face of the external and internal worlds, underpinned by an onto-ethico-epistemology, the critique of the literature has been in its biography, as well as its theoretical content because the two cannot be extrapolated. All theory is story, and we need to understand the story to know why and where ethico-agential cuts have been made. In this way I, too, looked for a way to manage the internal (theory) and the external (biography) of the literature review.

What the review revealed was that adult psychoanalytic suicide theory was, largely, built upon middle class patients where Freud's expertise was gathered by mapping out the intra-psychic domain of his neurotic and

hysterical (conversion) patients, where the immediate cause of their distress could not necessarily be discerned. Further, Freud's 1917 formulation of suicide was only in relation to the depressed patient. This was subsequently extended and developed by those who followed. However, the children's suicide literature, in stark contrast, was largely drawn from poor, immigrant children who were not obviously depressed. The bulk of the literature catalogues the desperate experiences these children had endured in the external, inter-personal world. Saturated with loss, often in receipt of statutory provision, this is where these children met psychoanalysis, predominantly practised by those who knew the perils of immigration themselves. Some practitioners tried to apply Freud's theory to these children but it would seem that the shadow of the objective fell upon the ego as external reality offered sufficient explanation. And whilst an internal chronical of the demands placed upon the ego, as in Cohen's paper, offers a more nuanced illumination, which might offer a crucial contribution to analysis of suicide risk it is secondary to the primary necessity for statutory safeguarding.

It was this objective reality that many of the practitioners gleaned from welfare records. In this way this literature sits at the interface of the workforce of sociology and psychology/psychiatry. Where the state intervened when the parent could not manage good enough. Arguably, where the state tried to make recompense for the wounds inflicted by the creation and maintenance of systems which allow for such iniquitous distribution of resources. Where the state created the conditions for love's loss and, in turn, suicide's

communication. But it was also where Freud and Durkheim passed like ships in the night, for whilst Freud said,

> it follows from the nature of the fact which form the material of psychoanalysis that we are obliged to pay as much attention in our case histories to the purely human and social circumstances of our patients as to the somatic data and the symptoms of the disorder. Above all our interest will be directed towards their family circumstances. (1901, p.17)

However, he did not necessarily take his own advice and psychoanalysis maintains an ambivalent relationship to external events when it comes to suicide. However, this is a study based in the statutory provision that is the primary school. It is a study of the socially disadvantaged. It is a psychoanalytically informed study of the socially disadvantaged child delivering their suicide-communication into the hands of the statutory representative that is a school staff member. Their communication, a matter of statutory record, available for government inspection.

Across the adult and child literature, it could be argued that the class structure shapes the psyche. However, when working with adults, as Freud did (with the exception of 'Little Hans' in 1909) childhood is a distant shore and has to be extrapolated, hence transference and the birth of psychoanalysis. With young children, however, the practitioner is necessarily swimming in more accessible waters, a stone's throw from the informing years However, whilst doing so they did not explicitly map out how they might impact the psyche in a

way that would result in a suicide-communication. Here lies the gap in the literature which this study seeks to fill.

2.15

Gap in the Literature

The gap in the literature is:

1. No UK psychoanalytic literature specifically addressing suicide-communication in primary-school children, beyond the single clinical case study approach.
2. No literature across psychology and psychiatry, from the UK, which specifically, and exclusively, addresses suicide-communication in primary school-age children.
3. Single case study dominates the literature regarding suicide across the lifespan and psychoanalytic studies of larger research cohorts are rare.
4. There is no psychosocial literature, attending to young children.
5. There is only one psychoanalytic study (Hendin, 1969) of how social disadvantage might impact upon the psyche resulting in a suicide-communication and this focuses upon Black, male adults.
6. There are no suicide studies built with a Baradian onto-ethico-epistemology.

2.16

Research Question

Therefore, I am looking to add to the psychoanalytic suicide literature with specific focus upon socially disadvantaged children. I can do this by

accessing these children via primary school staff, amongst the first representatives of the state they encounter independent of their families. The data these staff can provide might offer the opportunity to specifically examine the possible relationship between 'states of mind' in these children and state sanctioned social disadvantage. Because there is such a paucity of UK literature beyond the single case study, this research will focus soley upon first hand accounts of what those in receipt of these communications *say* about them. This is because I wish for the research focus to remain on the children and their lives. I will not be seeking to analyse the recipients as my focus is neither upon them, how they feel and felt, what they did or did not do. Nor is the focus upon the relationship between them and the children. This is for another study. To this effect, the following research question is identified, "What do primary school staff say about suicide-communication in socially disadvantaged young children?"

It is this question that will be taken into the data collection phase of the research. In an effort to study across social disadvantage and internal worlds/states of mind, it is important to develop a suitable method, and for this to be informed by an appropriate theoretical and epistemological approach. As such, in the following chapter, I will be looking to Barad to help build an epistemological base with which to do so.

Chapter 3

Methodology

Chapter Outline

Section 3.0 considers the ethical complexities of interviewing vulnerable children and why the research set out to capture the voices and experience of those children through their encounters with primary school staff. Section 3.1 outlines the plan for sampling and recruitment of participants. Section 3.2 considers the challenge of doing interviews about sensitive topics, paying attention to the particularities of being a clinician researcher in terms of dual ethical responsibilities. Section 3.3 considers ethics in relation to Agential Realism concluding that it enriches the ethical frame. Section 3.4 attends to epistemological positioning and the issue of reflexivity. Section 3.5 offers up the idea of 'diffractive reflexivity' and seeks a rapprochement between Barad's dismissal of reflexivity and assertion of diffractive practice. Section 3.6. attends to the qualities of qualitative research and the contribution of psychoanalysis. Section 3.7 explores the interview question, and the idea of a single question interview. A perspective on an agential realist frame of the participant researcher is considered. Section 3.8 discusses the rationale of a psychoanalytically informed thematic analysis as a method of data analysis.

3.0

Ethical Challenges and Procedures

The literature review provided an orientation to answering the question as to how S-C in primary school-age children has been understood to date. This supplemented my own experience from practice. It also generated the research question to take into the data collection phase of the research: 'What do primary school staff say about S-C in socially disadvantaged young children?' My plan was to ascertain if it would be possible to generate further data which would seek to address this, a way of triangulating the literature with my experience and perspectives from others. Initially, I considered the possibility of interviewing young S-C children themselves. However, having looked closely at the literature on researching children (Alderson & Morrow, 2004; Alderson, 2007; Tisdall *et al*, 2008), and the ethics of researching vulnerable populations (Liamputtong, 2006; ESRC, 2018), and at risk children in particular (Gorin *et al*, 2008; Skånfors, 2009), I concluded that existing ethical infrastructures were inchoate and insufficiently robust to progress this idea. My second choice then was to capture data from those adults who had encountered these children and had intimate knowledge of them through their contact in primary schools. In other words, my aim was to harness the voice and experience of S-C children refracted through the lens of those whom they encountered.

3.1

Cohort Recruitment

I approached colleagues in my school and across my network of contacts to let them know about my research, a type of 'snowball sampling' (Noy, 2004) or convenience or purposive sampling (Robinson, 2014). This approach can be subject to criticism for lacking the empirical rigour of randomisation for instance, and can stall with hard to reach populations, for example when researching problem drug users (Water, 2015). But it has been shown that there is additional worth to snowball sampling when researching new research areas where there might be emergent social networks (Noy, 2004).

My sampling method might be said to be fitted in regard to my position as an 'insider researcher' (Greene, 2014) where my stake was clear in so far as I presented myself both as a researcher and, in some cases, a fellow practitioner, in other cases, an external colleague, in others again, an internal colleague. There are some research academics who would see insider research as devoid of the necessary objectivity to constitute what some might call good science (Unluer, 2012). There are advantages to insider research insofar as there is access to networks, familiarity with custom and practice, and it makes it clear that the researcher's stakeholder interests are transparent and not neutral. But there also can be dilemmas where conflict of interest can present, a "*double edged sword"* according to Mercer (2007).

The research participant letters and consent forms were carefully considered and revised in collaboration with the University of Exeter Ethics Committee

(see Appendix A) outlining the planned steps for the interview in terms of setting, audio recording as well as an introduction to the aims of the research. Even though I was planning to interview non-vulnerable adults, there still remained a level of ethical responsibility toward the children, paying particular attention to the traffic of communication out of the interview, if it was considered that the children under discussion had been insufficiently safeguarded and were without service involvement to monitor risk. Further, I intended strenuous efforts to anonymise data with no mention of identifiable detail such as school name and geographical location, whilst maintaining the routine anonymising probity of clinical practice.

3.2

Doing Sensitive Interviews - Ethics and the Clinician Researcher

My plan was to interview staff working in primary schools and I anticipated that I would recruit teachers, teaching assistants and counsellors. In regard to the challenge of doing interviews one of the particularities of the ethical steps for the research was a consideration of possible modifications to the orthodox stance of social science researcher, with the added dimension of being a clinical practitioner conducting research outside of a clinical setting. The clinical psychotherapy researcher is a relatively new breed[15] and perhaps we are yet to fully articulate the challenges and potential of the cross-over of psychoanalytic practice skills, with the capabilities of trained qualitative and quantitative researchers (Tillman *et al*, 2011). Arguably, a clinician researcher is distinct from a social science researcher in several ways. There are certain

[15] Arguably, all psychotherapists are involved in a process of research in their practice, see Rustin (1997) and Hinshelwood (2013 & 2018) for further discussion.

attributes, but one of the clear lines of demarcation is that a clinician is governed by an additional Code of Ethics, or an Ethical Framework, drawn up by the practitioner's registering body. In the UK there are a number for the psychotherapy and psychology professions, each having a code of professional conduct and a code of ethics for researching client work, however, when I embarked upon the research, these were insufficiently delineated to encompass a clinician researcher working outside of the clinical setting, capturing information from non-patient populations.

The British Psychological Society's (BPS)[16] Code of Human Research Ethics supplements the Code of Ethics and Conduct and uses the term 'participant', however, the Association of Child Psychotherapists' (ACP) Code of Professional Conduct and Ethics refers to the 'patient's welfare' but, nowhere does it refer to the research participant's welfare. It does refer to research in section 5 but it refers to the clinical process of psychotherapy, remaining firmly within the frame of clinical practice. The British Association of Counselling and Psychotherapy (BACP), likewise, does not encounter the psychotherapist researcher outside the consulting room. Therefore, I approached the research as a psychotherapist conducting research into a non-clinical population (although some of the participants were talking of clients), meeting the university's ethical requirements which was sufficient to press ahead, but navigating less charted territory in terms of ethics governing

[16] Interestingly though there is a clause in the BPS's research guidelines that allows for research in exceptional circumstances going ahead without consent if the benefit is seen to outweigh the prospect of not going ahead with the research.

me as a clinician researcher carrying out research beyond psychotherapy practice.

In regard to the application of clinical practice skills in doing interviews, Parker (2010) argues that an understanding of transference can help the social science researcher optimise the conditions for the participant to narrate their experience. In psychoanalysis there is a legitimate and necessary role for the analyst's reverie and self-reflection when relating to the client, there may be long pauses, and the analyst might plumb their own interior and emotional depths in order to make sense of the analysand's situation. Arguably, in the social scientific research interview this depth of engagement needs to be more tempered and the interviewer stays more on the surface in order to maintain focus, particularly with interviewees unfamiliar with a psychoanalytic clinical encounter, for example, when interviewing teachers.

As Risq (2008) points out, the psychoanalyst must be cautious about over analysing the participant in the qualitative research interview process. I was particularly aware that participants had agreed to be interviewed, not analysed, as an analysis of their unconscious process was not something they had signed up to. These considerations also impacted my decision not to adopt the Free Association Narrative Interview (FANI) approach outlined by Hollway & Jefferson (2000), which has increasingly been used by other researchers who are not psychoanalytically trained. Instead, I endeavoured to create an open and facilitative space for the participants to be fully explorative of their responses to the launch question.

Hollway & Jefferson (2001; 2008) talk of the 'defended subject', positing the idea that all research participants begin from a position of anxiety. This view is not without controversy, but it feels an appropriate assumption in terms of my focus of research inasmuch as the topic of child S-C might well locate already existing anxiety regarding the subject. Klein (1948) suggested that all anxiety was an innate fear of death and therefore a study exploring what were, essentially, death narratives, might well have an intensification of anxiety attached, particularly when those issuing such communications were young children, and the adults receiving these have a duty of care toward those children which is part of their contractual responsibilities in their workplace.

I would not know the life histories and psychological stability of those I interviewed, or even if they were experiencing suicidal feelings themselves at the time of interview. It is estimated that around 19%[17] of the UK population have experienced suicidal thoughts (Gov.UK. 2017), and primary school teachers have a 42% higher completed suicide rate than the national average (ONS. 2017). As such I needed to approach participants with additional sensitivity. There have been concerns around what is termed the 'iatrogenic effect' (Schaffer *et al* 1990), which is where discussing suicide might exacerbate suicidal feelings. However, I was reassured by Gould *et al* (2005), Cukrowicz (2010), and Hom *et al* (2018) who found no iatrogenic effect from suicide research among people who were experiencing suicidal ideation.

[17] The figures were broken down by ethnicity with stats ranging from 13.1 in those identified as Asian, 20.7 Black, 17.9 in Mixed/Other, 21.6 in White-British and 20.8% White–Other. The survey was a probability sample of the general population.

I was also aware that the subject of the interview could be distressing to the participant insofar as they would be returning to reflect on prior experiences of upsetting encounters with children. However, there is some reassuring, and related, research that far from causing further harm, participation in research for those who have witnessed suicide can, in fact, have a tonic effect. Dazzi *et al* (2014) and Dyregrov (2004) emphatically demonstrated that among a research cohort of parents who had experienced suicide bereavement, 100% found participation as either, "*positive or very positive*", and none regretted participating. Therefore, I considered there might be a possibility that far from causing harm, the research participants might find the research beneficial to their own wellbeing. Further, I also considered that the research itself might offer a process of, 'secondary mentalization' (cf. Allen, Fonagy & Bateman, 2008.) for the children discussed. By this I mean the clinician researcher, and participants, thinking into the mind of the child under discussion offers up something containing on some level.

The skill and deployment of a social science research interview is well described in the literature, as well as the potential of emotional harm for participants when engaging in in-depth interviews focusing on sensitive topics (Lee, 1993; Allmark, 2009). Corbin and Morse (2000) point to the protective element in the qualitative research interview where the participant can self-monitor and so limit the level of disclosure to avoid personal distress. This might be the case but, arguably, there is a degree of responsibility for the researcher to maintain some empathic, and indeed sympathetic, response to

possible participant distress. It would seem a dereliction of duty to be complacent about the possibility that an interview might be upsetting for the participant, however, whilst academic researchers prioritise participant wellbeing above research agendas, and might be anxious about participant upset undermining this stance, it is arguable that clinician researchers consider the expression of upset as an opportunity to process feeling states in the presence of another equipped, through training and practice, to manage these, after all it is not the interview process that is upsetting, it is the experiences the research participant is bringing, and these pre-date the interview.

Ethically, I was preoccupied with whether or not the research was going to help these children, and the staff that encountered them. Doctoral research is not necessarily put in the service of the researched as it can remain unpublished in journals, unspoken of at conferences and presentations. However, the express remit of clinical doctoral research is to return the research to the patient population researched. Typically, the clinician researcher has already dedicated professional energies to ‘making better’ in addressing health inequities. If you are a clinician researcher who has stayed in the field during the research, and, will continue to do so after the research is completed, then the immediacy of research yield being returned to the researched, and integrated into the field, is reasonably expedient.

3.3

Ethics and Agential Realism

Karen Barad (2003, 2007, 2014) proposes her theory of 'agential realism' as an ethico-onto-epistemology. Here, I reiterate my understanding of agential realism and why I believe it offers up a welcome extension to the multi-disciplinary needs of a 'suicidological' study. Further, it is outlined within the ethics section because, after becoming conversant with the literature on suicide, in conjunction with my clinical experience, I believe the phenomenon of S-C needs first to be situated within ethics. By this I mean that it comes under the auspices of moral governance, not in the sense of individual morality, which is where early philosophers from Plato through to Locke (1689) and Hume (1777) placed it, but within what we might refer to as 'social morality'. Barad offers this possibility. Agential Realism is defined by Barad (2007) as,

> an epistemological-ontological-ethical framework that provides an understanding of the role of human and non-human, material and discursive, and natural and cultural factors in scientific and other social-material practices… (p.27)

Barad's work is both a continuation, and reconsideration, of the ideas of Niel Bohr's (1885-1962) philosophy-physics. One of his ideas, relevant to this research and agential realism, is his proposition, that measurement is the meeting point between nature and the social and as such it is impossible to

separate out what is measured from that which measures. Barad suggests that,

> the agencies of observation are inseparable from that which is observed. Measurements are world-making: matter and meaning do not pre-exist, but rather are co-constituted via measurement intra-actions. (Barad, 2007. p.6)

Barad sees agency as coming into existence as a product of 'intra-action' which is the mutual constitution of entangled agencies. Importantly, intra-action is constituted from within, as distinct from interaction which is between. By within, Barad means that there are no pre-established bodies that then interact, nothing pre-exists the intra-action. In this way individuals exist because of intra-action and only exist within phenomena, '"in their ongoing iteratively intra-active reconfiguring." (Barad in Kleinman. p.77).

Applying agential realism to child S-C, as far as my preceding literature review stands, we might say the phenomenon that is child S-C emerges through the intra-action of politics, religion, capitalism, technology and material discourses concerning the socially deprived, class, human bodies, children, gender, patriarchy and mental illness. Intra-action then becomes an ethics as we are all contributory in terms of the phenomenon of child S-C. Whereas relatively few people will interact with child S-C, particularly if it remains localised to a mentally unwell individual as is often the case with the medical model, many more of us will intra-act with the co-constituting phenomenon of child S-C.

Barad's approach is post binary and, as such, her ideas could be seen as democratising in that they challenge the status quo, collapse hierarchies and, as such, have the potential to contribute to social and global action as hierarchies and stasis can inhibit such action. As the suicide literature finds (Durkheim, 1897; Halbwachs, 1930; Richman, 1981; Van Orden *et al*, 2010, 2012) the threat of falling out of the fabric of the social can be an indicator of suicide risk, then Barad's theory keeps the individual entangled within and holds others to account. As such, it was ethically indicated to make use of an agential realist approach, particularly as access to these troubled children was *through* adults.

Lastly, Barad impresses the importance of understanding her theory of intra-action as, "a radical reworking of causality" (2007. p.33). Arguably, S-C needs a radical reworking of causality as in over 100 years of dedicated interest, globally, suicide is on the increase (WHO. 2017) as is youth suicide in the UK (ONS. 2018). Of note, most of the research informed risks could be identified by the end of primary school, and, sadly, a small number of children I currently work with are shaping up to meet many of these. An agential realist, psychoanalytically informed, ACE sensitive, suicidological study allows for the adumbration of such suicide risk profiles. Barad claims that agential realism, by going beyond political and social theorists, allows for "political possibilities for change" (ibid. p.34) and, as such, I was interested to work within it. Further, it locates the researcher who might be researching causality, to look

at their contribution to that causality, thus generating the possibility of action, and therefore change.

3.4

Epistemological Positioning and Reflexivity

As we have explored epistemological positioning, briefly, in the introductory chapter, here I will elaborate further, with a particular focus upon reflexivity. Barad (2007) argues that we need to collapse notions of knower and known, subject and object, inside and outside, as such all researchers are seen as insider, or within. Barad sees researchers as emerging through co-constitutive intra-action with research participants. Reading this position through psychoanalysis, it could be said that my biography intra-acting with each participant's biography produces the data. In my case, Barad would contest that it was not just school counselling services I was part of, I was co-constituent of all the intra-acting entanglements which produce child S-C and, indeed, the research data itself. It would be impossible for me to stand outside of this world in an effort to know about it. Further, as previously touched on above, the researcher is an integral part of the measuring apparatus and the knowledge that is produced:

> Knowing is a distributed practice that includes the larger material arrangement. To the extent that humans participate in scientific or other practices of knowing, they do so as part of the larger material configuration of the world and its ongoing open-ended articulation. (ibid: p. 379)

Further, she argues:

> The separation of epistemology from ontology is a reverberation of a metaphysics that assumes an inherent difference between human and non-human, subject and object, mind and body, matter and discourse. (ibid. p.185).

A flattened hierarchy of intra-acting agencies, reconsideration of the porosity of self, and post-binary sensibilities call reflexivity itself into question. Arguably, reflexivity assumes an independent self and a particular position in relation to subjectivity and, as such, Barad seeks to dismantle its dominance in the social sciences. She is not the first to call it to account, "…my suspicion is that reflexivity, like reflection, only displaces the same elsewhere, setting up worries about copy and original and the search for the authentic and really real." (Haraway, 1997. p.16). However, according to Ashmore, 1989; Lynch 2000; and Dowling, 2006, there are several interpretations of reflexivity. Weick (2002) suggests reflexivity identifies the author's position and is concerned with, "turning back on one's self. It is about seeing oneself in the data." (ibid; p. 984). Bolton (2010) suggests reflexivity is, "finding strategies to question our own attitudes, thought processes, values, assumptions, prejudices and habitual actions, to strive to understand our complex roles in relation to others…to be reflexive involves thinking from within experiences." (p.14). However, Barad takes issue:

> Reflexivity, like reflection, still holds the world at a distance. It cannot provide a way across the social constructivist's allegedly unbridgeable epistemological gap between knower and known, for reflexivity is nothing more than iterative mimesis: even in its attempts to put the investigative subject back in the picture, reflexivity does nothing more than mirror mirroring. Representation raised to the nth power does not disrupt the geometry that holds object and subject at a distance as the very condition for knowledge's possibility. Mirrors upon mirrors, reflexivity entails the same old geometrical optics of reflections. (*ibid*. p. 87-88).

There is no doubt that this position is challenging, particularly for a psychoanalytically informed clinician researcher whose use of reflexivity is a mainstay of practice. For the purposes and duration of the thesis, the working definition of reflexivity is, 'the scrutiny of researcher self in relation to the research and the researched.' Arguably, reflexivity holds the mirror intact, even if it does turn the mirror around to reflect the researcher, and her internal machinations, researcher position remains focused upon the research and, as such, stays within a clinical and academic bubble.

Barad mentions psychoanalysis once in her 2007 book, *Meeting the Universe Halfway.* Talking of Brittlestars, once again, Barad finds Brittlestars are able to reconfigure their body boundary by jettisoning one of their 5 limbs when under threat, possibly as a decoy to avert attack. Barad considered whether this detached limb continued to be part of the body of the Brittlestar, or

whether it became part of the environment, and this led onto a reconsideration of what constitutes body and environmental boundary. This is particularly pertinent in a suicide study where the literature confirms that the body and consciousness afterlife and continuity of being is not contingent upon contiguity. Further, this led to a recalibration of what constitutes brain and thinking, whether thinking was the exclusive domain of humans, and whether nature and culture were distinct, boundaried entities. This then led on to a reconsideration of embodiment and the possibility of a reconsideration of physical trauma, lost limbs, and memory which, in turn, leads into Barad's challenge of "rethinking psychoanalysis" (ibid. p.377)[18]. By this, I think she offers the possibility that connectivity is not contingent upon contiguity. But perhaps, most challenging to psychoanalysis, although Bion (1967) was ahead in terms of his thoughts waiting for a thinker, and Freud (1913) in terms of the past is the present, Barad wishes to recalibrate how the mind thinks and the wall between the unconscious, the conscious, inside and outside, past and present.

In agreement with Barad's point that, "turning the mirror around, as it were, is a bad method for trying to get the mirror in the picture" (ibid. p.418), I decided against a heavy reliance on reflexivity, but did not dismiss it altogether. Instead I opted for, what might be referred to as a 'diffractive reflexivity'. In physics diffraction is where a wave (sound, light, electromagnetic) encounters an aperture or obstacle, instead of maintaining its straight trajectory, it either spreads out or bends around it. To illustrate Barad's diffractive methodology,

[18] I correspondended with Barad (30.10.19). She said that the relationship between the unconscious and agential realism was an area that was of interest to her.

she gives the example of 2 pebbles being thrown into a pond simultaneously. Wave patterns emanate out from each, and, at a certain point, each wave pattern encounters the other forming a new wave pattern. It is a model for change as opposed to continuity, and the study was change seeking. S-C is change-seeking. Suicide-communication acts as a portal for experience to push through and to not continue as before. It also holds reflexive and reflective capacity.

For the purposes and duration of the thesis, whilst accepting there could be numerous interpretations of, what I have come to call, 'diffraxivity', its working definition is, 'the position of the researcher in relation to the broader intra-actions which bring the phenomena under research interrogation into being.' As such it is more 'outward' looking than reflexivity, as it pays attention to universal entanglements and the researcher's role outside of the research. It concerns itself less with subjectivity. It breaks the mirror to refract and reflect the bigger picture. In doing so, arguably, diffraction offers more opportunities for change than reflexivity. Significantly, it can take us beyond the social, and into the physical and post-human realm.

For example, taking the research situation, when what one participant says encounters the portal or obstacle of the research/er, what is said will inevitably change shape or direction. Preserving what has been said as if it didn't encounter a portal, obstacle or receptor would be a denial of the research encounter, and the entangled transaction therein. Whilst reflexivity draws attention to this, and is interested in how subjectivities shape research, it

treats the researcher as distinct and outside of the research process, looking in, commentating on the researched other.

3.5

Diffractive Reflection

In keeping with the post binary sensibilities of this study perhaps one of the few splits Barad indulges in is the oppositionalism of reflexivity and what I have referred to as ‘diffraxivity’. Reflexivity has its critics. Lynch (2000), amongst others, also hold reservations, suggesting reflexivity, ‘has little value as a critical weapon or source of epistemological advantage” (p.26). However, psychoanalysis is steeped in reflexivity and reflectivity, with Lacan (1949) and Winnicott (1971) making particular contributions to mirroring in the human development of self, drawing on the materiality of the mirror in Lacan’s case and the body (Mother’s eyes) in Winnicott’s. I was reluctant to relegate this mainstay of both research and practice without further consideration. Barad, for all her critique (which she does not advocate and sees as a practice of negativity…distancing and othering) of reflexivity/reflectivity, and her advocacy of diffractive practices, she remains a post-binary ‘intragrationist.’ So why is she so binary and critical when it comes to this? I wondered that Barad takes to extremes, when she encounters the, “unexamined habits of mind” (2003. p.802), for example, in relation to the dominance of language and, in this instance, reflexivity. Why did reflexivity and reflection and diffractivity and diffraction need to be such sworn adversaries?

Continuing with Barad's metaphor of the mirror, Barad stands on the mirror and shatters it into many pieces. While each maintain their reflective capacity if one were to behold the world they reflect it would be significantly changed from the one it reflected when intact. Perspective would be altered. There would be gaps, interruptions, discontinuities and new ways of seeing would be made possible as the mirror is diffracted by an act of challenge to existing ways of seeing.

I remained ruminating the issue and in so doing recalled the painting by Veláquez, *Las Meninas* (1656), of the Spanish royal family. Veláquez included in the family portrait the edge of the back of the artist's easel. It is not the painting that is mirrored in the painting, it is the apparatus that holds the canvas that is displayed. In doing so not only is the artist, who is outside of the frame, now in the frame, so is the back of the frame in the front of the frame. Spectators looking at the front are simultaneously looking at the back. In doing so they are also 'asked' to question their position in relation to the painting and its construction. Viewer and viewed, subject and object collapse, and this is executed without mirroring the spectator or the artist. This work was subsequently 'mirrored' by Picasso (1957) who produced 48 'versions' of *Las Meninas* in an effort to draw attention to the processes of mirroring, facsimile and time, which was subsequently further explored by Warhol. Barad's bringing together of 'natureculture' has also been explored via the optics of Rauschenberg's *Monogram 1955-1959* and, more recently, through Olafur Eliasson's 'natureart' installations, *In Real Life* (2019). Arguably, these artists serve to both mirror and put the mirror in the picture, philosophically

and physically, whilst managing continuity, sameness, and difference via a process of reflexivity, diffractivity and mirroring. I wondered if it was not beyond research practice capability to hold onto the sands of the mirror whilst looking beyond the reflection of self and sameness, whilst at the same time seeking rupture and change.

When I was first mapping out the methodology, and before I had read Barad, I tried to create a metaphor to describe what I understood to be the aim of the research in an effort to help me clarify it. I called it, 'Pebble in the Pond' (PIP). I wondered if research was akin to throwing a pebble in the pond, but its focus was neither pebble nor pond. The focus was the aftermath, in this case, the waterjet that shot up as the pebble entered the pond. This waterjet would hold information about the pebble, the energy with which it was thrown, the weight of it, the event of impact, and the pond itself, for it had previously been an integral part of it. It would reflect the surrounding landscape, the sky overhead and the surface of the pond, including the visual impact of the pebble on its surface, its reflection of the sky and surround now changed by the ripple effect. The waterjet would even reflect the thrower of the pebble. Further the visible waterject is a mirror image of its invisible inverse waterjet below the surface. As such, the waterjet held information about the surface, what lay beneath, the surround and the interaction between them, the event of the throwing of the pebble, the pebble thrower, and the pebble itself.

I returned to my PIP 'theory', armed with Barad's idea of a diffractive methodology and reconsidered whether it was an example of diffractive

reflexivity. The waterjet came into being through an intra-action, it did not have an *a priori* existence. It held, in the moment, its past, present and future. In its agential moment it could have been seen to belong to both to the pond and the surrounding environment, collapsing inside and outside, and now the waterjet contained the pond rather than the pond containing it, offering a container/contained inversion, and a conversation about what constituted within.

Significantly, the waterjet has both reflective and mirroring function. I wondered if the waterjet was the mirror and the mirrored. Was the ball that formed at the peak of the waterjet, an example of a diffractive curve? Further, it was its curvature which denoted its limits and demise as a waterjet, and, as such, its temporality and 'death' would be 'known' to it. The waterjet, which moved medium, water to air, would inevitably change its shape and re-join its original environment, holding this information (if we accept water has a memory), which it would then 'communicate' to the rest of the pond. As a result of this 'intra-action' the pond is forever changed, 'knowing' more than it did before, the latter being an example of research dissemination. Therefore, was it possible for a researcher to adopt a diffractive, intra-active, reflexive, reflectivity? I remained uncertain, but decided to abstain from reflecting upon my experience of the interview whilst, instead, aiming for transparency in terms of agential cuts.

This is how I understand diffraction, and this is how it will be made use of in the research for any thing passing through any other thing, in this instance,

say, when a psychoanalytic idea of protective shield encounters ACE literature it will diffract and not continue as an instinctual, biological concept, more a psychological concept. When this idea intra-acts with Barad's idea of universal entanglement then, for example, the physical world that allows radio transmitters to convey social media communications to a child then protective shield can be thought of as both a biological phenomenon, a social phenomenon, and a physical phenomenon. In effect, Barad gives an idea 'legs' by calling into question fixity of place, space, time and matter.

3.6

Qualitative Research

The research questions asks for a qualitative approach to answer it and yet it is commonplace for researchers to justify why they are deploying a qualitative approach as if it is the poorer cousin of a quantitative approach. Niels Bohr states, "The more exactly I have measured an organism quantitatively, the less I know of it as a living developing body. Quantifying measurement gives only insufficient information about the bios." (cited in Rozenthal, 1967, p.92.) The prevalence of epidemiological studies in suicide research, and the deployment of the psychological autopsy (Shneidman, Farberow & Litman, 1958) takes the dead and resuscitates them, but taking a qualitative, prospective approach offers up the possibility of putting the defibrillator to the side for there is no safety in numbers when it comes to suicide.

Qualitative approaches have been refined in relation to ground breaking in-depth and sensitive research where human emotion and experience lie at the

heart of the researcher's interest (Denzin & Lincoln, 2000), often concerned with localised aspects of social life that are, maybe, sometimes considered as marginal (Holman-Jones, 2005), and especially where the researcher encounters the research subject in an intimate setting such as an interview (Yardley, 2000). Although there are multifarious types of qualitative research, there are usually commonalities in regard to qualitative research showing demonstrable yield in accessing finer grain lived experience within the frame of naturalistic settings (Kvale, 2007). Qualitative case study research has, arguably, been the cornerstone of psychoanalytic facing research, where researchers looking at small numbers of research case subjects are aggregated across repeated like-minded projects in order to build a critical mass of generalisable assumptions and theories thereafter (Rustin, 2006).

Perhaps, what is missed with psychoanalysis, with its aloof reputation, is that it achieved its insights, not by donning a white coat in hallowed ivory towers, it achieved these by toiling in the field. Clinical psychoanalysis is action research reimagined, it is grounded theory applied, it is thematic analysis with bells on, a discourse analysis par excellence. Researcher as researched, in relationship to, it has demonstrated an unerring capacity to generate theory from the science of the singular. The story that psychoanalysis tells has spanned three centuries and continues to be practiced in laboratory consulting rooms across the globe (Rustin, 1997). As such it holds credibility as both a qualitative and quantitative research endeavour.

3.7

Research Interviews

Specifically, my plan was to hold a Baradian position of an entangled withiness as a researcher and making the singular agential cut of interviewing with only one structured question. Any other questions I intended to ask would be in response to what the participant brought, or for the purposes of clarification. Further, when Barad (Kleinmann. 2017) talks of 'response ability' she talks of this in terms of enabling a response from the 'Other'. A one-question interview allows for this. In Baradian terms it might be more accurate to refer to the interview as an 'intraview'[19] (Kuntz & Presnall. 2012. Peterson. 2014) in that it comes into being through the intra-action of the researcher and researched. Also, in this new paradigm, it might be more accurate to describe data as 'creata' (Stainton-Rogers. 2001), as data suggests something static and pre-existing that sits awaiting gathering.

Barad argues that, "language has been granted too much power" (ibid, p.132), however, whilst interviews still trade in the old currency of human language I found the format had something to offer as an 'intra-active event', recognised as a piece of creational choreography, if you will. I was trying to access child voice diffracted through adult voice and, in turn, this was diffracted through thematic analysis, psychoanalysis and Barad. However, attention to what S-C children were saying, as well as doing, seemed critical. But Barad cautioning about too much emphasis upon language is on to something when it comes to suicide-communication. For when a patient or client speaks of their suicidal

[19] Although for the purposes of the thesis I will continue to make use of the term interview.

state one of the first questions that is asked as part of a risk assessment is, “Do you have any plans?” What might escalate concerns would be a patient who has purchased a rope for example. In the action speak louder than words culture it is not only the action that generates concern it is the materiality of the rope, or the paracetamols, or the gun that is noteworthy. And it is the lack of materiality that is the absence that is death that causes the action of safeguarding. Further, it is not that Barad wishes an annulment of the spoken word, more that she seeks to challenge;

> “the unexamined habits of the mind that grant language and other forms of representation more power in determining our ontologies than they deserve.” (2003. p. 802).

Barad takes issue with the emphasis, perhaps, upon the ‘linguistic turn’ in the 1980s where participant ‘voice’ became much more important (Elliot, 1999). Habermas (1992) asserted that linguistics had triumphed as the new claimant of the explanatory level, reassuring us that we might be safe in the knowledge that post-modernism had passed into a new sturdy epoch where text could outlast and outstand other observable data sets. However, Barad reinstates the material, and in particular, its discursivity, and at least with the interview captured on a recording device, the role of the participant researcher is made more transparent. It is the materiality of that recording device that holds the linguistic information. For example, an observation that is subsequently written up rather than recorded with a device means that others rely upon language, exclusively. If the recording device is used then others can bring

their perspectives to bear. Arguably, objectivity and subjectivity both come together but it is the materiality of the recording device that facilitates the turn of the linguistic.

Arguably, the best we might hope for is that the yield from interviews produces multiple truthful perspectives rather than a singular truth (Tullis, *et al*. 2009) and that we begin with the acceptance that an interview will yield a localised account shaped by the co-constructed mores and idiosyncrasies of the interviewee and interviewer (Alvesson, 2003). Hammersley (2005) argues that interview data amounts to a socio-discursive construction rather than as a source of so-called evidence, that is to say, language constructs rather than mirrors phenomena. However, agential realism tells us that reality is not fixed but comes into being through intra-action, and in this way anxieties about what is true and what is real are re-shaped and reformulated.

I would remain receded, whilst holding the acknowledged power of 'agential cuts,' boundary-making practices embedded in the apparatus employed to interrogate phenomena that, "enact what matters and what is excluded from mattering" (Barad, 2007. p.148). Semi-structured interviews, and the questions deployed, are a way of doing just that. In this way, the participant researcher is seen to make momentary 'agential cuts' that facilitate the emergence of differential becoming. By this I mean all intra-action births new existences and these are different to what went before. The interview setting, the room, the chairs, the recording device, the researched, the consent form, make for a veritable soup of human, and non-human, relational exchange.

Freud said of the consulting room that the whole family was under the couch, In the agential realist research room there is a whole universe.

3.8

Data Analysis Approach

Whilst I maintained my position as a psychoanalytically informed clinician researcher, and intended to make use of practice skills in interview, my plan for the data analysis phase of the research was for psychoanalysis to operate in a supporting role in the identification of themes. The idea of data interpretation has a sometimes contested place in qualitative research with arguments about subjectivity sullying validity, but nonetheless, it has strong claims for legitimation for example in the research method of Interpretative Phenomenological Analysis (IPA), which has been used in psychoanalytic research (see for example Midgely *et al*, 2009). According to Ramzy (1963) psychoanalysis can be defined as firstly a therapy, secondly a body of knowledge and thirdly as a method of research. Devereux (1967), however, saw psychoanalysis as first and foremost an epistemology and a methodology, but not necessarily as a method of research. Cartwright (2004) reflected on the absence of interest in research methodologies in psychoanalysis:

> "(1) Psychoanalysis has primarily developed within a treatment setting where treatment aims have overshadowed the need to adopt research methodologies from other disciplines. (2) Psychoanalysis is not only a theory but is also a methodology in itself developed specifically for

exploring unconscious processes. As a methodology of inquiry, it has always been inextricably linked to the treatment setting, making it difficult to develop other forms of research methodology using psychoanalytic principles. (3) As a consequence, other possible forms of research from the empirical and hermeneutic traditions are seldom taught or encouraged in training institutions." (p. 82).

However, the literature review really demonstrated the ability of psychoanalytic case studies to generate theories for subsequent testing. I selected Thematic Analysis (TA) for the actual method of data analysis for a number of reasons. In some ways a process of elimination identified it. I had considered, and dismissed Glasser and Strauss's, Grounded Theory as I did not expressly seek to build a theory. I considered and dismissed Discourse Analysis. As I was working within an agential realist frame, which seeks a relegation of discourse, this did not seem fitting. I considered but dismissed Interpretative Phenomenological Analysis (IPA) as it was better suited to smaller numbers. I had 16 interviews and IPA best suits 4-10 participants (Smith, 2009).

However, TA was also a positive choice. Recommended by Braun and Clark (2006/2018), it is seen as a flexible and relatively straightforward approach to data analysis, and a foundational method for qualitative research. TA was selected, in part, because, unlike Grounded Theory, for example, it is requiring of additional support to deepen analysis and therefore had sufficient space to accommodate both psychoanalytic and diffractive interpretation.

Whilst TA is malleable, rigorous, theoretically accommodating, and capable of bringing depth of analysis, Braun and Clark (2006) warn that TA has compromised interpretative power beyond mere description if it is not used within an existing theoretical framework that anchors the analytic claims that are made. I saw psychoanalysis as being able to do this. Working together, psychoanalysis could aid in the identification of themes and diffractive practice could then be brought in to attend to cuts.

TA and psychoanalysis are both ways of extrapolating out themes, either from data sets or from an associative tangle of relational fuse. Cartwright (2004) asserts that the psychoanalytic practitioner's attention to narrative and the search for the core threads, should be an informing frame for conducting research. In terms of identifying codes I was mindful of Boyatzis' (1998) suggestion of latent and manifest content where the question as to what participants mean requires looking below the surface. This chimed with psychoanalytic sensibilities. TA was the least theoretically laden of the methods. Razinsky (2012) suggests, "Theory creates blindness…In illuminating reality, they (theory builders) ipso facto relegate other parts of it to the darkness." (p.6). I imagined TA offered fewer dark places for data to hide whilst holding open a space for psychoanalytic practice skills to breathe and as such I deployed it in an effort to answer the following question: 'What do primary school staff say about suicide-communication in socially disadvantaged children?'

As previously stated, in an effort to answer this question the method of interview will be deployed. The interviews will then be transcribed with the participant researcher then becoming immersed in the data, listening to interview recordings, reading and re-reading transcripts with the aim of starting to get a sense of codes and then common patterns across interviews. An initial map will be generated and this will then lead to the identification of sub-themes, which will be honed in secondary mapping, which, in turn, will result in the identification of overarching themes. Transcript excerpts will be selected in support of these themes, and a psychoanalytically informed thematic analysis given.

By this I mean I will interpret themes with a ‘psychoanalytic mindedness’. As in any reading of data, and the subsequent act of analysis, will necessarily be shaped by the epistemological instincts of the researcher, and if the researcher is psychoanalytically minded, then the reading of transcripts will arouse responses which the researcher might find coalescing around familiar terms of reference, for example attachment theory, object relations, or may even respond to data in terms of counter-transference. This is a point that Anderson (2006) makes in relation to grounded theory. Here, she points out that even Glaser admits that there is no such thing as an empty research mind, and that the researcher will be sensitive to their data in light of their experiences of education and training and she adds, “In the same way, the psychoanalytic clinician will bring their psychoanalytic thinking to the data analysis and the development of theoretical codes”. (Anderson, 2006,

p. 333).

As such, moving forward into the data collection phase of the research, the answer to the question generated from the gap in the literature, “What do primary school staff say about suicide-communication in socially disadvantaged young children?” will be answered by joining with another, “How can psychoanalysis, diffracted through a Baradian portal of intra-activity, make sense of what primary school-based staff say about suicide-communication in schoolchildren?”

Chapter 4

Data Analysis

Chapter Outline

In the opening of this chapter, section 4.0 outlines how the data is presented. Section 4.1 draws brief participant profiles. Section 4.2 gives key information pertaining to interview data. Section 4.3 explores the issue of 'Domain Summaries' of each of the 16 interviews in relation to researcher positioning. Section 4.4 outlines the initial coding steps and the development of the idea of a child S-C hypothesis (CS-C Hyps). An initial coding map is presented. Section 4.5 offers further analysis of CS-C Hypothesis with closer reading of the transcripts, identifying and delineating codes in terms of semantic and latent content. A developed map is given. Section 4.6 gives account of how codes from the developed map were further clustered into sub-themes which then culminated into 3 key overarching themes. Section 4.7 documents the process that culminated in the first theme, 'Familial Abruption'. Section 4.8 documents the process that culminated in the second theme, 'Psymatic Abruption.' Section 4.9 documents the process that culminated in the third theme, 'Social Abruption'. Section 4.10 briefly looks at the by-product of the above themes, 'social bleeding' which culminates in a suicide-communication.

A further developed map is given followed by a final thematic map. 4.11 Offers a diffractive understanding of the themes with a map given.

4.0

Data Presentation

In the first place, I present an overview of identified codes, which are then cohered into the sub-themes that informed the development of the overarching themes. These are also rendered as visual graphics in the form of thematic maps, initial, developed, final. I then draw verbatim accounts from the interview transcripts, giving voice to the research participants. In some places I quote at length from the interview as the theme is seen to require illustration from a narrative sequence. Typically, brief excerpts are used to illustrate the themes. Occasional use of the literature is also made in support of identified themes.

4.1

Participant Profile

In total there were 16 participants (15 females, 1 male). There were 2 Teaching Assistants (TAs), 3 Teachers, 9 Counsellors/Psychotherapists, 1 Designated Safeguarding Lead & Family Support Worker and 1 Pupil and Family Support Worker. All these participants, apart from a retired psychotherapist/clinical lead, were school-based and were working in schools at the time of interview. The participants were broadly representative of the known school staff demographic, with two identified as Dual Heritage and the remaining 14 identified as White.

The cohort ranged from having a few months experience working with children, to over forty years and an age span from early twenties to seventies. All, participants came from schools that had an existing counselling service. Lastly, all the participants who agreed were those who were willing to give of their time to research explicitly considering suicide communication in children and this indicates that they arguably began with the concept as thinkable. I had approached other school counsellor colleagues, for example, who had worked in the field for several years, serving catchments of social-deprivation, but who did not opt to be interviewed because they could not recall a single incident of child S-C. Therefore, the research cohort could is representative of those working in primary schools, serving catchments of social deprivation, with in-situ school counselling services, having some experience of child S-C.

I initially met with two participants to pilot the interview method. Subsequent to this, I reviewed my choice of questions and settled on the idea that I would simply open with the question; '*Can you tell me something of your experience of suicide-communicating children*?' and then see how the interview unfolded thereafter. Further initial interviews confirmed that this approach yielded a good response from interviewees. In my opening question I did not clarify what I meant by S-C children, leaving this to the participants' interpretation. I did not assume a shared meaning, simply that they spoke to what they understood of the term. Two participants sought clarification early on, as in, "*Is this what you want*?[20]' to which I gestured for them to continue, but not one asked what I meant by the question or term. Some began with instances of

[20] This suggests that at least some participants were 'giving' me what they thought I wanted, pointing to the power dynamics that operate in a research interview.

self-harm, some brought direct verbal S-Cs, some brought children behaving dangerously, others brought children whom they harbored concerns about, but the child had never explicitly uttered a S-C in either gesture or word.

4.2

Key Interview Information

In total there were 793 minutes of recorded data across the 16 interviews. Data regarding specific children came from 10 primary schools in England. In presenting data here I have used pseudonyms to refer to participants, and identifying detail has been carefully rendered to protect identity. What is noteworthy is that all participants spoke in intimate detail about the children they encountered and there was some resemblance in the data to what we might think of as a case study. Some 40[21] different children were spoken of All, other than 2 children brought by May, were at primary school at the time of interview.

4.3

Domain Summaries

After thoroughly familiarising myself with the interview transcripts I was struck that in only looking for links across interviews, a same-seeking exercise, I was not adequately able to capture the rich idiosyncratic narrative of each interview and so I, initially, set out a brief synopsis of the interviews. In the terminology of TA, these synopses operated as 'domain summaries' (Connelly & Pelzer, 2016), a conflation of the participant perspective in relation to a

[21] Some staff were talking of the same children.

question or topic. As a psychoanalytically informed researcher, making use of stream of consciousness, I considered everything said a response to the 'launch' question. Clarke and Braun (2018) argue that contextual meaning is key to TA, in other words, TA begins with context before digging down and drawing out more exact key patterns and themes, and as such the domain summaries served a useful function in this way. However, on reflection, I felt these prioritised researcher perspective, overly, and the recipient of the research would first encounter the research via the researcher's construction of each interview and, in turn, participant. In light of this I decided against including the domain summaries in the main body of the thesis and placed them in the cutting 'togetherapart' (Barad. 2014) of the appendix (Appendix B). At least then the reader could make the cut themselves, for there is an argument that researcher synopsis affords a greater transparency about the researcher, and what they deem as noteworthy of inclusion alongside what the application of what TA asserts as redeemable for inclusion.

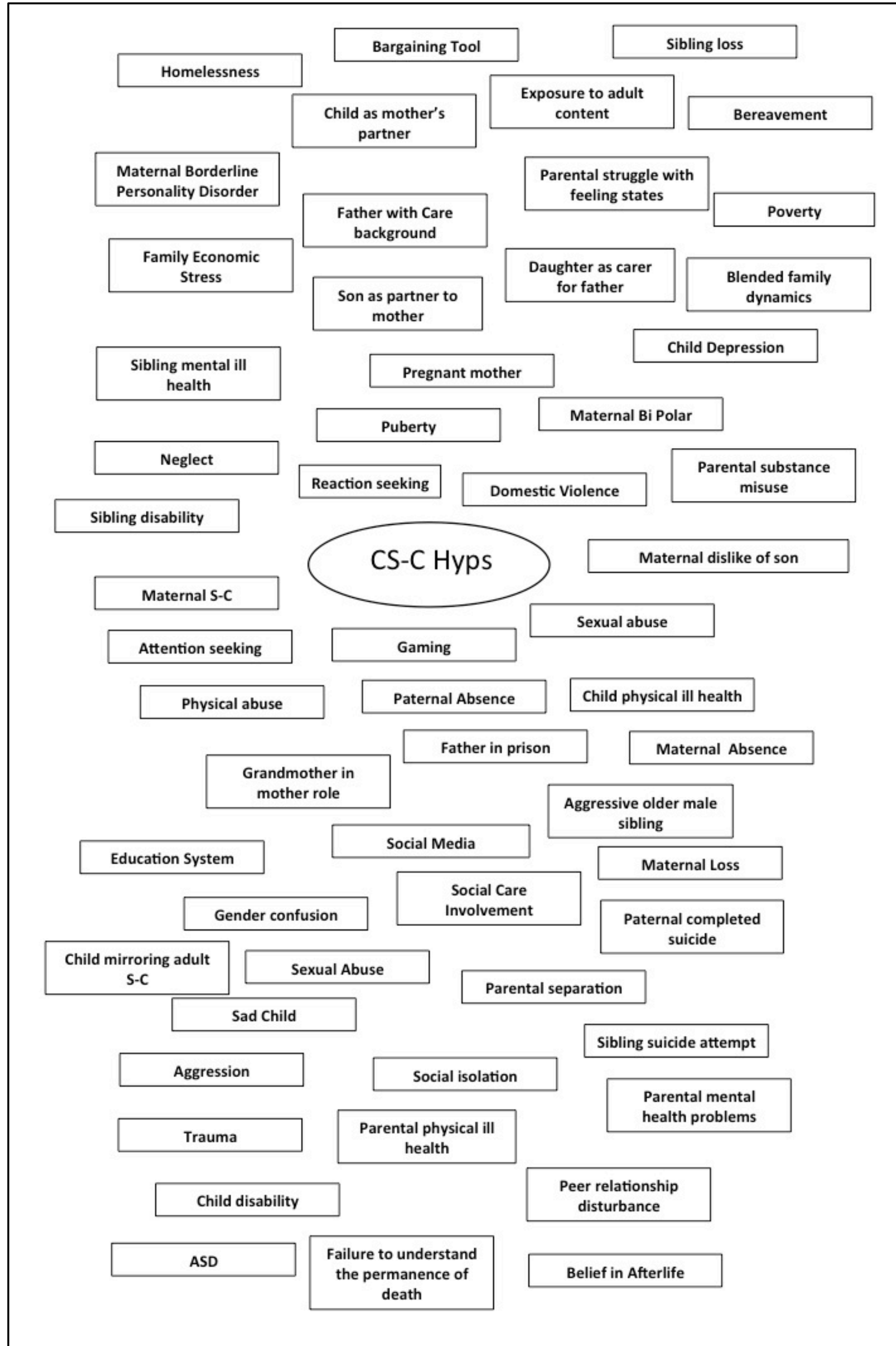
4.4

Initial Coding

Initial codes were generated from listening to the audio-recordings of the interviews and then a close reading and re-reading of the transcripts. I was struck by how the voices of the participants stayed with me into the phase of reading the transcripts. I was able to hear the nuance of the voices in the transcripts, as if the words retained some of the personality of the encounter with the participant. I began by highlighting, using different colours initially to code data items of interest and as I went through each transcript highlighting

in this way I began to form some generic codes such as ‘behaviour’, ‘family life’, ‘absent fathers’ (Appendix C shows full exposition). I noted, in particular, that in each participant’s account of their encounter with a S-C child, they had subsequently, or in interview, tried to make sense of the situation. I thought of this as a process of ‘meaning making’ and insofar as the participants formed an informal ‘hypothesis’ about why the child might be expressing such a communication, it seemed reasonable to refer to these as Child Suicide-Communication Hypotheses (CS-C Hyps). This was my initial frame within which I began to organise the data. The initial coding map below, Figure 4.0, offers the first raft of identified codes generated in relation to participants’ CS-C Hyps.

Figure 4.0: Initial Coding Map: Child S-C Hyps

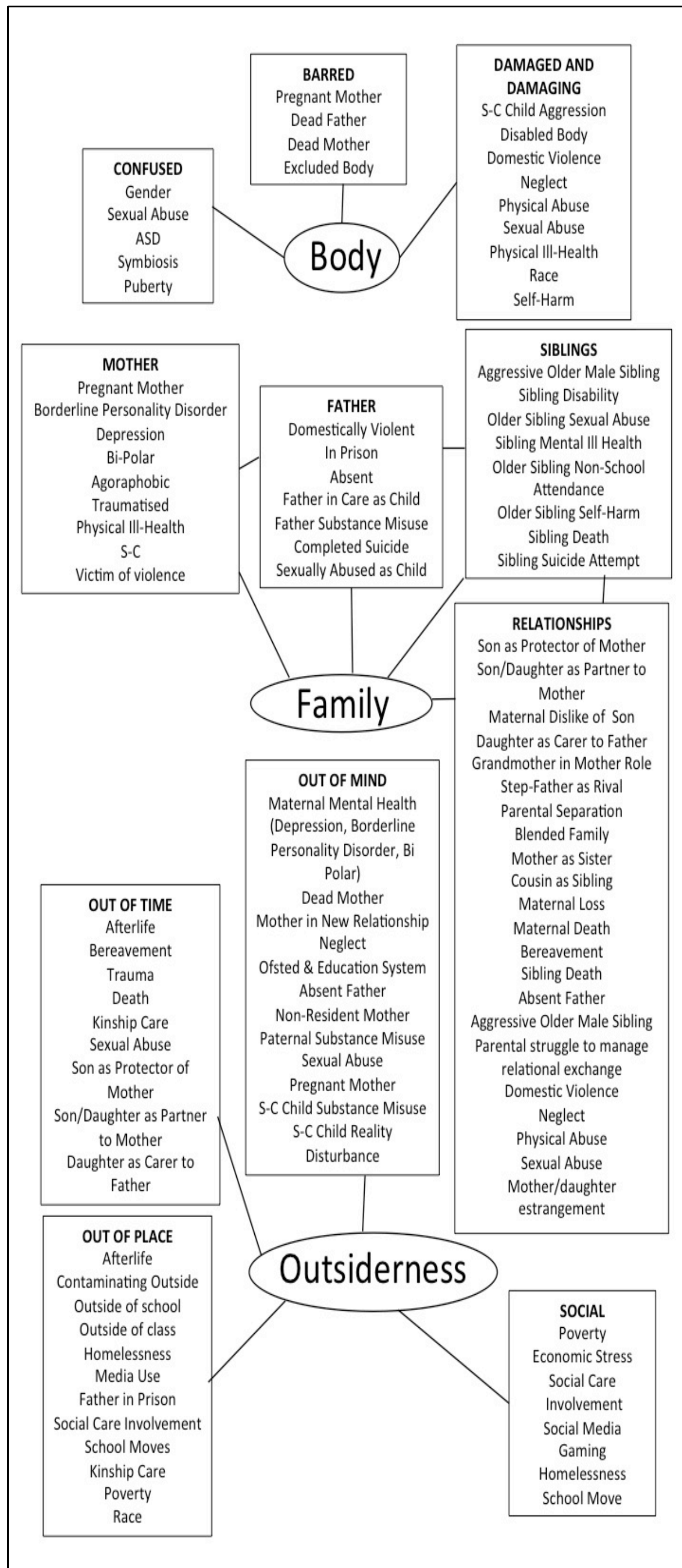


4.5

Developed Analysis of Coding

Looking in greater detail at the CS-C Hyps codes, all were congregated to form code clusters. Common and uncommon ground was identified. The 'Family' as possible source of child S-C dominated as all participants, without exception, made explicit mention of the S-C child's troubled family. The 'Body' also featured heavily and formed the second theme, although this was slightly more secreted within the data. The third category, identified as clustering around 'Outsiderness', was much more embedded, or latent, and this was identified after several re-readings of the transcripts. There were a number of overlapping codes that found different expression as to whether they were placed within 'Family' or 'Body', for example.

The diagram below, Figure 4.1, shows a Developed Thematic Map 1 of codes clustering around these 3 provisional themes.


BARRED
Pregnant Mother
Dead Father
Dead Mother
Excluded Body
DAMAGED AND DAMAGING
S-C Child Aggression
Disabled Body
Domestic Violence
Neglect
Physical Abuse
Sexual Abuse
Physical Ill-Health
Race
Self-Harm
CONFUSED
Gender
Sexual Abuse
ASD
Symbiosis
Puberty
Body
MOTHER
Pregnant Mother
Borderline Personality Disorder
Depression
Bi-Polar
Agoraphobic
Traumatised
Physical Ill-Health
S-C
Victim of violence
FATHER
Domestically Violent
In Prison
Absent
Father in Care as Child
Father Substance Misuse
Completed Suicide
Sexually Abused as Child
SIBLINGS
Aggressive Older Male Sibling
Sibling Disability
Older Sibling Sexual Abuse
Sibling Mental Ill Health
Older Sibling Non-School Attendance
Older Sibling Self-Harm
Sibling Death
Sibling Suicide Attempt
RELATIONSHIPS
Son as Protector of Mother
Son/Daughter as Partner to Mother
Maternal Dislike of Son
Daughter as Carer to Father
Grandmother in Mother Role
Step-Father as Rival
Parental Separation
Blended Family
Mother as Sister
Cousin as Sibling
Maternal Loss
Maternal Death
Bereavement
Sibling Death
Absent Father
Aggressive Older Male Sibling
Parental struggle to manage relational exchange
Domestic Violence
Neglect
Physical Abuse
Sexual Abuse
Mother/daughter estrangement
Family
OUT OF MIND
Maternal Mental Health (Depression, Borderline Personality Disorder, Bi Polar)
Dead Mother
Mother in New Relationship
Neglect
Ofsted & Education System
Absent Father
Non-Resident Mother
Paternal Substance Misuse
Sexual Abuse
Pregnant Mother
S-C Child Substance Misuse
S-C Child Reality Disturbance
OUT OF TIME
Afterlife
Bereavement
Trauma
Death
Kinship Care
Sexual Abuse
Son as Protector of Mother
Son/Daughter as Partner to Mother
Daughter as Carer to Father
Outsiderness
OUT OF PLACE
Afterlife
Contaminating Outside
Outside of school
Outside of class
Homelessness
Media Use
Father in Prison
Social Care Involvement
School Moves
Kinship Care
Poverty
Race
SOCIAL
Poverty
Economic Stress
Social Care Involvement
Social Media
Gaming
Homelessness
School Move

4.6

Themes, and sub-themes

The following is an account of how codes from the developed map were further clustered into sub-themes that then culminated in 3 final themes. However, before moving forward into an account and presentation of these themes it is to be noted that in looking at the initial categories above, the titles did not adequately describe the quality of what the participants were conveying about the lives of the S-C children. The terms ‘Family’, ‘Body’, ‘Outsiderness’, in particular, seemed too neutral. The discussions were consistently concerned with conflict, loss, trauma. The concept of abruption was selected because it conveyed the quality of these children barely holding on. The term ‘abruption’ was specifically selected to make links with the term ‘placental abruption’ where the placenta separates prematurely from the uterus proving a potential threat to the life of both mother and baby. I specifically sought a term that had associations with life, death, relationship and within. I also sought a process that had the threat of ‘bleeding out’ as the data ‘spoke’ of what could be described as a bleeding out into statutory service use.

Further, the term held an interiority which found alignment with a psychoanalytically-informed study, held within a Baradian ‘universal philosophy’. Lastly, trying to grapple with the psyche and body as separate entities was causing problems due to their indivisibility. For example, CSA could not been seen as something which happens to the body alone, although it is the body that is the site of the abuse, it is also the psyche that is

concurrently impacted. Therefore, for the purposes of the thesis, I created a neologism and coined the term, ‘psyma’, for both ease and recognition of the insoluble relationship of psyche and soma. The term also sat comfortably within a post-binary Baradian frame. This then allowed for the incorporation of parental and child mental health problems to come under its auspices.

The following is a presentation of the 3 main themes, the sub-themes which culminated in their formulation, and the data in support of each.

Theme 1: Familial Abruption

Sub-Themes

I) Generational Inversion

II) Negative Familial Transmission

III) 2/2 Mother

IV) Father Poverty

V) Sibling Disturbance

Theme 2: Psymatic Abruption

Sub-Themes

I) Damaged and Damaging Body

II) Confused Body

III) Barred Body

Theme 3: Social Abruption

Sub-Themes

I) Outsiderness

II) Out of Mind,

III) Out of Placetime

IV) Negative Technology

4.7

Theme 1: FAMILIAL ABRUPTION

The family was often portrayed as disrupted. Edith, May and Kate spoke about different children who lived with family members other than mother and father. These children, therefore, had been subject to significant losses and changes, which in some cases had meant estrangement from their siblings as well as their parents, with the significant loss of mother.

Sub-Theme i) Generational Inversion (GI)[22]

The first sub-theme, Generational Inversion, gathered together data which pointed to a porosity of generational boundary where children and adults did not stay within their chronological generational frame. Participants spoke of S-C children who were given free rein on the internet, who were allowed to play on adult rated games such as Grand Theft Auto (GTA), who watched certificate 18 rated films, who took drugs, who hung out in gangs, who had to fend for themselves, who were not protected. These S-C children did not inhabit the time allocated to childhood and were prematurely positioned in adulthood, as if time had been compressed for them. Paula talked of the

[22] Whilst the term 'generational inversion' might be seen as culturally insensitive as there are cultures where children are routinely brought up my grandmother and live with extended family members, in the circumstances described, generational inversion was a result of breakdown and rupture of the original family structure, not a cultural elasticity.

autistic child where there was a confusion of self and mother and as such the child was, essentially, a continuity of mother's self.

Support from the data for Generational Inversion (GI)

'There's one girl, she's in Year 2, 6 years old, and she lives with her grandma and her two cousins. She's from a family with two older siblings and three younger ones. The three younger ones are no longer with them, been removed. She has an older sister who was taken into care. The school knows a lot about the family. The main issue she came to counselling with was the family, was just their ability to keep the children safe. The mothers pick partners that aren't the best and grandma has brought all the children together, blending the family together…the TAs have reported her saying things like, she wants to go home and kill herself." [Edith]

In another example, Kate spoke of a grandmother who looked after three of her grandchildren, commenting, "she has threatened on many occasions that she can't manage them anymore." [Kate].

Edith, May and Kate brought examples of GI, as seen above, but there was also a more subtle form of generational inversion where children were seen to operate as partner to mother. Jess spoke about the son who had been relegated when his mother entered into a new relationship, "he's used to protecting mum, he's used to being the man of the house and his world's changed and he's furious about it". Barbara also spoke of a child who felt

usurped by her mother's new partner and she saw her S-C as a manoeuvre to oust him.

> "I think her, her, this might sound like a blunt instrument, her motivation was to get her mum to be so scared about her, how she was, that she would leave her boyfriend or ask him to leave … [Barbara]

Antonia spoke about a Year 6 boy who has a really close, 'strange' relationship with mother where he slept in her bed and not his own. Sharon spoke of a child where, "her mum and her had a really strong dependent relationship". Melissa identified that there were boundary issues, particularly with mum. Dad was non-resident, and they lived with maternal grandfather, and, arguably, already something generational is inverted with grandfather becoming father. As the majority of these children lived without a father figure, it was not surprising that lone mothers might look to their children to meet emotional needs that might, typically, be met by a partner, although this might also happen in families with a present partner. These scenarios could result in confusion as to whether child is offspring or partner. Certainly, Barbara's child was portrayed as a 'spurned lover' threatening to end her life if her mother's new relationship did not end. The S-C only abated when the child found herself a boyfriend and yet this relationship was fraught with another generational inversion where she and her boyfriend of 13 were edging an adult sexual relationship.

Sub-theme ii): Negative Familial Transmission (NFT)

The second sub-theme, 'Negative Familial Transmission', is borrowed from Brent et al (2008) who use the term 'Familial Transmission' specifically in terms of the transmission of suicidal behaviour from one family member to another. I employ a broader usage here to mean any behaviour that might be handed down. I have also prefixed it with 'negative'.

Support from the data for Negative Familial Transmission

Participants spoke of family life falling apart but also of a troubled transfusion from one generation to another. That is, when there was continuity, it was seen to be problematic. Tilly said, 'I don't know how much she's seen at home in relation to suicide or things, the mother has told my supervisor she's had like suicide ideation, we don't know how much more there is or whether there has been an attempt of suicide or anything within the house, but it must be clear to my child that her mother is extremely sad.'

Kate was alert to mother, 'handing down', emotional material in the aftermath of trauma, "mum's had some traumatic times and incidence from her own life that she finds difficult to address and so, and I wonder how much of it filters down to him." Jess talked of a mother with a diagnosis of Borderline Personality Disorder (BPD) as seeing it manifest in her son, "mum thinks that the boy who says he wants to kill himself has got a personality disorder too." Pearle spoke of completed suicide within the parents in her school, "we've had three parents who have committed suicide…" clearly making links between general transmission of S-C.

Whilst Lucy thought of S-C in terms of mimicry, “I think he’s heard mum say it.” And in this way the idea of mimicry seemed to ‘explain away’ the S-C but at other points Lucy sees this as a reason to explain why the child might be distressed, “I feel with [Child 1] and they might have had experience at home of people hurting themselves.”

Verity also questioned whether or not the children were mimicking what they had heard adults say as if there was a linguistic transmission of S-C, in the way young children pick up expressions from those around them, as in some sort of subversive psycho-educational model, “Is it just words that they’ve heard and they’re repeating because it’s clear at that age (Year 2) there is some experimental thing going on with language, again, I don’t get enough time to think about it.”

However, both Lucy and Verity hold onto other possibilities to explain the S-C, “home life is so unsettled” [Lucy], “she has a mum who doesn’t really want her.” [Lucy].” Is it because they have a need that isn’t being met, erm, it’s about deep, deep sadness, you know, deeper than we’ve got any understanding of...” [Verity]

In this way the S-C children were either having their relationships broken or, if they were maintained, what remained continuous was damaging to them.

Sub-theme iii): Too Close, Too Far Mother (2/2 Mother)

The third sub-theme, Too Close, Too Far Mother (2-2 Mother), was used to try to express a ubiquitous feature in the data where mothers were portrayed as unable to regulate a healthy distance from their children. The term was chosen not only to capture mother's lack of physical presence but the possibility of mother being preoccupied and struggling to keep the child's needs in mind (2 far), the intrusive, disliking, libidinally confused mother and the narcissistically devouring mother (2 close). This sub-theme shared some territory with GI, for example the very close bonds with mother that Barbara and Sharon refer to, but was broader and required its own sub-theme.

Support from the data for 2/2 Mother

Relationship to mother was brought frequently. Paula, Kate, Jess, Sharon, Lucy, Edith, Tilly, all spoke of strained and troubled relationships between mother and S-C child. There were 4 S-C children who no longer lived with their mother, with one of these due to maternal death. Although the term mentalization was not used there were several mentions of mothers struggling with empathy, or being unable to think their way into the minds of their children. Kate spoke of children being, "used emotionally" by mother and spoke of a mother who said of her S-C child that, "we shouldn't talk to him about his emotions because he was ASD[23]". Lucy feared, "I'm not sure she's got anyone at home who understands what she's going through."

[23] Autistic Spectrum Disorder

Other children had, what might be described as, ‘emotionally estranged’ relationships with their mothers. Sharon spoke of a child where she felt that, ‘his mother dislikes him’. Kate spoke about an angry mother, ‘carrying a lot of baggage’. Sharon spoke of a mother who was struggling with a drinking problem. Kate spoke about a child whose mother was erratic in her contact with her daughter, “sometimes she doesn’t see her mum when she’s supposed to.” Barbara spoke of the struggle to get mother engaged with her S-C child where upon being told that her daughter had talked of a suicide attempt, her response had been, “ooh really, what she like, silly little mare”.

Poor maternal mental health was described as possibly causal in relation to the child’s situation. This, too, had overlaps with NFT. Tilly spoke of her child, “Her mother is umm clinically depressed.” Lucy, too, “Mum is Bi-Polar and agoraphobic.” Jess spoke of a mother with Borderline Personality Disorder.

Sharon spoke of a mother becoming a mother when she was a child herself, “‘his mother was very young when she had him, she was fifteen, father was seventeen.” This also offers up GI, and it is not to suggest that young mothers are less able to navigate healthy enough distance from their children but they have not managed the distance of adult and child as they are a child becoming mother to a child.

From the accounts mother might well have been too caught up in dealing with the demands of her own mental health challenges (whether mother is medicated or not is not discussed but it is likely, and, arguably, this can really

impact on clarity of mind and availability), lone parenting or blended family life, along with the stresses and strains of social deprivation, to be available and alert to the child's needs.

Sub-theme iv): Father Poverty (FP)

This term was chosen to express the thinness of father's presence in the child's life but also the impoverishment of father's life. Absent fathers were so prevalent in these schools that participants did not bring father other than to talk of their violence, imprisonment or troubled childhood. Lucy noted that none of the children that she spoke of lived with their father, and she added that this was the case with approximately 2/3 of her class not living with father. Of note, Lucy was talking about her Year 1 class. By the time children reach Year 6 of primary school then that figure, in all likelihood, would have increased. Twelve of the participants pointed to the absence of fathers in the lives of S-C children. Only five of the children mentioned by the participants had resident, biological fathers. Between them Rebecca, Kate, May and Antonia talked of 5 S-C children who had fathers, or resident step-fathers, in prison, or who had been in prison previously. All other participants made mention of either absent fathers or fathers who moved in and out of the children's lives. Sharon made mention of the intermittent presence of the father of one of her children and Melissa, Paula, Jess, Barbara, Lucy, Rebecca, Tilly, Edith, Antonia and Verity mention absent fathers.

Melissa, specifically spoke of her child expressing a S-C directly after speaking with her about his father. Other participants spoke of a troubled

figure: “Her father was alcoholic and was in and out of the family.” [Sharon]; “His father had been in care as a young child.” [Sharon]; “Her father had mental health issues.” [Sharon]; “Dad was sexually abused as a child.” [Kate]; “Dad had problems with alcoholism and depression.” [Sharon]; “Dad had committed suicide by hanging himself.” [Kate]. Father was also portrayed as aggressive, “He understands his dad to be a bully and to be violent.” [Kate].

Sub-theme v): Sibling Disturbance (SD)

There were numerous examples in the data of what I came to term, ‘Sibling Disturbance’. Jess, Hayley, Sharon and Tilly all made mention of older brothers behaving in a threatening manner to the S-C child. Barbara, spoke of an older sister with a history of self-harming. Sharon spoke of a sister with a tumour. Hayley and Kate spoke of a disabled sibling. There were sibling deaths, 2 in utero and one stillborn. Further, Lucy and Edith spoke of children being separated from their siblings through Social Care interventions and removal from the family home. In summary there were numerous examples of sibling relationships, which were a source of threat, loss, anxiety or disturbance. Participants also spoke of some children remaining in the family but losing contact with siblings.

The family was presented as fragmented, fragile, barely holding. There were several mentions of domestic violence and either the threat of, or actual sexual abuse, where fundamental protection for these children had been absent: “There’s an uncle in the family who abused his own children and

served time in prison for that…he's not allowed to be around (child's name) but he was at his dad's house the other day." [Kate]

4.8

THEME 2: PSYMATIC ABRUPTION (PA)

Sub-theme i): Damaged & Damaging Body

Support from the Data for Damaged & Damaging Body

How the body, the children's own, and others were experienced was ubiquitous in the data. Kate, May, Antonia, Jess, Rebecca, James, Sharon, Barbara, Melissa, Hayley and Lucy all made mention of the body in some way. There were several references to domestic violence, "Mum said he was exposed to domestic violence" [Kate]. There was mention of stillbirth, death, physical and sexual abuse, physical ill-health and disability, self-harm and harm to others, all of which sent powerful messages about bodies. Fathers themselves had not experienced body safety in childhood, "Dad was sexually abused" [Kate]. "Dad was in Care as a child" [Kate]. As above, several had to be physically locked away to keep society safe. Home environments were portrayed as threatening with what could be termed as, poor body modelling, "they might have had experience at home of people hurting themselves" [Lucy]

"They are constantly around adults, arguing, fighting." [Kate]

The children's bodies were portrayed as unsafe, "there was physical and sexual abuse" [Sharon], unwell, "he's had times when he's been critically ill"

[Kate], “she was 9 and had a benign brain tumour and she had expressed a wish to be dead.” [Sharon].

Further, the body was portrayed as unknown and unpredictable, “They both came in with bites, massive bites on them, they’re flea bites and the little one, he thinks they’re mosquito bites and he’ll die because of them and umm I assured *him he wasn’t going to die and they will go but they feel horrible and itchy.”* [Jess]

May linked psyche and soma, and which informed the other,

> In my class, one little boy concerns me a lot. His mood, his pallor, his down-ness, his lack of engaging. He was really upset about his sore throat, and he started crying, and he said it was burning. I assume it was a sore throat, but I made the connection that he just seemed so miserable and down, and I spoke to his Grandma at the end of the day. I said he’s got a burning in his throat and that he’d burst into tears. There was no reaction from her, no; ‘give me a hug’, no cuddle. Another little girl is continually run down, she has swollen glands and liquid coming out of her ears. I looked in her mouth and she’s got this abscess in her mouth with yellow puss. I spoke to her mum and I said, she just seems down all the time, is it because she’s physically ill all the time or is she physically ill because she’s down? ... and I was just thinking, clearly either something is physically wrong with her …

Also, the peers of S-C children in school demonstrated self-harming behaviours,

> A child would just smash their head down repeatedly on the desk in front of the rest of the class so erm biting, biting themselves…scratching arms, self-tattooing, things like that, hair pulling, face gouging erm, so a fair sort of mixture of self-harming and occasionally at the other end of the school we had girls that were cutting. [Barbara]

The S-C children were routinely encountering body harm, it was unsurprising then that these children went on to attack their own bodies, as the threshold for body harm was, arguably, lower in their lives, "Well, I'll get a knife and I'll stab myself and it was very specific how, I'm sure she said, "I'll stab myself in the tummy."" [Lucy]

> …but the day I saw, now she was controlled, she was definitely controlled, she was going from one window to another and banging her head on every one of them, … [Kate]

The bodies of family members were also damaged, 'His mum and stepdad had long-term illness' [Rebecca], "she had a brother who was quite severely disabled" [Hayley], "his brother's got additional needs (Cerebral Palsy)" [Kate]. This child's brother was damaged during birth and this lends an additional layer to the damaged body as mother's body damages as it births, or gestates, as with the stillbirth and the two lost twins.

As well as aggression to self, interviewees talked about the threat of violence and aggression to others, "he destroyed a room last week, destroyed a room… 'there was 4 people holding him last week and they couldn't hold him… he's quite violent to his brother', Mum can't manage him, he's violent at home." [Jess]. Pearle talked of two children who had made threats to kill themselves, and added that they were also, "aggressive so people are scared of them." But, perhaps, the greatest violence was reserved for the S-C child against themselves, "And when he knocks his head it's not a light, you know, I'm just gonna show you (participant demonstrates) and you know it was an absolute knock on his head." [Jess]. Jess goes on to talk of the knit between suicidality and murderousness, a cornerstone of psychoanalytic S-C theory, "It could be a possibility where he wants to kill himself or kill someone else…to be killed or to kill is the question and hopefully it won't be either of those, but, you know…" [Jess]

I think Jess was talking of the child killing themselves here but it is not entirely clear, other than there was murderousness afoot. Sharon brought a child; "'She also said she wanted someone to kill her formula in family breakdown scenarios and suicide bombers, and yet what Jess recognises in her child is fear, "but the nub of him is that he's fearful he's watched all sorts of horrible things happen and he's scared." [Jess]

Sub-theme ii): Confused Body

Support from the data for Confused Psyma

This had less support in the data than the D&D psyma but it presented as a separate category and, as such was worth noting. The body that changes with puberty can be experienced as unsettling, threatening, even. Sharon implicated puberty in the S-C of the first Year 6 child she spoke of, as did James, more broadly, "As far as I see, it (S-C) is tied in with puberty and an attack on the body and a whole range of other factors but, fundamentally, I see it as attacking the body and the body is pubertal and it's growing and it carries all sorts of anxieties." [James]

The issue of gender was directly brought. Rebecca spoke at length about a S-C child whose communications were understood in relation to gender, "One day in class he wrapped something round his neck and said to his teacher, 'he wanted to end his life, he wanted to end it sooner', and then a few days later he wrote a letter to his class teacher that he wished, no, he should have never been born, erm and that he wished he'd be hit by ten trucks and he wouldn't be in this world anymore." [24] [Rebecca]

Rebecca's account suggests that there were a number of agendas that seemed to shape responses to the child, but the child seemed to be looking for ways to acquire mother's love, and perhaps changing gender was one of them. Whatever the credibility of the child wishing to realign his gender,

[24] With this child, he imagines 10 perpetrators of his death. It is to be noted the difference in threatened method of death and whether or not it involves others, as in the wish to be killed. This seems particularly pertinent in those children who threaten to run into roads or play on railway tracks.

gender consternation finds correlative links with S-C (*ibid*), and, if nothing else, this vignette demonstrates that there were powerful dynamics operating around a child who expresses their discontent through gender.

Pearle brought the prevalence of S-C in children with a diagnosis of ASD, although she did not elaborate upon this a great deal. Antonia, Barbara and Rebecca all suggested a possibly con(fused) relationship between child and mother. Paula spoke of a violent autistic child who she did not think had worked through his separateness from mother. His mother was also aggressive and had been banned from being on school grounds, so, certainly, there appeared to be boundary issues if the school had to forcibly separate her from her son during school hours.

Sub-theme iii): Barred Body

There was also another minor key subtheme worthy of mention and that was what I have called the 'barred body'. This term was used in an effort to describe the child's blocked access to a significant other as well as a possible barring of the child's own body. This has shared territory with the confused body but sufficient distinction to merit its own category.

Support in the Data for Barred Body

There were three mentions of the pregnant body, taken up with the making of a new sibling. Pregnancy and birth can unleash all manner of anxieties, not least guilt if the sibling is feeling attacking, even murderous toward the baby and then if their 'wish' is fulfilled, as in there is a miscarriage or stillbirth, then

the sibling can feel remorseful and take aim at himself. One of the S-C children had experienced a stillborn sibling, and there were also 2 surviving twins mentioned in the study.

Further, there was the idea of the dead body that is barred. Jess spoke of a child who repeatedly tried to climb out of a top floor window as he wanted to die and be reconciled with his recently deceased mother. Whilst notions of an afterlife fall under the subtheme of Social Abruption below, loss via death is also the physical loss of a psyma. The body's physical presence gone forever from the child's known world. Whilst the child has the memory of the person they have lost they are deprived of their corporeal presence. They are also deprived of maternal mind and being held and understood by it. There was no mention made of father, so perhaps this child had the experience of losing both parents. The same could be said of Sharon's child whose father had killed himself the previous year. Sharon's other child wished to die and be reconciled with a neighbour who was important to her. Kate spoke of a child who began talking of wanting to die after the bereavement of a loved grandparent.

An imprisoned father could also be seen as a barred body. This same term could be applied to the child whose bodily pain thresholds appear high. This can be seen in the child who appears not to feel physical pain as they attack their own bodies, as if they distance from their bodies in some way. Antonia spoke of such a child,

> It happened with friends before the trip and (Child's name) couldn't cope with it and when he was sitting next to me he was literally punching either side, to the point where he would break the skin and start to scrape his arm with his nails again and again and again, and that was because he was angry, mmm, but that only happened once and then, another time, he was outside the classroom, having some time out because he was angry and banging his head against the wall. [Antonia]

This boy's tolerance of pain appears to be high and opens up an opportunity to think more broadly about boys and their bodies, the exploration of which falls between the body and the social. How boys are reared in relation to responding to psymatic pain might facilitate higher pain threshold than girls. This may or may not go some way to account for the 3-1 ratios of male to female completed suicide. Certainly, there were a higher number of boys S-C than girls in this study.

Finally, as psyma encompasses mind, as in what impacts body, impacts mind, the state of minds in the children's lives also requires attention before we leave the theme of 'psymatic abruption'. In Theme 3 attention is paid to 'Out of Mind' and support from the data given. I would wish to pull this data, and the data used in support of sub-theme III and IV in Familial Abruption whereby parental mental health is acknowledged as a potential contributor to the S-C child, into this category. These minds of parents were, arguably, taken up with their own challenges that, for some, the capacity to contain, think into, and

contain the mind of the child was compromised and this was contributory to psymatic abruption.

Love's Loss

Whilst the word 'love' was not mentioned once by participants, I did not want to conclude this section without its inclusion as it is embedded in the testimonies of the participants. Whilst an absent father does not mean that they do not love their child, it can mean this. A deeply depressed mother who is unavailable, equally, might love their child, but the child might struggle to reach it. However, if we were to take love as the verb it is, we might see that a number of the examples shared by participants, could be experienced by the children as love's lack or loss. Therefore, I have included it as a latent theme. Further, as love is such a cherished 'commodity' and its lack or loss such a feature of the literature, it seemed incumbent upon this study to dredge it from the underbelly of the data.

4.9

THEME 3: SOCIAL ABRUPTION

Theme 3 was not immediately identifiable within the first tranche of CS-C Hyps shown in Diagram 4.1, but was processed through a closer reading of the transcripts. As such theme 3 was more latent than Familial Abruption and Psymatic Abruption. In the developed thematic map (Diagram 4.2 above) I used the term, 'Outsiderness', but, on reflection, 'Social Abruption' seemed better suited. However, I maintained, 'outsiderness' as a contributory sub-theme'. Within the theme of Social Abruption, a broad definition of social is

applied, i.e. the society of the classroom, of the school, as well as society itself. As all the participants worked in schools serving communities of social deprivation, mainly in the thick of estates, originally built to remove and re-house the poor from the city centres, in terms of town planning, one could argue, that social abruption had already begun, that these children were born into fringe estates, into poverty and all the inequities it brings.

Sub-theme i): Outsiderness

Support in the Data for Outsiderness

James was the only participant to comment directly upon poverty, in part because he brought the issue of class but May and Antonia also made mention of its fallout. Poverty and its infringement upon belonging to broader social networks can foster a sense of 'unbelonging',

> "I think poverty is a real factor, it adds an enormous amount of strain and anxiety on everybody, particularly parents and it strains their capacity for tolerance, for forbearing. The facts are also that many middle class families have very disturbed, distressed, tormented children. They're free from the factor of poverty but other factors come into it, aspiration, fear of poverty." [James]

May also talked of the government drive to push parents back to work and the impact it had on children becoming estranged within their own families. She also talked of how tough it was for parents to find time for their children when they were working all hours,

> Pressures on families and also working patterns, like I'm saying the X family, he never sees his mum, weekends, nightshift, crossing over, never seeing and so it's been a whole cultural change that means children have been left out of the loop a little bit and that parenting isn't given the time because people have other things they need to juggle, really important things, so I think that all impacts on it. [May]

Antonia shares below what children might experience, and how this might get in the way of the S-C children securing good peer relationships engendering a sense of belonging,

> She tried to climb up the window and was banging her head against the window so she, she's on the radar and her twin brother, he got some thick silver masking tape, after having a bad day, and cut some off and put it over his mouth and, obviously, that's a worrying sign too, there's lots of children, even early signs, there's (another female twin) in year 2, who I was telling you about, erm and she, in assemblies, she can't handle assemblies, not that it's self harm, but she'll sit there and scream or she'll, she just can't deal with just sitting there so she'll run around and do laps of the hall…. It was her birthday and at playtime, you see I don't know any of the previous as to what happened but she, basically, tipped her classroom upside down.

As Pearle mentioned previously, other children are sometimes scared of the S-C children and therefore they might very well feel like outsiders, unable to sit amongst the congregation of their school. Some have relinquished social embarrassment and any hope of normative behaviours. They have, arguably, travelled beyond the society of school. However, there was one example in the data where peers brought their concerns about a S-C child, “He talked about hanging himself, and this was reported by other children that he was saying these things and it was taken seriously." [Kate] This could be seen as the S-C child being taken outside of the peer group and to he teaching staff

So, clearly, this particular child entrusted his feeling into the care of his friends, they recognised the seriousness of the S-C and sought trusted adults to help both them and the S-C child,

> My first contact with him was when I’d heard about an incident outside of school that had seeped it’s way into school and he’d apparently come out of school and threatened some people with a knife, a boy who was kicking the fence down on their garden, erm, and it came, it seeped into school and I was asked to just sit with him whilst things were being dealt with and he struck me as an incredibly er sad, angry child who was really, really, disengaged, I mean obviously the situation we were together in was difficult for him but I remember he silent cried and he turned himself away from me. We talked about, err, erm, we talked about, he said he didn’t think anybody liked him and he didn’t like himself. [Kate]

Sharon and Pearle, noticed that the S-C children of whom they spoke were isolated and lonely. Sharon spoke of 2 children, one who felt a, “sense of aloneness” and, “appeared to be very much alone.” Another child was reported to have spoken of her wish to be dead, “she said that she wanted to be dead and she got this feeling mainly when she was alone.” Pearle suggested that the S-C children, “don’t have many friends”, and that they have, ‘”found friendships difficult”. Further, Pearle found that, “I don’t see those children having a best friend so maybe they don’t quite fit in with their peers for whatever reason.”

However, it was not just that some of the S-C children had experiences of outsiderness there was something around borderlines. Kate brought the child who banged her head against the window, Antonia, the child who put masking tape across her mouth, Barbara, the girl who tried to hang herself from her bedroom door, the boy who pulled a knife on those kicking down his fence, fathers in prison. May’s mention of the boy up at the top of the playing field GI, amongst others. All these bring borders and boundaries into focus, as well as outsiderness. The membrane between inside and outside, social and anti-social, adult and child etc. seemed porous, as was a feature of GI in Familial Abruption.

However, there was another dimension of outsiderness where there seemed to be a wariness of what was outside of school and how it infiltrated the environs within. Paula made mention of the violent mother who was banned

from the school premises. Kate talked of how a S-C child's story 'seeped' into the school as if the social space crept into the interior of the school in an unwelcome way. Across a number of interviews, Ann, Antonia, Kate, Barbara, there was a distrust of the outside on several levels. There appeared to be a distrust of outside agencies and some idea of a contaminating outside that when it came into school was unhelpful.

> Mum says she remembers his first comment saying he wanted to kill himself was at the age of 5, he's 7 now. Just prior to me starting he'd taken a knife to hisself at home, it was a butter knife and he said he wanted to kill himself, he didn't want to live anymore. Mum took him to the hospital the day after on the advice of the social worker and he stayed in for four nights. Mum was told he don't have mental health problems. [Rebecca]

However, it was not just external agencies that were criticised. May spoke of systems within schools that move toward excluding S-C children and the complex manoeuvring that takes place when there are safeguarding and behavioural concerns,

> "I've spoken to the Ed Psych about (Year 3 child), she's coming in, in a couple of weeks, and the social worker, and I've said, look, and put it on the line, this is what I think, I don't have evidence for this, but this is what my worry is, this is what my concern is, I've had a conversation with (Head Teacher) and he said, do you know, we need to get her excluded,

we need to get her to partner class and get her excluded, and my conversation was, I am not happy about that, she is not a naughty child, I don't think that would be a safe thing to do and then he very quickly said, you need to talk to the social worker, you need to express your concerns, so he didn't not enable me but he would have gone down that route if I hadn't said, hang on a minute, Now I think another teacher might have said, get her out of my hair, you know. And he also had another conversation with me this week saying, I think she'll move school, she'll be better off moving schools, and moving away, so she's away from this extended family, and I was thinking, I actually had a bit of a palpitation, because I thought if she starts from scratch and they won't know her and I'm not saying I'm doing a great job with her, but I know her, I know she can't be excluded before somebody else would."

Here, the school is thinking about excluding a S-C child, in order to move her away from a family where there are concerns and yet the result of this would be that the child loses the continuity of relationships with school, with teachers. Further this manoeuvre would not necessarily result in a removal from the child's concerning family. One of the schools a number of staff worked in, was in special measures and had been subject to forced academisation. Staff predicted that the children who were seen to be causing turbulence, and their behaviours would not have shed the school in a good light whenever they were subject to inspection, would be moved out of the school. This child brought by May, above, was subsequently excluded from the school but remained within her family. A further 4 of the children

discussed by the staff were permanently excluded before data collection came to a close with 2 further children being subject to 'managed moves'. Of the other children discussed 3 moved on to different primary schools as a strategy by their mothers to manage their behaviours/discontent.

Lastly, Pearle spoke about S-C and children who were on the higher end of the spectrum being outsiders. This recalls Tustin's work (1981/92) concerning encapsulation where there is a retreat from the outside and others. According to Kate's records several of the children had experienced school moves and external and internal exclusions

Sub-theme ii): Out of Mind

The second sub-theme warranted its own consideration, as it seemed to hold a specific meaning and, arguably, held a specific resonance, particularly as psychoanalysis places great emphasis on mother's mind in child rearing. I chose this as a term to try to capture the child's experience of not being mentalised by parents and systems. In sexual abuse the mind, often has to disconnect. This failure of mentalisation might be responsible for the child's movement out of their own mind into virtual and alternative, or, possibly, 'extended realities'. As in S-C children might have to stretch their minds until they encounter a 'mind' that can encounter theirs, so to speak.

Support in the Data for Out of Mind

It was not just mother and father who, possibly, struggled to keep the S-C child in mind. May spoke of her struggle not to become inured, "It's (S-C

children) just being ignored somehow, it's being seen through all the time and the picture is over time, we get used to (Year 3 girl) being quite timid but actually I do remember a year ago last September she wasn't like that, actually…"

Also the child's mind came under scrutiny. Lucy brought a Year 2 boy she had concerns about the state of mind he was in,

> "When I think of Child 5 he was really in an altered state, it was really bizarre to see and he wasn't a small boy, slim but strong, and I do think if he wanted to hurt himself, he could…He was in the other building, running from room to room, and you know, when you just feel like someone looks through you, and he wasn't bothered that I saw him be naughty, he was, "need to catch them and I need to get the guns" and sort of, like he was in army mode, hiding behind things and there was literally no one else in the building and it was like there was this imaginary place going on… the Head Teacher was there, so in terms of authority, as if we weren't there, totally unfazed by us. And when I said something…it was bizarre and the other high profile don't behave that way, he didn't want anything from us." [Lucy]

Here Lucy was concerned as the child was not relationship-seeking and this was what elevated his risk in her mind amongst the other children who were S-C but relationship or attention-seeking. Lucy discussed 6 S-C children in total but this child was her greatest concern in terms of vulnerability to future

suicide risk and there was something about him inhabiting a space that could not be entered into by others, that could not be made social that contributed to this ‘risk assessment’. and unwanted psychic material is projected out, only to return as bizarre objects.

Some participants, Pearle, May, Kate, spoke about the possibility of the S-C child being depressed,

> it seems, I’m not qualified to say someone’s depressed but that’s what I would say…in the long term as they get older because if things don’t change for them I worry the depression will get greater and I think possibly for one or two children I think a mental health issue and I think that worries me long term for them.” [Pearle]

Again, with depression there is a ‘psychic retreat’ (Steiner. 1993) from the outside, from the social, and a residency within the interior. Perhaps with all the maternal mental health conditions mentioned by participants, arguably, all of them impede the mother’s capacity to keep the child in mind. Further, as explored in Chapter 2, the relationship between aggression and depression is confirmed, and aggression is the behavioural manifestation of anger, and these children had much to feel angry about but, perhaps, some were not able to express their anger, hurt and disappointment as they did not live in families where there was sufficient receptivity to these feeling states.

Sub-theme iii): Out of Placetime

Finally, whilst the third sub-theme captured the child's elasticity of mind there was the issue of 'another time, another place' where children, perhaps, were exploring the universe in all its possibilities. I chose this term in an effort to capture the lack of a 'secure base' for the S-C children, wandering the streets, school corridors and virtual highways, the threat (or promise) of removal by Social Care, father outside of society in prison, an ethnocultural heritage from another place, moving from school to school, grandmother where mother should be, homeless, looking for another place to set up a new life, perhaps. I also used this term to try to capture the child's elasticity of mind in terms of time and space but also the different timescale of trauma, and the distortion of time in sexual abuse and GI, where someone who belongs in one generation and time moves generation and time.

Support in the Data for Out of Placetime

Certainly, the afterlife featured several times in the data.

> I remember with Child 3, he'd been to church the day before and he was questioning about meeting God in Heaven and then he sort of pieced together that you need to die to meet God and I want to go to God and I want to ask him something and you know he wasn't saying, "I want to kill myself", but it just worried me that his train of thought could lead to a, well, if I kill myself then I can ask God and then I can come back, yes, so that just raised a few alarm bells. [Lucy]

> a grandparent had died recently and he wanted to be with him [Kate]

> she talked about not wanting to be here and, yeah, she really didn't like herself… she spoke about it in terms of an afterlife as well you know, wanting to get to a better place and wanting things simply to stop, the way things were now… [Kate]

> He had said he wanted to kill himself and be with mum, they were very religious and his concept of death was that she was waiting for him. [Paula].

Quite a number of the children discussed were from faith families and therefore the notion of an afterlife, another place called heaven, would have been part of their 'toolkit' for making sense of the world.

Sub-theme iv): Negative Technology (NT)

I used the term, 'Negative Technology', in an effort to underline how technology can be misused. Whilst there was less reference to social media than I expected, and that might have been to do with the socio-economic profile of the children as very few had phones and devices, it still warranted acknowledgement.

Support from the Data for Negative Technology

Melissa's S-C child had been befriended via gaming by an older man who the child considered to be his 'best friend'. In fact, the session where the S-C took place was the first after the child had been banned from using Playstation. This child did not have a resident father and it is possible that this older man was a father figure of sorts. However a number of participants made no mention of technology and this might have been because a number of the discussed children were young enough for it not to be such a dominant issue in their lives. With May concerns around social media came toward the end of the interview but she did not clearly articulate what the influence of social media might be upon S-C in young children, "I think social media, we've not even touched on social media…but it's massive and within primary schools as well and I think it's getting earlier and earlier." [May]

As stated under 'generational inversion', some of the participants spoke of the children spending too much time playing violent video games or watching violent films. For example Sharon said, "they watch films they shouldn't be watching, very gory, very violent films, scary really scary films." It is possible that the more dislocated the child's sense of belonging is in the school the more likely they are to turn to social media to find some sort of community on-line. However, Pearle's example is where technology is put to use to educate the child on suicide. Below she is talking of a 7 year-old child with a diagnosis of ASD who quite clearly stated he wanted to, "commit suicide". This was a child that Pearle had described was without friends but he did not use technology to acquire them,

Because that child would look on the internet he would read about it and he'd knew he knows a lot about it because that's also a worrying aspect that's he's gone to the trouble to read about it on the internet and I think that's really worrying in different ways and that bothers me …I'm not sure if it was linked to any video games. He was very, he was always on the computer and the computer was used at home as a controlling of his behaviour because while he was on the computer he wasn't destroying everything around him… [Pearle]

One of the features of video games is that characters can die and return to life, and although Pearle did not expressly state this gaming offers conceptual stretch around the idea of death being reversible. It also offers the young child, who might have very little agency in their own lives, power and control over life and death.

4.10

By product: Socio-Familial Bleed (S-FB)

Socio-Familial Bleed is the by-product of all of the above abruptions. This term was chosen to capture the entanglement between the struggling family and social structures, such as the law, civil and criminal, welfare, health, education, housing and technology, a 'bleeding out' into statutory provision. The social bleeding is a by-product of the triptych of abruptions.

Support in the Data for Socio-Familial Bleed

Participants spoke of a number of families with Social Care involvement. Sharon, Verity, Kate and Edith[25] all made mention of S-C children being subject to statutory child protection services. Some children had been removed from their family permanently. Sharon spoke of two of her S-C children being taken into Foster Care, "gone into a permanent foster family with a view to being adopted." Other children had on-going statutory monitoring with social work involvement as routine. The excerpts below concern different children.

"Social Care is involved" [Verity]
"There's a lot of social workers around the family" [Kate]
"They are all under Care" [Lucy]
"She's got an older sister in Care" [Edith]
"Social Care have always been involved with them for like years" [jess]
"The family was known to social services" [Sharon]
"She was initially in her own family and then went into foster care" [Sharon]

Kate and Hayley spoke of older siblings with disabilities. Edith, Sharon and Kate spoke of the removal of siblings. Edith spoke about one child who exemplified the, 'broken but holding' family environments that some of the S-C children came from. Jess talked of the network of professionals around the struggling family and offered an idea of family life for one particular child.

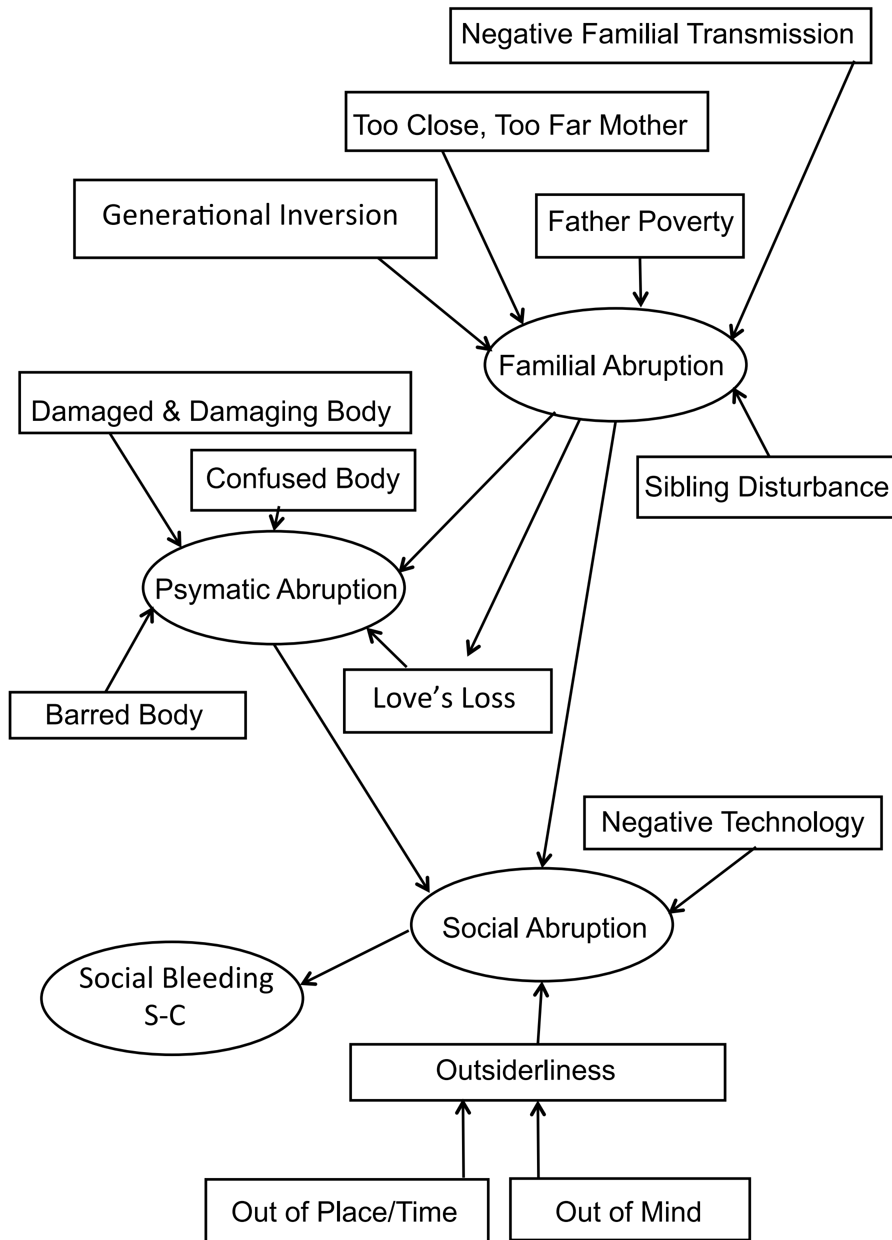
[25] Although some participants worked in the same school they each were talking of different children unless otherwise stated.

> "Well, Social Care are involved anyway with all of this and I mean the dialogue is that Social Care know, the SENDCO knows, you know they have meetings about him, about the whole family actually and there's a (Multi-Agency Team) is involved again…and umm they've witnessed domestic violence all their lives…and there's a referral that's gone to CAMHS recently, and they've got a Family Support Worker coming in to work with mum and Social Care have always been involved with them for like years apparently and yeah, he's like staying with his dad two nights a week because mum doesn't want him to be at home all the time because she can't manage him because he's violent at home." [Jess]

The S-C children were often displaying behavioural difficulties which transgressed the 'laws' of the school. These children were also talking about murder, albeit self-murder, and this, too is 'law encountering'. Some played on train tracks, used drugs, set fires, all behaviours that, potentially, invite the 'long arm of the law'. Further, as stated, there were a number of fathers in prison and a health care provision also featured heavily. But, perhaps, it is the excerpt from Jess's interview above which best illustrates how families bleed into statutory service provision.

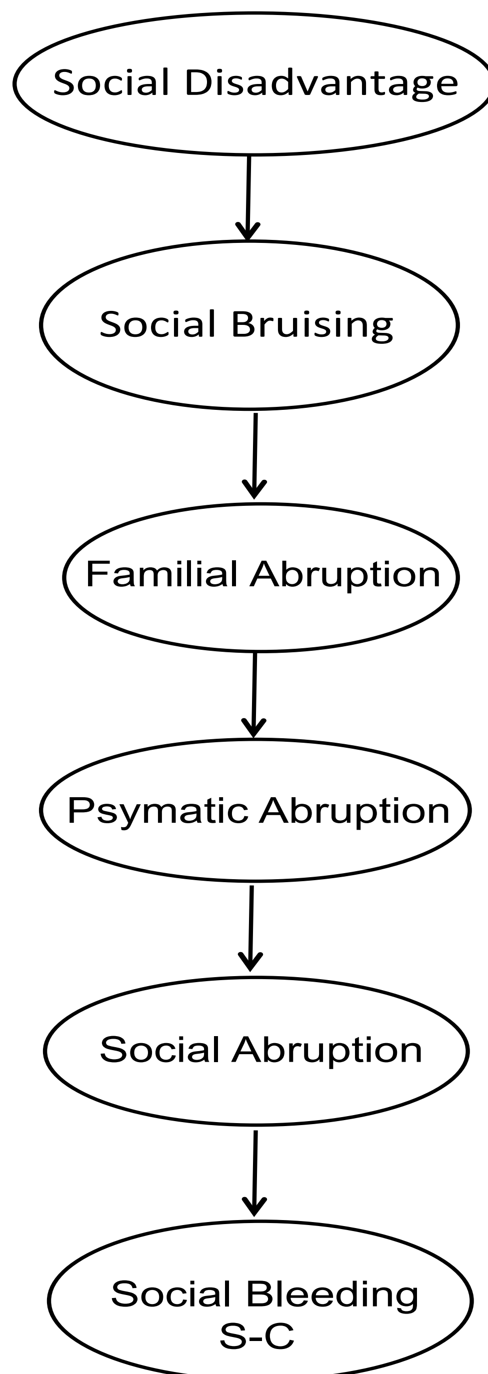
The above culminates in Developed Thematic Map 2. Figure 4.2

Figure 4.2 Developed Thematic Map



This is further distilled into the final thematic map below,

Figure 4.4 Final Thematic Map: The Suicide Communicating Child



4.11

Psychoanalytic Thematic Analysis Diffracted

In an effort to test diffraction I took the above final thematic map and looked at whether diffraction might offer an extended understanding of how social disadvantage considered within a psychoanalytically informed thematic analysis, and held within a triangulation of 'holding', 'protective shield' and cumulative trauma might extend and deepen our understanding. What the table below demonstrates is that the three themes diffracted through a Baradian portal of intra-activity, and a theoretical triangulation of holding, protective shield and cumulative trauma, found their intra-active relationship in the following entanglement:

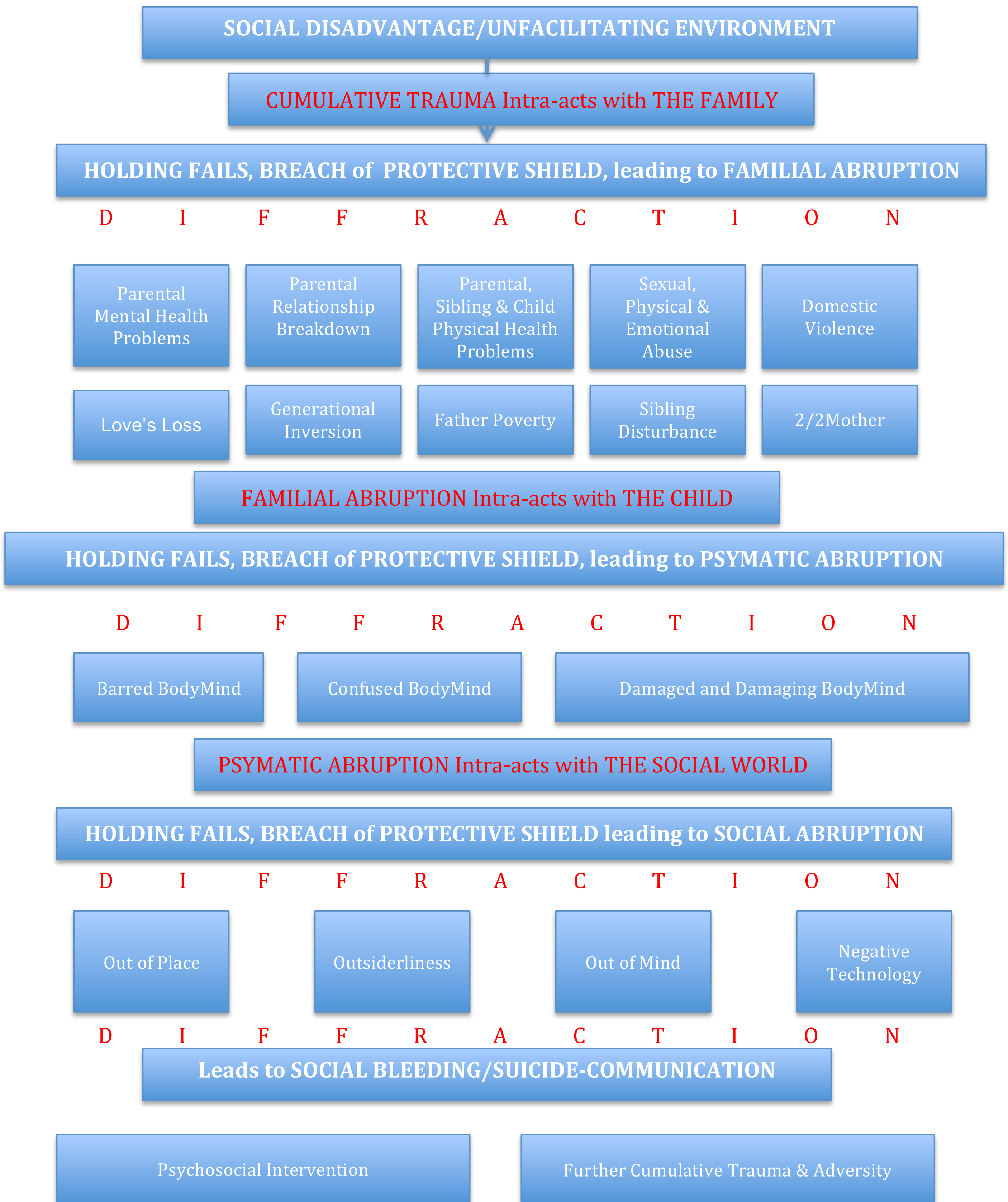
1.Social disadvantage and the unfacilitating environment diffracts through the family breaking protective shield, resulting in familial abruption.

2. Familial abruption diffracts through the child and breaks protective shield resulting in psymatic abruption.

3. Psymatic abruption diffracts through the social and breaks protective shield resulting in social abruption.

This leads to social bleeding of which a suicide-communication is an expression. Either this is responded to via a psychosocial intervention or the child is subject to further cumulative trauma and adversity, and their continuity-of-being comes under threat.

Figure 4.4: Map of a Psychoanalytic Thematic Analysis Diffracted



Chapter Summary

With some exceptions, the participants spoke of the challenging and painful lives of the S-C children. Absent fathers, and either intrusive or absent mothers were noted. Generational inversion, where children were treated like adults, was a feature. Children had to contend with multiple losses and were exposed to traumatic experiences. Often bodies were experienced as failing or damaged and parental mental and physical ill health was also present. Technology was brought as a negative and often indicated parental lack of supervision as the children experimented with alternative realities they could control. Participants brought a model of negative familial transmission where the struggles of the previous generation, were brought to bear on the children. This is what the staff said. This was then taken and cohered into sub-themes, then gathered into three overarching themes, Familial Abruption, Psymatic Abruption and Social Abruption. These were then diffracted through the encounter with the family, the child and the social. This then lead to social bleeding of which suicide-communication is one expression.

Chapter 5

Discussion & Conclusion

Chapter Outline

Section 5.0 revisits the research question and outlines the key findings revisiting the idea of unfacilitating environment, breach of holding, protective shield and cumulative adversity. Section 5.1-5.4 looks to the multidisciplinary literature for support for the key findings. Section 5.5 reflects on the method of interview in capturing the voice of the child diffracted through the voice of the adult participants. Section 5.6 reflects on the choice of a psychoanalytically informed thematic analysis as a way of making sense of the data. Section 5.7 reflects on study limitations. Section 5.8 outlines unique contribution. Section 5.9 argues a case for the earliest of interventions. Section 5.10 reflects upon the epistemological position arguing in support of an ethico-onto-epistemology in spite of the challenges of taking Barad's agential realism as foundation to the build of knowledge Section 5.11 looks at the clinical implications of the research. Section 5.12 considers research dissemination and recommendations. Section 5.13 offers concluding remarks.

5.0
Revisiting the Research Question: Key Findings and Psychoanalysis

The first research question, generated from the literature review, and the gap therein, was, ‘What do primary school staff say about socially disadvantaged suicide-communicating children?’ The second question, identified in the methodology chapter was, “How can psychoanalysis and agential realism make sense of what primary school staff say about socially disadvantaged suicide-communicating children?” The following section tries to answer the question, ‘to what extent did the research answer these questions?’

Firstly, as stated in the previous chapter, employing a psychoanalytically informed thematic analysis to cohere what primary school staff said about S-C in socially disadvantaged children into themes, extrapolated three overarching themes; ‘Familial Abruption’, ‘Psymatic Abruption’ and ‘Social Abruption’. These themes were built from a number of sub-themes which were, themselves, gathered from what the staff said about the children. The interpretation of what staff said about the children was that their suicide-communications could be seen as the sequelae of social disadvantage. This was expressed in terms of parental relationship breakdown, absent fathers, mothers struggling to regulate distance between themsleves and the child, both psychological and physical, domestic violence, generational inversion, where sons and daughters become partners, and grandmothers become mothers, sibling disturbance, mental and physical health issues, negative technology and love’s loss, alongside parental S-C and Social Care involvement. In this way the first research question and part of the second question was answered.

What was clear from the findings was that much of it was echoed in the psychoanalytic literature found in the literature review, however, psychoanalysis was able to offer a more nuanced map between the 'objective' intra-acting environment and the inter-subjectivity of a suicide-communication. After all, many children experience social disadvantage and not all of them communicate suicide. As the literature confirmed the centrality of mother, and the early years in the suicide scenario, it is here where we will return for a moment. Winnicott (1958) introduced his idea of 'holding environment' or 'ego-supporting environment' in his paper, "The Capacity to be Alone." Then in 1960 he introduced the idea of holding. As touched upon briefly in the literature review, holding is a process whereby the infant's fragile omnipotence is maintained by mother, by meeting the infant on its terms (sleep when the baby sleeps). This facilitates the infant's 'continuity-of-being', allowing it not to be ruptured before it is able to encounter the me-not-me phase of development via the world in small doses. In this way Winnicott is suggesting the baby as universe.

In order to facilitate this mother has to enter a state of 'primary maternal preoccupation', which Winnicott likens to a kind of psychosis as reality has to wait in abeyance. For mother to enter into this state she, herself, requires a facilitating environment where she is supported to attend to her infant in its very early stages of post-uterine life. Mother and infant enter into this mutual deception together which is a sort of uterine continuity where the infant was the world and its minions, the placenta, the umbilical chord, the amniotic fluid

and uterus are all there to serve it. If the mother is unable to manage primary maternal preoccupation then Winnicott finds that the infant experiences interruptions in its continuity-of being which he refers to as 'impingements'.

Therefore when continuity-of-being is subject to environmental impingement such as parental relationship breakdown, and maternal mental ill health or loss, then carrying on being, is interrupted, and, already, the foundations of a discontinuity-of-being are laid, particularly with traumatic impingement, which carries with it a threat of death, symbolic or actual. As the diagram (Figure 4.4) in the previous chapter illustrated, although all the above terms refer to the environment that is mother as she rears the infant in its first 30 months, with some reference to the immediate environment of family, they have adaptive utility in relation to the broader environment. In terms of social disadvantage, we might translate each into the 'unfacilitating.' 'ego-unsupporting', 'unholding' environment to make more use of the concepts. These could threaten to overwhelm protective shield. If this environmental stress then translates into cumulative traumatic experience, (Khan, 1963) then this can result in ego dis-integrity. If the ego already holds the scar tissue from previous failures in holding then it can become overwhelmed and struggle to manage further challenges to its integrity.

I want to particularly focus upon the idea of continuity-of-being and impingement. Essentially Winnicott's theory is also a theory of time and temporality because holding creates beingness. As discontinuity-of-being is a no-thing, the no-thing is death, and death is supposedly the aim of suicide

then we need to mine this relationship, particularly in a study within a Baradian epistemology where time is not seen to be forward moving and linear. Both Freud (1915) and Jones (1912) attest that the idea of death is impossible to encounter, and is beyond both unconscious and conscious thought. Not being is, simply, inconceivable. Heidegger (1927) reminds us, that being is time. Barad tells us that continuity is not dependent upon continguity.

These ideas are particularly relevant to the socially disadvantaged suicide-communicating children who are talking about calling time on time? Arguably, children who have experienced multiple discontinuities-of-being from their earliest moments, in the form of impingement from cumulative traumas are more likely have a different concept of time, death and their relationship to the universe. This is confirmed time and again in the literature as they seek rebirth, afterlife and continuation of consciousness somewhere in the universe, but not 'here'. So let us return to that universe and Winnicott's infant who is exposed to the terror of their anaclitic vulnerability before time? The primary school age child is still dependent. What happens when the protective shield that is mother becomes a source of attack, or she is so depleted by that her circumstances that her protective shield is weakened by exposure to multiple impingements? Might they look further afield, to teacher, to Social Care, to the universe for solutions? It would appear they do. Particularly those who have experienced trauma will have already experienced 'post-death life'. They already have this narrative in situ. Suicide is continuity of unbeing, if you will.

5.1

Support in the Multidisciplinary Literature for the Key Findings

It is my intention in this next section to look at where my research finds resonance in previous multi-disciplinary literature. In the process of generating new knowledge, Frith & Gleeson (2004) encourage looking at new findings in light of previous knowledge. I look at each of my three main abruption categories; familial, psymatic and social abruption in relation to existing literature.

5.2

Familial Abruption

The overarching theme of family abruption was drawn from data pointing to collapsed childhoods, lost mother, out of reach father, abuse, adversity and incest, violence and blurred generational boundaries leaving these S-C children struggling to find a foothold in the space called childhood. What the family handed down to children was seen by participants as contaminated in some way, as in negative familial transmission, in terms of coping, and being in the world that were less than optimal. These children were left flailing but whilst they were seen as jettisoned from the surety of 'good enough' family life they were also seen as being subject to unwelcome experience and conditions passed down and into the S-C child threatening their connectivity to life sustaining sources, and in some cases replacing these with death-connecting sources.

There are a number of non-psychoanalytic studies which point to the central role that families play in the life of the child who is suicide communicating, and in the following studies I find particular echoes of my idea of familial abruption. Due to word constraint I will acknowledge the literature whereby family disturbance is found in relation to S-C in young children but only explore it further if the contribution seems particularly significant. Further, the family section will be divided into family literature and literature that pays specific attention to mother. Serin (1927); Fowler (1943); Kanner (1957) found that significant psychiatric disorders such as schizophrenia and depressive psychosis were only attributable to a small number of child suicides and that most suicide attempts on the young did not have the goal of death and that they were largely staged to alarm the family and secure attention; Despert (1952); Lieberman (1960); Hendin (1964) and Otto (1964); Koller & Castonos (1968); Connell (1972); Renshaw (1974) Paulson *et al* (1973, 1974, 1978) concluded that S-C children came from pathological homes.

Pfeffer's (1981) study of the family systems of suicidal children found 5 common territories: 1) Fluidity of generational boundaries and insufficient individuation from the parent's family of origin. 2) Inflexible spouse relationship. Anger and the possibility of separation ever present. One parent may be depressed or suicidal. 3) Parent projects unconscious feelings of hostility into the child. Extreme rigidity in parent-child conflict. 4) Symbiotic parent (typically mother) relationship with the child. 5). Intransigent family system.

Elkind (1984) writes of the 'Hurried Child's' premature thrust into responsibilities that leads to a suicidal crisis. This finds convergence with the sub-theme of generational inversion which was also confirmed in Anderson *et al* (2012) whereby they used the term, 'intergenerational confusion' as part of a formulation explaining S-C in children and adolescents. Orbach (1988) says there are three ways in which family life contributes to child suicide:

1. "The 'multi-problem' family where there are multiple crises and the child feeling weary and overwhelmed becomes suicidal.
2. The family communicates a 'deadly message" where they communicate to the child that they wish them dead
3. "Destructive family processes" where there are symbiotic processes which destroys individuality and prevents the child moving away from the family." (p.154)

Asarnow (1992) found that children who described their families as less cohesive, less expressive and higher in conflict were more likely to attempt or think about suicide. Bush & Pargament (1994) found that suicidal preadolescent children came from families with a deficit of emotional bonding. Wise and Spengler (1997) confirm a link between family dysfunction in S-C children 14 years and younger. Vinas *et al* (2002) look at family factors associated with suicidal ideation in preadolescents and found that their families were perceived to have low family expressiveness with excessive punishment and family conflict. In my data poor parental mental health and family history of suicide was one of the recurring features of family abruption. Pfeffer *et al* (1977 and 1980) found that young S-C children had parents who

experienced suicidal ideation and Beautrais (2004) confirmed that those children who made suicide attempts often come from family backgrounds where disadvantageous characteristics included: parental separation and divorce; parental mental illness; domestic violence; and childhood abuse and neglect.

Dervic *et al* (2008), drawing on data from their 2006 study, found that suicide only occurs in vulnerable children. Their vulnerability is identified as being sourced in parental mood disorder and impulsive aggression, and a history of family suicide. Fu-Gong (2014) looked at 979 children and found a quarrelsome family environment attributable to a 3.7 fold risk of suicidal ideation. Taussig and McGuire (2014) studied preadolescent children aged 9-11 years who had been maltreated and had entered foster care within the prior year and found that 26.4% had a history of suicidality with 4.1% being imminently suicidal. Non-Hispanic, younger, abused children who had experienced multiple forms of maltreatment, more welfare referrals, more house moves and longer lengths of time in foster care were found to be at the highest risk. The study also found that physical abuse and chronicity of maltreatment to be the greatest predictor of suicidality.

As captured in the psychoanalytic literature there is a good deal of focus upon the role of father in the suicide scenario. What follows is further endorsement from the broader literature. In 1971 Shneidman wrote about male suicide in participants recruited for the Terman Study.[26] One of his findings, which he

[26] An American study of 1,528 gifted children who were tracked from the 1920s.

identified as key to suicide, was father rejection. French and Steward (1975) offer a single case study of a S-C 7 year-old boy focusing on depression and family dynamics, noting the child's distant relationship with the father as significant. Bron (1991) found that the increased incidence of suicide attempts could be explained by how the individual processed the loss of father.

Further, the psychoanalytic child literature documents the desperate children who had lost the protective shield of mother, and emphasised the role of mother, either too close as in symbiotic or violent, or too far, dead, depressed, absent, in the suicide scenario. This was confirmed in this data. Pfeffer (1981a) looks at the family system of suicidal preadolescents and concludes a symbiotic relationship with mother is contributory. Orbach (1981) and Orbach, Gross and Glaubman (1981) looking at 11 suicidal 6-12 year-olds, found a symbiotic relationship between child and parent and premature responsibility in the child. Orbach (2007) looking at symbiotic families, found that adolescents rejected and abandoned in early childhood have developed an insecure attachment along with an insufficient ego. They are often scapegoated by their family and are held in place by their family so they can serve as a repository for negative projections and they are not allowed to separate out and find autonomous existence. Klimes-Dougan *et al* (1999) found that children of depressed mothers were more likely to report suicidal thoughts and behaviours, which could be an example of a mother that is too far.

5.3

Psymatic Abruption

The term 'psymatic abruption' was chosen in an effort to acknowledge the indivisibility of psyche and soma. Here the data confirmed that the S-C child had much to contend with. Their experience of their own bodies, and the body of others as damaged and damaging was pronounced in the data, as was their barring from the bodies of significant others, and, perhaps, their own as they had to remove themselves from bodies that were under threat. Psymatic abruption was proposed as a product of something that had already been experienced by the S-C children and this resulted in a S-C in an effort, perhaps, to stem the abruption from continuing, a distress signal, if you will.

Psymatic abruption could be seen as a defence strategy, to break away from that which troubles the child, possibly akin to a splitting ego or psyche. It could also be a dissociative move away from body, it might take the form of stretching reality until it extended to include some place where the child could better manage their psymatic pain. The threat of the termination of the current body was offered up in appeasement, possibly, to the dissatisfied mother, or to secure the child's sanity, or to strengthen capacity to tolerate ongoing painful experience. Further the ubiquity of parental mental health issues and the challenge of a struggling mind to mentalize and rear the mind of a child is noted. As only one of the children discussed had a diagnosis of ASD the research was not in the area of psychiatric diagnostics, and as such the body mind required thinking about as a unified unit. For example, it would not be possible to extrapolate out how, say CSA, impacted the psyche apart from the

body or the body apart from the mind. There is much written of in the literature whereby it is suggested that to condition the pre suicide state the body becomes jettisoned (Orbach, 1988) but I am not sure that there is a collapse between psyche and soma, as in young children's drawings where there is only a body, then later the neck and external arms and legs appear. In this way, there is a regression to an earlier state of development.

As 'psyma' is a neologism specific to this study it is not possible to find examples of psymatic abruption in the literature and therefore I attend here the literature on body and mind in relations to suicide, and find that there are continuities between this research and my findings. Ronningstam (2008), making reference to Fonagy's Mentalization treatment (1999), suggests that the failure of mentalization leads to objectification of one's body, therefore it is not only the mind of the child that is impossible to separate out from the body it is also the mind of, typically, mother, that impacts both body and mind in the child.

One of the sources of bodily abruption, and in the literature the most significant in terms of suicide outcomes is sexual abuse. Children are most likely to be sexually abused between the ages of 7-13 yrs (Finkelhor. 1994) but 20% of children who are sexually abused are abused before the age of 8 (Synder. 2000). Therefore primary school age children are most vulnerable with the statistic that 1 in every average classroom (1 in 20) will experience sexual abuse (Allnock & Miller 2013). In my data, out of the 40 children there were 3 children who were discussed in relation to CSA.

As previously discussed, the sexual abuse of children and S-C has been found in the clinical literature dating back to Freud. In 1896 he suggested, ‘Our children are far more exposed to sexual assault than the few precautions taken by parents in this connection would lead us to expect.” (quoted in Bonhomie, 2017 p.33.). Although some subsequent studies, possibly, allude to S-C and CSA, for example Bender & Schilder (1937) suggest that the suicidal child punishes those, “who have interfered with the child” (p.225), it was not until the 70’s and 80’s when a more concerted literature on the link between CSA and suicide was made. Even then there were dissenting voices, with Sedney and Brooks (1984), and Peters (1988), for example, concluding no relationship between CSA and later S-C. Pfeffer (1986), in her 290 page book dedicated to S-C in young children only makes one reference to possible CSA, “Other family factors that are commonly associated with suicidal behavior in children include parental violent and sexual abusive patterns.” (p.128). Bensley *et al* (1999) and Brown *et al* (1999) found CSA had the greatest risk of subsequent suicide with the risk of accumulated suicide attempts 8 times greater than those who had not experienced CSA. Hawton *et al* (2002) confirmed that adult suicide attempts are greater in those who have experienced CSA. Ulman & Brecklin (2002) suggest that accumulative experience of CSA and subsequent sexual abuse increases S-C.

Brodsky *et al* (2008) found that CSA correlated with suicide attempts. Colquhoun (2009) offers up a comprehensive account of the relationship between CSA and suicide. Lopez-Castroman *et al* (2013) found that, “earlier

onset of sexual abuse and its duration were associated with more suicide attempts." (p.1). Kõlves and De Leo (2015), found 850 youth suicides in Queensland, Australia, 43 of whom were aged 10-14 years. Of these they found that 2.3% had experienced sexual abuse. The American Association of Suicidology (2016) found young adults who experience sexual abuse in their childhood have a 4-11 times greater risk of suicide attempts if they are male and 2-4 times higher risk if they are female. Bahk *et al* (2017) found that only CSA directly predicted suicidal ideation.

There is also literature in relation to physical abuse, domestic violence and S-C. Thompson *et al* (2005), working from LONGSCAN data of 1,051 8 year-old children identified as maltreated, or at risk of maltreatment, found that 9.9% reported suicidal ideation. They also found that, "children who are maltreated and those exposed to community and domestic violence are at increased risk of suicidal ideation, even by age 8." (p.26). Appleby *et al* (2016) confirmed links with exposure to domestic violence across the cohort of completed suicide in those aged under 20 years.

The theme of loss, which includes the physical loss of the body of the person who is lost to the child, was ever present across my data, and chimes with previous research. It certainly is supported by the early psychoanalytic literature. Several of the children discussed had experienced such painful losses, mother, father, siblings. Loss, real or imagined is central to psychoanalytic understanding of S-C. Other research has confirmed this. In 1951 Schacter & Cotte write of parental death, finding deprivation of parental

love as contributory to suicide children and adolescents. Moss & Hamilton (1958) found that 95% of their patients (albeit not young children) had experienced a significant death prior to their suicide attempt. Alarron (1982) reported work with a S-C 7-year-old and found a history of being in and out of Care, loss of siblings to Care and loss of father at the age of 5 years to divorce. Zirin (2006) noted bereavement and loss of father as being significant in his three case studies of suicide-communicatiing young children. Appleby *et al* (2016) made links to a recent bereavement in the young people under 20 years who had completed suicide.

Another element of Psymatic Abruption in my data pointed to the role of physical illness in parents, siblings and the S-C child. Fritz (1980) wrote of his 5 year-old S-C patient and linked this to his sister's ill-health. Pelizzo *et al* (2013) wrote about suicide attempts in pre-adolescent children who have life-shortening diseases. Kõlves and De Leo (2015) found that 9.3% of 43 children aged 10-14 who completed suicide had a physical condition. Appleby *et al* (2016) found 38% of those 20 years and under who had completed suicide had a physical illness.

Within the data there was reference to both sexuality and gender issues in relating to the S-C children. What was clear in the literature, and the data was that there were a greater number of suicide-communicating boys than girls. The issue of gender was briefly touched upon in the literature and I suggested there that as girls are born from the same (mother) and boys from the other this might impact how early self is foundationed upon a continuity-of-being for

females and discontinuity-of-being for males, simply because of their biological sex. In this way, it might be possible that the female body is never entirely owned by the self, and in this way when it is disowned after fusion in, say, intense romantic love, which Freud (1917) compares with the state of suicide, it is returned to a shared ownership, a continuity-of-beingness, if you will. Whereas males are returned to aloneness, or a discontinuity-of-beingness, for they are other and 'over there', and if they were to belong/identify in this way it could be at the expense of their male self. As such male processes of identification are already infused with loss from the beginning as they begin from a point of 'not me'. However, what was not really attended to in the data was the sex of the children. It was mentioned, but not seen as an explanation of their suicide-communication. But because it was integral to the data it warrants mention here.

The same could be said of the children's ethnocultural background. Black bodies are experienced differently in the world than white bodies. Black bodies have been more damaged and Black bodies continue to be subject to damaging experience. With the help of the Black Lives Matter (BLM) movement we are reconsidering our intransigent iron and stone bodies of history, Rhodes in Oxford, De Montfort in Leicester, Colston in Bristol.[27] Whilst culture lies beneath the surface, the skin that covers the body is critical in the experience of the young child's developing sense of self. This has not been attended to in the psychoanalytic suicide literature for decades, with only

[27] Although we might need to look closer to home for a reconsideration of those, such as Enrico Morselli (1852-1929), a eugenicist and early suicide researcher whose eponymous medal is awarded to those who have made an outstanding contribution to suicidology.

Hendin (1969) offering a sustained focus. As previously stated, Freud (1923) said the ego was first and foremost a bodily ego he followed this with, “it is not merely a surface entity it is itself a projection of a surface.’ Bick (1987) wrote of the skin as definitional in building the self so what happens when that which contains you is seen to contaminate you in the eyes of the racist? There were a number of Black and Dual Heritage (of Caribbean descent) children in this study, and they had to contend with both the fallout of social disadvantage and racism. Particularly the Dual Heritage children might have encountered a conflicted sense of belonging and processes of finding oneself though de-identification. There S-C needs to be considered within these alienating dynamics but it is noteworthy that this was not brought as a factor in the participant’s hypotheses.

However, the same could not be said for aggression, the ubiquity of which was in the data. Aggression is writ large across the early psychoanalytic literature, in particular. However, suicide was tallied with aggression long before psychoanalysis. The word ‘suicide’ (*suicidium*) is split and does not have its own etymological root, with ‘*sui’* being genitive of ‘self’ and ‘*cidium’* ‘a killing’ (see Bills, 2017, for a comprehensive account, Daube, 1977, for an exploration of the linguistics of suicide and Shneidman, 1985, for definitions of suicide). It is also a feature of the non-psychoanalytic literatures, probably because of the psychoanalytic interest in aggression’s role in depression, and depression’s role in S-C.

McNeil (1960) looked at suicide in children and considered how children's aggressive feelings are generated by rejection and lack of parental love. He identified six key aspects of suicide behaviour: 1) An introjection of the punitive parent who was then symbolically attacked by the suicide act. 2) The turning of aggression against the self in terms of avoiding external punishment for the expression of aggression. 3). Self-mastery and independence. Better the child have control over who punishes them rather than someone else. 4). An economical management of hostile feelings. The self is always available for attack. 5). A socially responsible management of hostile feelings which have internalized parental or social regulation. One becomes, judge, jury, executioner. 6) self-punishment as a way of salving the conscience to then be free to attack again.

Connell (1972), looking at 17 children under 15 years, 3 of whom were 12 years and under, found inability to express overt aggression, which resulted in emotional decompensation shown by depressive symptomatology in those in families where there is the transmission of impulsive aggression. Santostefano *et al* (1984) tabulated suicidal fantasies in 123 children aged 8-16 years.

Fantasy Wishes	Degree of frequency
To die	Very Common
To kill	Very Common
To be rescued	Very Common
To escape from an intolerable	Very Common

situation	
To be killed	Common
To punish others	Common
To reunite with a kind person	Common
To be relieved of inner turmoil	Less common
To gain revenge	Less common

Four of these could be seen to belong to aggression in some way but the other five are more passive, seeking relief, comfort, the proximity of a loved other. Here, we find S-C is an entanglement of sadism and passivity, of love and hate, of hope and despair. However, Apter *et al* (1988); Apter (1989), Apter *et al* (1990); Apter *et al* (1991) pay particular attention to the relationship between aggression and suicide, giving it equal weight to depression in assessing risk. Brent *et al's* (2003) study of peri-pubertal children confirmed an increased suicide risk of offspring of suicide attempters with siblings who were also concordant for suicidal behaviours where they displayed impulsive aggression.

5.4

Social Abruption

When first familial then psymatic abruption diffracts through the social domain in terms of the way in which the S-C child navigates social space, this results in social abruption. How the children struggled to inhabit the same space as their less troubled peers was a feature of the data. Some, might have to remove themselves from the 'here and now' to attend to intrusive thoughts,

some might be more alert to the door to the classroom as they hold an anxiety about who might walk through it, some are on heightened alert due to their traumatic experiences. Some might be waiting for either their longed for, or violent, father to return. Perhaps the parameters of their existence have been stretched to outer limits as they search the universe for the mind of their mother, pharmacologically distant, emotionally remote, preoccupied with getting through the day and thought blocking unspeakable experience. Or their interiors have been intruded into by violence and sexual abuse. Or no one has thought into the shape of who they are and they cannot find it themselves. Here we find S-C children in corridors, outside of classrooms, outwith friendship groups. The social abruption often seemed to be a replay of their circumstances at home, being outside the mind of mother and father, and living in circumstances of social deprivation, born into fringe estates. These children run out of school and into traffic. They exist under the threat of school exclusion, falling from the minds of government, losing the holding of the social as they are jettisoned outside of mainstream systems and into the margins. These children seem to haemorrhage having lost their boundary. Perhaps they perceive space, place and, perhaps, even time differently.

The idea of social abruption brought into focus the belief in death as an alternative to life where life was on-going but elsewhere. Further, arguably, virtual spaces were retreated into by some S-C children in an effort to remove themselves from space and time that is bringing feeling states which are too painful and uncomfortable to stay with. This could have been what was happening with the child who Lucy bought above in 'Out of Mind'. He was

inhabiting virtual space. In addition, there is the time subversion of GI. Campbell and Hale (2017), in asserting their theory of a 'pre-suicidal state', use Ringel's idea of 'dynamic constriction' that has its basis in stunted or frozen personality with the notion of time standing still. Trauma, which was mentioned twice by the same participant, Kate, in relation to various children also has a distorting relationship to time. In PTSD shards of the past become the present. It appears that a number of troubled children moved out of the classroom to express their discontent, maybe understanding that the time constraints that governed transitional spaces were different to the structured timetable of classroom life. This also enfolds with Barad's ideas around timespacemattering. The subthemes of 'out of time', 'out of place' and 'out of mind' all spoke of how 'unsituated' these children were. It is this experience of outsiderness which results in 'social bleeding,' an expression of which is a suicide-communication.

Making use of diffraction and agential cuts, the analysis of the data began and ended with the social. Social disadvantage creating social bruising. Social disadvantage is an objective, material, intra-active fact. It creates the unfacilitating environment, which, in turn, creates social bruising. I chose the term 'social bruising' as it indicates bleeding on the inside, as much of the damage from social disadvantage takes place within the body of the family, beyond the scrutiny of the outside world, and yet its damage is visible to those who care to look. Further, it delineates an exterior to interior process which charts what was once outside is now inside in the same way Freud (1930) wrote of external repression, eventually becomes internal repression. Here,

external deprivation eventually becomes internal deprivation in terms of family and child functioning.

In terms of the literature relating to social abruption, occasionally cultural historians, within broader studies, have taken interest in the social life of the young child and suicide. Murphy (1986); MacDonald and Murphy (1990); Shuttleworth (2010); Steinberg's (2011); Duncan (2016) have all made noteworthy contributions. They all draw conclusions about how the socio-economic and political impacts the suicide-communicating child. Early statisticians such as MacDonald (1907) furnish us with numbers. Psychiatry pioneers and 'men of letters', Winslow (1840); Jopling (1852); Brierre de Boismont (1856); Browne, (1860); Morselli (1879); Westcott (1885); Maudsley (1886; 1892); Strahan (1893), all paid passing interest, with minimal compassion and, on occasion, the suggestion that suicide is a form of natural selection, weeding out the damaged. Some paid closer attention; Durand-Fardell (1855); Emminghause (1887); Persier (1899), but few put the young suicide-communicating child at the centre. Even the earliest sociological literature (Durkheim, 1897) dedicated to understanding suicide only references children as a resource and prophylactic in preventing women from killing themselves.

Halbwachs (1930) wrote:

> "People only kill themselves following or under the influence of an unexpected event or condition, be it external or internal (in the body or

> the mind), which separates them or excludes them from the social milieu and which imposes on them an unbearable feeling of loneliness." (p. 322)

It is said that Durkheim was little interested in suicide (Marsh, 2011) he just required a phenomenon upon which to build sociology. Not long after '*Le Suicide's* publication in 1897 psychiatry appropriated the suicidal for their attention. This may go some way to explaining the lack when attending to the young child for important contributions from the sociologically inclined, such as Fedden (1933); Dublin and Bunzel (1933); Sainsbury (1955); Giddens (1971); Douglas (1967); Atkinson (1978); Taylor (1982) children barely scrape a mention. As a socio-clinical study the door remains ajar when trying to bring sociology and psychology into conversation with one another, particularly around young children and we might wonder if it that children are not seen to hold independent social currency as they are still seen as belonging to their parents. They neither earn, nor vote, and their belonging, and consideration, in terms of society, seems to exist in contested territory.

Interpretation of the findings looked to the social in the child's life. Attachment theory, in particular, highlights the importance of the other in a young child's life. Adler and Buie (1979) highlighted the essential role of aloneness in the suicide scenario and Joiner (1997) proposed 'thwarted belonging' as being critical in the suicide scenario but neither have attended to the young child. There is barely any showing from sociology when it comes to young S-C

children and this is telling because there is something about the young child's place in society that appears to merit attention.

However, what the data brings that these children experienced multiple losses, sometimes the loss of both parents and siblings, and this is loss of belonging to. The threat of loss through serious physical illness and the loss of health and ability. All these losses can destabilise a sense of belonging. These children also struggled to belong amongst their peers, within their classroom, in mother and father's minds and hearts. They were dislodged in multiple ways and inevitably would have experienced the pain social dislocation. Little wonder some looked for a place to belong even if it was out of life. Already they were wandering the universe looking for asylum. Some found temporary relief in the virtual highways but the four square walls of reality, family, psyche, society, were too difficult to bear and they needed to push against these, to alert those who might come to their rescue, whether that was mother, teacher, God, the afterlife, the past (regression).

For five of the children who were discussed during interviews, I subsequently learnt they had been permanently excluded from school. We might wonder what lonely trajectory this places them on. The Los Angeles Suicide Prevention Centre and the Samaritans were both established in recognition of the aloneness of the suicidal, and the importance of human connectivity in moments of crisis. Childline is well used by children but less so the very young who might live in households where there is no landline and they are without a mobile phone. Who is attending to their upset if they cannot turn to

their family? The answer is their primary school. If they are excluded from mainstream school then what does this say of the path they will walk in terms of belonging and connectivity to the greater social whole?

5.5

Reflections on Method

Having settled on the approach to interview school based staff, I found the research participants proved to be valuable witnesses. I was struck by the frequency of their encounters with S-C and the depth of their engagement was notable. The interview offered a space for reflection that was not always present at the moment they received the suicide-communication, and their testimony conveyed intimacy, compassion and curiosity, which I couched in terms of suicide hypothecation, in other words, the staff not only embraced the children's emotional presentation, albeit not without an unavoidable degree of anxiety, but they also were keen to understand how it was that a young child could come to contemplate and even wish their own death. However, three participants, in particular, moved between feeling that the S-C was about other matters than the child wanting to die, typically, responding to the immediacy of the situation, as in a small reprimand or consequence and acknowledging that the children had very difficult lives. However, the literature tells us that receiving a suicide-communication provokes complex feelings and, no doubt this shaded participant's contributions.

Educational staff have been found to offer helpful insight into the mental health challenges that face children, for instance the work of Simm et al

(2008; 2010) who looked at self-harm in children through the eyes of 15 staff across 6 primary schools in the North of England. Further, Bauer and Shea (1987); Leenaars and Wenckstern (1991 & 1999); Stone (1999); Barret and Turner (2001); Shaffer (2003), Wasserman *et al* (2015), tell us that primary school teachers can even play a vital role in the assessment of suicide potential. Hazell and King (1996), however, are more equivocal about the role that teachers can or should play in engaging with the challenges of mental health, and Guo and Harstall (2002), arrive at the conclusion that there is insufficient evidence to support that suicide prevention can happen in schools.

Many schools, with their well-being remit, are now more multidisciplinary with a stronger pastoral commitment to meeting the challenges of mental health. This research demonstrates that some primary school-based staff have both the acumen and receptivity to notice and receive S-C. However, in the current socio-political climate, teaching staff and leaders, particularly those in schools that serve socially disadvantaged catchment areas, are so overwhelmed with targets, behaviour and safeguarding that there needs to be an extra layer of support in responding to children that present with more serious distress such as S-C. This research points to teaching staff having a capacity to notice, but also that they are then uncertain as to how to think and respond to S-Cs. There is a necessary place for dedicated mental health leadership in schools, with practitioners who can cohere support for teaching staff around matters such as responding to S-C.

It is perhaps worth noting that my approach to the interviews may well have proved efficacious in helping the interviewees to narrate their experience, particularly in regard to their difficult encounters. The single question approach allowed plenty of space for the participants to tell their story, and it also allowed me the space to bring my clinical skills for listening and attentiveness to the process. An interview approach that might have been structured or semi-structured may have inhibited this process. Creating the conditions for stream of consciousness served the research well.

Whether the method of interview accessed the truth of the lives of the children is not possible to ascertain. What was given was an account of inter-subjectivity within the intra-objectivity of social disadvantage, for all the children discussed, experienced social disadvantage. I did not doubt that participants had been in receipt of what they understood to be a suicide-communication, whether the transaction was conscious or unconscious. The information that they brought, about family environment, in an effort to make sense of the suicide-communications fell completely in line with the existing psychoanalytic thinking. There was only one psychoanalytic practitioner amongst them. In this way the findings seemed to hold greater validity for, collectively, these primary school staff arrived at like conclusions.

Arguably, research participant data is always a ‘collaboratecho’ of and with others. The question as to whose reality it is, is in some ways redundant. Conclusions drawn about reality are always an entanglement of researcher, researched, voices from existing literature *and* the intra-acting universe. This

research is no different. Importantly, the children of this study entrusted, and, arguably, returned, their despair into the hands of the state, where it belongs. The suicide-communication of the socially disadvantaged child belongs as much to society and beyond, as it does the suicide-communicating child. It could be seen as social by-product where the unwanted of the unwanted 'unwant' themselves. Participants who report what these children said or did cannot be disentangled from what was said or done but to suggest that therefore there is no reality, as is commonplace in post modern thinking is simply wrong. This position can lead to intellectualization of very real problems and, significantly, inaction in terms of social change. My point was that there is *only* entangled realities but they are realities nevertheless. Whether this feels like the thesis sails too close to a positivistic landmass where the subjective ship of psychoanalysis might wreck is to misunderstand the post-binary waters that Barad maps and the opportunities for psychoanalysis to stay afloat within these. What Barad endorses is the subjective fact and that can only be a good think for collapsing the distinction between quantitative and qualitative research. This is particularly relevant in a study interested in the quantity of qualitative experience.

As Barad finds we are co-constituent of all phenomena, including intellectual output, the collaborative nature of the knowledge building practice of a doctoral thesis of which the primary school-based staff were a crucial and foundational part, but not its whole. The findings are a cacophonous collaboration beginning with the voice of the suicide-communicating child, diffracted through the adult voice of the participants. In turn, the voice of the

research participants are diffracted through the research process. Further, past voices of suicide theorists intra-act with the current research and a new, transitory, agential reality is formed.

5.6

Reflection on Data Analysis

Reflecting on the method of a psychoanalytically informed thematic analysis of the data, I would say that it allowed me similar freedom to develop my research in a way that was independent of the imposition of a tight theoretical frame, such as in IPA, I felt that the approach to thematic analysis accommodated a number of theoretical probes, psychological, social, political, and this was in keeping with the multi-disciplinary focus of the study. If there was a reservation it was the challenge of making use of themes within the intra-acting model of agential realism which pulls against boundary and, instead advocates a porosity. However I felt thematic analysis held its own and when I compared the two thematic maps at the close of chapter 4 I was not sure that the diffractive map added any more than an additional thematic map would

I did not analyse the difference between a school counsellor's response, as opposed to a TA, as opposed to a teacher, as opposed to a family support worker. As stated at the outset I did not wish to focus upon the participants, I wished to focus upon the children, as such I treated the data homogenously whilst extrapolating out themes across the data set. I was part of that group, and one of my roles was to make cuts. What differentiated me from the group

was that I was, at the moment of interview, operating in a researcher role. I had set the research agenda and I was responsible for inclusion and exclusion. Foucault writes that, "Knowledge is not for knowing, it is for cutting" (Foucault, 1994). No doubt this can be interpreted in a number of ways but the knowledge that this thesis produced, or perhaps any thesis produces, is knowledge which passes through the cut of the researcher.

Further, the use of a psychoanalytically informed thematic analysis allowed me to use practice skills to recognise thematic consonance in a way that employing thematic analysis alone might have missed. Psychoanalysis adds a layer of depth to thematic analysis. It finds relatedness in seemingly unrelated data and this helps distil a whole data set into both interrelated and distinct themes. I am not sure if the psychospatial dimension of the material cohered under social abruption would have found that coherence without psychoanalysis. I would certainly employ the combination again as I felt it was successful in not only privileging the voice and reported experience of the children but extending insights into the challenges they faced.

5.7

Study Limitations

The main limitation of this study was that I did not access the S-C children themselves due to the ethical restraints, as discussed in Chapter 3. Jacobsen *et al* (1994) did interview children, discussing the unique problems to be found in interviewing pre-pubertal suicidal children, including trying to assess intent and cognitive grasp of death, how to interpret suicidal play and how to

manage clinician and parental anxiety in relation to the assessment. Here, they found a valuable yield of data. Pfeffer (2003) found children to be the most reliable source of information as regards their own suicidality. However, these studies concerned children who had presented for assessment in a clinical space. So the research challenge in my instance was different insofar as I would have been seeking out children whose parents had not brought them forward for scrutiny. However, there is one example, Ialongo's (2004) study of a community sample of African-American children, aged 9 or 10 years. In that study the researchers found that the children, particularly girls, were able provide enough coherent emotional data through self-reports which proved useful in predicting subsequent suicide attempts, and that these self-reports were more predictive than teacher and parent reports.

However, in the absence of other examples, I did not feel there were sufficient precedents for me to conduct direct research with the children. In part, I was swayed by the general response of anxiety among colleagues when I began to talk about talking directly with the children. While I was both comfortable and familiar with talking to children about their feelings of wanting to die, I did not wish to get caught in an ethical crossfire on my first outing as a clinical researcher and, as such, put the idea to the side.

Further, in retrospect the study was overly ambitious. It wanted to do too many things that had not been attempted as singular endeavours, let alone together. Barad has not been widely used in social science research and, arguably, psychoanalysis is still finding its way as a methodology and a

method. Therefore bringing both together, in a study of what could be described as both 'unthinkable' and unchartered in the UK was ambitious. It was difficult to weave psychoanalysis, agential realism, social disadvantage and suicide-communicating children together at points. I am not sure that I always managed to.

5.8

Unique Contribution

In some ways, my study confirms what is already known. The prevalence of social disadvantage, poverty, family dysfunction, absent and estranged fathers, symbiotic functioning, parental mental health difficulties, exposure to suicide and violence, mother loss and mother hate, high thresholds of bodily pain, physical ill health, social and emotional exclusion. A broad familiarity of my findings in relation to previous research and literature has highlighted that there is a repository of knowledge, but we seem to acquire knowing, lose it, re-find it, only to lose it again. And so this knowledge about S-C in young children has not found its way into curriculum or practice, and there continues to be a reluctance to contemplate that young children do communicate feelings about suicide.

There are two important ways that my research addresses this shortfall, and contributes with a new perspective that builds from what is already known:

1) This is the first UK study looking exclusively at S-C in primary school-age children.

2) This is the first UK psychoanalytic study looking exclusively at S-C in primary school children.
3) This is the first study to try to map out the territory between social disadvantage and suicide-communication in primary school children.
4) This is the first study to consider suicide-communication within a Baradian frame.
5) This is the first study that attempts to bridge the techno-bio-socio-political with the intrapsychic.
6) This research is the first to assert that suicide-communication in socially disadvantaged children is a product of social bruising, diffracted through the family, resulting in familial abruption, which then diffracts through the child causing psymatic abruption, which then diffracts through the social and results in social abruption, which results in social bleeding of which suicide-communication is one expression.
7) This is the first literature review to attempt a Baradian onto-ethic-epistemological interrogation of the literature and its biography.
8) This is the first study to produce an early intervention, multi-disciplinary, unconscious informed, research informed, suicide risk assessment and suicide prevention tool to be piloted in a primary school serving a socially disadvantaged catchment.

5.9

Arguing for Early Intervention and the Young Child

From the earliest studies of S-C in children, early intervention has been advocated. In 1927 Dr Suzanne Serin, a French Psychiatrist, wrote of her

work over a 20 month period in the Henri Rousseau Psychiatric Hospital in Paris about the 420 suicides investigated in that period of which 17 were children aged 7-18 years of age. She concluded that many of the completed suicides were sourced in faulty upbringings and could have been avoided if the necessary support had been invested earlier. As stated in the literature review, there is a good deal of focus on suicidal adolescents as they transition into adulthood. Work and input into this group is seen as early intervention but, arguably, this is 'late intervention'. This continues a tradition of overlooking young children. What a good deal of the psychoanalytic literature confirms is that a suicide trajectory begins before we can barely speak of it. And socially disadvantaged children are so often put on mute. Whilst it was psychoanalysis, and in particular the early pioneers of child psychotherapy, who first paid close attention to this very early life, there is a good way to go before young children are given parity.

Undertaking research in the new millennium children can be seen as a burden on the state, on occasion, economic units for parents to lever government monies, generators of child-care costs, prey to on and off-line predators, victims and gauges of social media and technology, impediments to women's professional progress, generators of guilt, fought over fodder for warring parents, markers of global educational standing, symbols of personal fertility and national fecundity, facilitators of maternity leave, psychiatric diagnosis carriers to absolve parents of blame, pharmacologically modified with drugs such as Ritalin to ease parental load. Only occasionally are young children seen as worthy of equality and respect, unique, capable of complexity, deeply

moral, philosophical, nuanced in feeling and noticing, already citizens, profoundly impacted by those around them. This latter view of children is gathered, almost exclusively, from working with children from social disadvantage.

Pfeffer (1986) finds that S-C in pre-adolescents predicts S-C in adolescents. Ialongo (2001) looked at first grader's reports of mood and depressed feelings and found that these were predictive of later academic performance and use of mental health services, suicidal ideation and major depressive disorder by 14 years. Steinhausen and Metzke (2004) conclude that there is a heightened risk of abnormal psychosocial and psychopathological functioning for young adults if they expressed suicidal ideation in preadolescence. Whalen *et al* (2015) looked at suicidal cognition and behaviours in 3-7 year old and found that it is a marker of risk for ongoing suicidal ideation and behaviour. Further, early suicidal communications were found to continue into later childhood. The literature, alongside this study, confirms the necessity for the earliest of interventions. I think it also identifies the site where this might take place. Primary schools, serving communities experiencing social disadvantage are uniquely placed to capture information that can be put to use in adumbrating subsequent suicide risk. ACE studies tell us that it is not complicated, it is accumulative, and although its simplicity has been called into question, with a particular focus upon the lack of nuance and clarity with the 10 item questionnaire as a basis for calculating future vulnerability accurately (McLennan, MacMillan & Afifi, 2010) it remains relevant as a template and model. We might find that there are particularly potent combinations, say

mother loss and CSA, but at present it appears to be a case of adding adversities with a view to assessing future outcomes, including suicide, and we need to begin at the beginning (Devaney *et al*. 2012)

5.10

Reflections upon Epistemological Position

If I had my time again would I make use of agential realism as my onto-ethico-epistemological base? What did a greater emphasis on diffraction and a reduced emphasis on reflexivity bring to the thesis? Did I achieve what I set out to achieve? Certainly agential realism brought significant challenges, both within and outwith the thesis itself. I could not find a single clinical doctoral thesis that has made use of it, and when I called upon Barad for some steer, she was too entangled in her own universe to encounter mine. Others I sought academic support from were insufficiently acquainted with her work.

Perhaps this allowed for a certain elasticity of interpretation and freedom but agential realism proved an unwieldy co-constructor of knowledge. Barad is extremely difficult to make use of as she takes all known structures and upturns them. It felt, at times, as if I was busy putting up the scaffolding to build my thesis only to turn around and find Barad throwing the bricks away. As a thesis relies upon established structures to be recognised and succeed as a thesis, if these are overturned, the potential to overturn the thesis itself felt ever present. Perhaps, all knowledge building practices should exist in a state of trepidation, for Barad calls into question authority, human, colonial,

patriarchal, linguistic. As a doctoral thesis birthed in the belly of all of these, little wonder there was peril and quake in its construction.

Further, we don't have a developed language to accommodate post-binary thinking and being. It is inchoate. This is not to take up a tautological position however I found myself writing with post binary sensibilites whilst describing this with binary concepts. Arguably, the rules outlining academic writing style, expression and rigour were set by men and whilst Barad can write with lyrical and discursive abandon, a novice clinical doctoral researcher cannot. It was difficult to find a language and writing style to navigate the old and new worlds and as a result I produced an uneven topography. In spite of this, I recall the words of my father, a qualitative researcher and evaluator,

> Evaluators who choose the language of management empower management; evaluators who choose the language of academic social science empower themselves and their community; evaluators who choose a widely shared language at least have the possibility of empowering everyone. (Norris, 2015. p. 140)

I would like to think that the language I have chosen in this thesis is inclusive of the children and families I have written about, and for.

Inevitably, it is easy to get tangled up when working with the idea of entanglement, and this is compounded by tackling the issue of suicide which refuses to be neatly pigeonholed. The subject of suicide clearly piques great

academic, clinical and human interest. It has been written of in literature, captured in art, revered in popular culture, screened and scripted, argued about in law and statute, mapped in neurology, philosophy, physics, psychiatry, psychoanalysis, psychology, epigenetics, economics, compartmentalized and tallied by epidemiologists, demographers and statisticians, interrogated by academic researchers, addressed in religious texts, positioned in political acts and it has pulled history sideways. It all but seeded the discipline of sociology, and it is mulled over and enacted by impoverished farmers in rural outposts through to the anointed Gods of stage and state. Bringing this together with Barad's universal theory was overwhelming at times, particularly when alos trying to look at social disadvantage, the intra-action of the external and the internal, whilst also collapsing their binary distinction, even with the option of agential cuts.

Added to this, the thesis was looking at intra-objectivity and inter-subjectivity which engraved additional challenges to the challenges. Barad's disruption of chronological time created further black holes to fall into, particularly when the way a doctoral thesis is written creates the fiction of writing chronologically. For example, the methodology is written after the data collection, the title and abstract is written last. You look at what you have written then you and then you write what you have done as if you are going to do it. Also the VIVA and amendments are written back through. In this way the thesis remembers the future and jouneys forward into the past. This is, perhaps, where diffractive reflexivity comes into its own, as a qualitative doctoral thesis is never just reflexive, it is reflexively diffractive.

I was so clear at the outset that I did not want anything to impinge upon the voice and experience of the suicide-communicating child. I remained steadfast in not shifting the focus over to the participants. I did not want to use grounded theory because I thought it would become about the method of data analysis rather than the data. Then I brought agential realism and it certainly threatened to steal the focus at times. However, I liked how I could use diffraction to move away from, what I regard as, an overtaking of the research with the 'mesearcher'. Socially disadvantaged children need the space. They need Barad's redrafting of causality. They need her ethical stance. And the clinician researcher needs to think about their response ability to the phenomena in question, rather than seeing themselves as part of the solution. Barad helps to position ourselves as part of the problem and she is right to do so.

What is really clear from the research is that what exists now in its entangled intra-action is not good enough. I am not convinced that academic ideas are ever anything other than a defence against doing, even if those ideas concern democratisation. Ironically, I have spent four years entangled with Barad and my intra-action with the universe has reduced in this time. However, the children from these socially disadvantaged estates have been put in conversation with Marx, Freud, Hume, Winnicott, Heidegger and Barad. Instead of being victims the children become intra-acting agents with capacity to change their lives, for it is they who brought this study into being, after all. In this way the powerless children of the early psychoanalytic literature intra-

act with the psychoanalytic practitioner, and their future intra-action allows me to take their insights and possibly help children in the here and now. Perhaps the time for the material turn has arrived, less talk, more intra-action.

However, there is also something about agential realism which seems to be about a defence against loss, the birthing partner of psychoanalytic suicide theory. Bion says we need to prevent someone who knows from filling the empty space, and, certainly, Barad does that. Agential realism appears to be without depressive or schizoid position, with death just a matter of an agential cut before life begins again. Where do we go from here, when there is no loss, only relentless intra-actions and births? When a child kills themselves, surely, the universe should stop? Barad overlooks the child. They are nowhere to be found in her galaxy of ideas. Barad's posthuman position so eloquently elevates the seemingly 'simple' organism to a rightful parity, if not superiority, with humans in her natureculture collapse but she completely overlooks the extraordinary unspent capacity of the infant and young child. She is not alone for no philosopher pays them individual attention. Further, if feminist ideologies cut the chord between the child and women, who will advocate for our pre-democracy non-citizens? It would appear that Barad's campaigning is directed elsewhere.

Psychoanalysis is a model of how adults learn from the infant and child and perhaps the next phase of theoretical development after Marxism, feminist studies, post colonialism, STS and post-humanism will be the belated reconsideration of our youngest humans. As such, the question remains,

would I choose agential realism if I had my time again (and Barad says I will)? Probably. The idea of entanglement, co-constitution and the inseparability of an ethico-onto-epistemology seems irrefutable. Diffraction, alongside reflection and reflexivity seems to expand perception, and that can only be a good thing. The researcher needs to find themselves outside of the research endeavour, not just reflected within it. And Barad, Barad might just need to bear the absence and mourn her losses.

And the intra-action of Barad and psychoanalysis? Barad (2007) tells us psychoanalysis is dead in the water, or at least drowning (p.399). For its part, psychoanalysis has all but ignored Barad, a handful of neuropsychoanalytic papers aside. Psychoanalysis continues to assert its supremacy in giving account to intrapsychic processes, and inter-subjective exchange, whilst Barad creates a universal intra-activity whereby the wall between the conscious and the unconscious has fallen into a sea of oceanic oneness. However, Barad is not the first to relieve us of our old war sensibilities, objectivity and subjectivity are no longer considered the sworn enemies they once were (Ogden, 1994). That which is measured can no longer be separated from that which measures. Whilst Barad heralds a new post binary dawn we have seen this sun set before. Freud's sensibilities where life and death are two sides of the same coin, and ego is first and foremost a body ego, where Klein's good and bad breast are found to be one and the same, where Bion's thoughts wait for a thinker, find inside is out. Where processes of identification mean that self is other. Where ambivalence is seen as integral to the human condition. Psychoanalysis got there first. Both psychoanalysis

and Barad claim the withinworld and yet clinical psychoanalysis limits its focus to the dyad, latterly the triad (Ogden, ibid), within the consulting room. This thesis was an effort to go beyond the clinical and the psychosocial to find the 'analytic fourth' of Barad's universe. I am not at all sure that I succeeded in achieving this.

However, whilst I did not choose agential realism to analyse my data, I chose a psychoanalytically informed thematic analysis, I did choose it as the epistemological base upon which it sat. At the end of this thesis I feel that a reduction in use of reflexivity was helpful and that diffraction allowed me to take response ability for child suicide-communication, rather than being a 'compassionate bystander' but I am not convinced that diffraction added anything to the thematic analysis. Having written that, it is probably not possible to extrapolate out my encounter with Barad in terms of how the thematic analysis came together in the way it did, such is the nature of entanglement and intra-action.

5.11

Clinical Implications

The clinical implications from this research are manifold with the proviso that suicide-communication in the socially disadvantaged child is not the exclusive domain of the clinic. The first implication is that this research echoes and confirms existing psychoanalytic contribution on the subject, in both the child and adult literature. In this way it strengthens psychoanalytic perspective. In particular, it confirms the theories derived from single case study practice. The

role of the absent father, symbiotic functioning, maternal hate, love's loss, cumulative trauma, early life challenges, aggression, depression, generational inversion and CSA, are all confirmed in this study.

Further, the hope of the study was to recapture the spirit of suicidology, with its inclusive remit to integrate multidisciplinarity into understanding and preventing suicide. The clinical implications of this study, might be that psychoanalytic insights could be reintegrated into the more recent body of literature concerning suicide-communication in young children. The research also gives credence to the insights that primary school staff hold about what has hitherto been assigned to the specialism of the clinic. The findings were drawn from a professionally eclectic cohort of primary school staff, none of whom would refer to themselves as clinicians. The data derived from a non-clinical setting, drawing upon a, largely, non-clinical population. Yet the findings do have clinical implications, not least because in a Baradian study, the the clinical and non clinical are not seen as dinstinct, rather they are entangled

In this way perhaps the clinic needs to move into the primary school in an effort to progress early intervention and suicide prevention. Better still, perhaps we might integrate therapeutic thinking with educational provision as there is clearly a communicable relationship to be had. Primary school staff need help in holding the suicide-communicating child and training given. Although the same could be said for clinical staff. School staff need to be given the time, however, without the demands of curriculum pressure and

results, to spend time with the children they spend every day with and know so well, unlike non-school-based clinicians who might see a child for an hour a week at best.

What this research has tried to offer is a way of looking at how the broader environment can impact upon intra-psychic processes. Broadening understanding that the socially disadvantaged S-C child is more than a product of a damaging family, they are, most likely, a product of a family who has been damaged by iniquitous social forces. Psychology is much better at working with the idea of the external and the psychoanalytically minded can be inclined to state that the external world has minimal bearing when it comes to suicide. Alvarez (1990) writes, 'It goes without saying that external misery has relatively little to do with suicide' (p.88). Bell (2008), 'Suicide attempts never take place for the stated reason. At most, the cause given is the trigger and, relatively speaking, only a superficial explanation.' (p. 48-49). Hale (2008) writes that, 'It is the internal trigger that matters' (p.18).

Whilst I understand this position as an attempt to counter the avalanche belief that exam pressures, bullying and unrequited romantic love are the sole explanation of suicide, still being asserted to this day (de Sousa *et al* 2017), it is a regrettable and insensitive position to take, not least because it denies the impact social disadvantage has upon prevalence of suicide. However, it is precisely this schism, between the external and internal, that this study has sought to address. It is neither the external or internal trigger, it is their meeting point, their intra-action and the agential reality they produce, with

suicide being one of these. Exam pressures and unrequited romantic love bring the fear of failure and not being good enough and, arguably, this only threads its way through to a suicide-communication if there is primary experience of which it is an echo. And it is these primary experiences that have delineated our internal worlds. Barad is right, there is no external and internal, there is only their intra-action and the dance of time and space. This study began with Glenn *et al* (2015) confirming that our capacity to predict suicide is no better than a flick of a coin. Perhaps, what I have learnt at the close of this study is that instead of concentrating upon what side the coin lands the focus should be upon its spin in the air as it moves between heads to tails.

Finally, as part of the hope of this thesis was to reinstate psychoanalytic insights in an effort to make a contribution to risk assessment an, in turn, suicide prevention, I want to take this opportunity to cohere what the literature and these findings, could offer the practitioner working with the primary school-age child communicating suicide. They might wish to hold the following questions in mind.

1.Do/es the child's parent/s suffer from mental health problems?
2. Has the child experienced physical abuse, including from an older sibling?
3. Has the child experienced sexual abuse, made a disclosure of sexual abuse, or demonstrates concerning sexualised behaviours?
4. Has the child experienced trauma, directly or transgenerationally?
5. Has the child experienced significant loss/bereavment?
6. Has the child experienced sustained socio-economic disadvantage?
7. Has the child experienced the impact of immigration?

8. Does the child demonstrate self-harming behaviours?
9. Does the child appear to hold significant feelings of guilt?
10. Does the child have a belief in their continued existence after death?
11. Does the child, or any of their siblings, have a significant health difficulty or disability?
12. Does the child identify with those who display aggression?
13. Does the child appear to have a deficit of love in their life?
14. Has the child experienced any nurturing, restorative relationships?
15. Does the child struggle to belong amongst their peers?
16. Does the child struggle to stay in class?
17. Has the child experienced internal or external school exclusions?
18. Does the child spend excessive time in virtual reality?
19. Does the child's mother express significant and sustained hostility toward the child?
20. Has the child experienced domestic abuse?
21. Has the child experienced multiple home/school moves?
22. Has the child, or their family, experienced racism or cultural prejudice?
23. Is the child exposed to experiences that are not fitted to their chronological age?
24. Is there evidence of symbiotic functioning with mother/another?
25. Does the child appear depressed or might their life circumstances suggest depression?
26. Does the child have a family member/s who has/have completed suicide?
27. Do any of the child's family members communicate suicide?
28. Is the child preoccupied with death?
29. Does the child have an absent or receded father?
30. Has the child/family experienced a Social Care intervention?
31. Does the child struggle to communicate feeling states?
32. Did the child experience significant difficulties in the first 30 months of life?
33. Is the child living in Kinship Care or Looked After?
34. Does the child have a DSM diagnosis?
35. Does the child have a close family member who has been to prison?

36. Does the child struggle to express sadness (are they able to cry?)?
37. Might the child be struggling with issues of sexuality or gender?

Some of the above questions cover overlapping territory. Whilst most are worrying alone, when they begin to build then a growing concern would accompany. Significantly, most could be answered by those in pastoral care in consultation with teaching staff, others might require some clinical oversight. However, bearing in mind, most have come from precisely this combination of pastoral and teaching staff, then focusing upon these questions when trying to build a picture of the suicide-communicating child would be possible, particularly if the school had the support of an embedded counselling service.

5.12

Research Dissemination and Recommendations

We understand from the literature that the fallout of ACEs reach beyond a single generation and inform trajectories across generations (Larkin *et al.*, 2012; Leitch, 2017; Lomanowska *et al*., 2017). Thompson *et al* (2016) tell us, "Intervention strategies need to prevent ACEs from occurring and, if they do occur, should take into account the impact of cumulative ACEs on suicide risk." Having considered the literature, and the possible needs of the S-C children identified in this study, it seems indicated to create a research-informed inventory that documents adversity from its earliest moments. Wingenfeld *et al* (2011) confirm that the ACE is, "a reliable, valid and economic screen for the retrospective assessment of adverse childhood experience" but I am not aware of ACE being used prospectively for the

express purpose of suicide risk, for use with primary school children. Finkelhor *et al* (2013) have suggested an elaboration and edit of the original ACE to be administered to 10-17 year-olds. Further, in Wales, they have piloted an ACE Whole School Approach in 3 primary schools in Bridgend (Barton, Newbury & Roberts. 2018). This offers a template for what this research recommends.

The recommendation from this research is to take its findings and integrate them with the existing psychoanalytic insights, alongside other findings from multidisciplinary suicide research. A research-informed inventory will be built to pilot a longitudinal research study that begins in a primary school that serves a socially disadvantaged catchment. Here, the most vulnerable children can be identified from nursery onward and detailed histories taken of the adversities the children have encountered to date (including transgenerational adversities). The targeted gathering of this data can be steered by the existing research regarding what increases future suicide-risk. An adversity inventory, Vulnerability to Adverse Life Experience (VALE), (see Appendix D), will be built, and added to, throughout the child's primary school life. Service involvement and protective factors would also be recorded. When the child reached the end of Year 5, and if the child's VALE score hit a threshold, support for the duration of their time in compulsory education, (whether in mainstream schooling or not), when their suicide risk increases exponentially, could be identified and resources sought as part of a package of statutory repair and suicide prevention.

5.13

Concluding Remarks

What is clear from this ‘clinical’ thesis is that when it comes to the suicide-communicating child, the clinic is a mere bit player. Marx (1838), when translating the work of Peuchet, an early pioneer of suicide research, inserted his own thoughts, “I found that, short of a total reform of the organization of society, all other attempts (*to stem suicide*) would be in vain.” (quoted in Plaut & Anderson. 1999. p. 50. Italics my own), When Freud (1933) wrote, ‘Why war?” one of his conclusions was, “that community is held together by two things, the compelling force of violence and the identification between its members” (p.208). Whilst Freud was not talking about economic violence I would like to do so here, briefly, for poverty is violent. It is violent not just because poor children are exposed to greater levels of violence (Aber *et al,* 1997). It is violent because it is life and quality of life depriving. It is violent because it makes parents watch as it steals the opportunity of their offspring to climb out from under. But most importantly it is violent because it can so often steal love from those who are in its grip, and there is no greater theft.

The first published psychoanalytic comment on the cause of suicide was lack of parental love (Sadger in 1910 in Friedman, 1967). A child can endure all manner of social disadvantage if they have it, and repeated exposure to the sequelae of social disadvantage can kick it to the ground. And so we have to ask ourselves why we, and ‘we’ includes researchers and psychotherapists, seem surprisingly at ease with existing ‘suicide conducive conditions’ which find poor children looking for alternatives to living?

Freud was also talking about identification and I remain interested in processes of identification and de-identification as this thesis comes to a close. Here, I am interested in the psychoanalytic practitioner, and the socially detached intelligentsia, who participate in the 'me, not me' maintenance of the status quo which appears to dictate that for society to function there needs to be poverty and disadvantage, and there needs to be varying levels of privilege culminating in extreme wealth. I am interested in those who work with the socially disadvantaged whilst being grateful that it is not they who are poor and disadvantaged.

The following controversial questions remain with me. Can a Conservative voting psychotherapist ever be involved in an authentic, therapeutic transaction with a client/patient suffering from social disadvantage? By the same token, can the middle class psychoanalytic practitioner, irrespective of their political allegiances, ever truly make the socially disadvantaged client better? Can a White psychoanalytic psychotherapist ever heal the individual Black or Asian client? [28] Would the internalisation of the new object relationship of the White psychotherapist with the Black client be an act of colonisation or integration? Does achieving the depressive position dampen the revolutionary spirit and allow the maintenance of the status quo? Is psychoanalysis Botox for the furrowed brow of the poor?

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[28] Did ethnocultural differences have anything to do with the failure of Khan's long analysis with Winnicott?

However socialist-leaning and repair-seeking the psychoanalytic practitioner, we are involved in a complex ‘therapeutic’ transaction when working with the socially disadvantaged child for we are part of the problem by virtue of not being part of the broader solution. Ditto, the clinical researcher. In much the same way as charity is an accommodation of government lack, and then becomes an economy of its own, arguably, the psychoanalytic practitioner, and the academic researcher, working with the socially disadvantaged, profit from their despair. Whilst processes of identification can be seen as forming the structural underpinning of empathy and therapeutic and social change, the psychoanalytic practitioner and clinical researcher enters into the therapeutic and research ‘alliance’ from a point of culpability. Barad creates a space to acknowledge this and to pose one last question. There are no clinical sociologists so I will ask the question of psychoanalysis, psychiatry and psychology. Can we ever offer more than to move deckchairs on the Titanic when it comes to suicide? If the film is indicative, what was promoted as the greatest love story saw the poor boy drown as the rich girl clung onto the float…and the jewels. Perhaps Szasz (1998) is right, we don’t need psychoanalysis, (or, even, research), we need revolution. With suicide this revolution might begin with, in the first place, investing in frontline service provision *within* schools serving socially disadvantaged communities.

References

Abbass, A.A., Hancock, J.T., Henderson, J., Kisely, S. (2006) Short-term psychodynamic psychotherapies for common mental disorders. Cochrane Database Syst. Rev. 4:CD00468710.1002/14651858.CD004687.

Aber, J.L., Bennett, N.G., Conley, D.C., Li, J. (1997) The effects of poverty on child health and development. *Annual Review of Public Health*, 18, 463-483.

Ackerly, W.C. (1967) Latency-age children who threaten or attempt to kill themselves. *Journal of the American Academy of Child Psychiatry,* 6, 242–61.

Adler, G., & Buie, Jr, D.H. (1979) Aloneness and Borderline Psychopathology; The Possible Relevance of Childhood Development Issues. *International Journal of Psychoanalysis,* 60, 83-96.

Ainsworth, M.D. (1963) The development of infant-mother interaction among the Ganda. In B.M Foss (ed). Determinants of infant behaviour. New York: Wiley. p. 67-112.

Ainsworth, M.D.S., Bell, S.M., & Stayton, D.J. (1971) Individual differences in strange-situation behaviour of one-year-olds. In H.R. Schaffer (ed) *The origins of human social relations*. (p.17-58). London and New York: Academic Press..

Alarron, O. (1982) Outpatient treatment of a suicidal seven- year old child. In C. Pfeffer & J. Richman (eds) *Suicide and the Life Cycle: Proceedings of the 15th Annual Meeting of the American Association of Suicidology*.

Alderson, P & Morrow, V. (2004). *Ethics, social research and consulting with children and young people*. Barkingside: Barnardos.

Alderson, P. (2007). Competent children? Minors’ consent to health care treatment and research. *Social Science and Medicine*, 65, 2272-2283.

Alexander, F. (1929) The Need for Punishment and the Death-Instinct. I*nternational Journal of Psycho-Analysis*, 10, 256-269.

Allnock, D & Miller, P. (2013) *No-one noticed, No-one heard: a study of disclosures of childhood abuse*. London: NSPCC.

Allmark, P.J., Boote, J., Chambers, E., Clarke, A., McDonnell, A., Thompson, A., Tod, A. (2009). Ethical issues in the use of in-depth interviews: literature review and discussion. *Research Ethics Review*, 5 (2) 48-54.

All Party Parliamentary Group for Children (2016). *No Good Options.* On line: https://www.ncb.org.uk/resources-publications/no-good-options-report-inquiry-childrens-social-care-england (accessed 30.01.20)

Altman, N. (1995) *Theorizing the Social in Psychoanalysis: The Analyst in the Inner City: Race, Class, and Culture Through a Psychoanalytic Lens*. Hillsdale, NJ: The Analytic Press

Altman, N. (2020) *White Privilege: Psychoanalytic Perspectives*. London: Karnac. New York: Routledge

Alvarez, A. (1971) *The Savage God: a study of suicide*. London: Weidenfeld and Nicholson.

Alvesson, M. (2003). Beyond neo positivists, romantics and localists: A reflexive approach to interviews in organizational research. *Academy of Management Review,* 28 (1), 13-33.

Anderson, J. (2006). Well-suited partners: psychoanalytic research and grounded theory. *Journal of Child Psychotherapy*, *32*, 3, 329-348.

Anderson, J., Hurst, M., Marques, A., Millar, D., Moya, S., Pover, L., & Stewart, S. (2012) Understanding suicidal behaviour in young people referred to specialist CAMHS: a qualitative psychoanalytic clinical research project. *Journal of Child Psychotherapy*, 38 (2), 130-153.

Appignanesi, L., & Forrester. J. (1992). *Freud's Women*. London: Weidenfeld and Nicolson.

Appleby, L., Kapur, N., Shaw, J., Turnbull, P., Windfur, K., Ibrahim, S., Rodway, C., Tham, S. (2016) *Suicide by children and young people in England: National Confidential Inquiry into Suicide and Homicide by People with Mental Illness.* (NCISH) Manchester: University of Manchester, 2016.

Applegate, J.S. (2000) Theory As Story. Clinical Social Work Journal. 28(2), 141-153.

Apter, A (1989) Defence mechanisms in risk of suicide and risk of violence. *The American Journal of Psychiatry*, 146 (8), 1027-31.

Apter, A, Bleigh, A., Plutchik, R., Mendelsohn, S., Tyano, S. (1988) Suicidal behaviour, depression, and conduct disorder in hospitalized adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry*, 27, 969-699.

Apter, A., van Praag, H.M., Plutchik, R., Sevy, S., Korn, M., Brown, S.L. (1990) Interrelationships among anxiety, aggression, impulsivity and mood: A sertonergically linked cluster? *Psychiatry Research*, 32, 191-199.

Apter, A., Kotler, M., Sevy, S., Plutchik, R., Brown, S.L., Foster, H. (1991) Correlates of risk of suicide in violent and nonviolent psychiatric patients.

Journal of the American Academy of Child and Adolescent Psychiatry, 148, 883-887.

Apter, A., Gothelf, D., Orbach, I., Weizman, R., Ratzoni, G., har-Even, D (1995) Correlation of suicidal and violent behaviour in different diagnostic categories in hospitalized adolescent patients. *Journal of the American Academy of Child and Adolescent Psychiatry*, 34, 912-918.

Apter, A. (2004) Personality constellations in suicidal behaviour. Imago xi, 1, 5-27.

Asarnow, J.R. (1992) Suicidal ideation and attempts during middle childhood: Associations with perceived family stress and depression among child psychiatric inpatients. *Journal of Clinical Child Psychology*, 21, 35-40.

Asch, S. S. (1980). Suicide and the Hidden Executioner. *International Review of Psychoanalysis, 7, 51-60.*

Ashmore, M. (1989) *The reflexive thesis: writing sociology of scientific knowledge*. Chicago: University of Chicago Press.

Bakwin, H. (1957) Suicide in children and adolescents. *Journal of Pediatrics*, 50, 749–69.

Bahk, Y.C., Jang, S-K., Choi, K-H., Lee, S-H. (2017) The Relationship between Childhood Trauma and Suicidal Ideation: Role of Maltreatment and Potential Mediators. *Psychiatry Investigation,* 14 (1), 37-43.

Barad, K. (2003) Posthumanist Performativity: Toward an Understanding of How Matter Comes to Matter. *Signs,* 28 (3), 801-831.

Barad, K. (2007) *Meeting the Universe Halfway*. Durham and London: Duke University Press.

Barad, K. (2014) Diffracting Diffraction: Cutting Together-Apart. *Parallax*, 20(3) DOI: 10.1080/13534645.2014.927623.

Barnes, M. C., Gunnell, D., Davies, R., Hawton, K., Kapur, N., Potokar, J. and Donovan, J. L. (2016) Understanding vulnerability to self-harm in times of economic hardship and austerity: a qualitative study. *BMJ Open*, 6 (2), 101-131.

Barton, E.R., Newbury, A., Roberts, J. (2018) An Evaluation of the Adverse Childhood Experience (ACE)-Informed Whole School Approach. Wales: National Public Health Service for Wales.

Bauer, A. M., Shea, T. M. (1987) The Teacher's Role with Children at Risk for Suicide. *Educational Horizons,* 65 (3),125-127.

Beautrais, A.L. (2001) Beautrais, A.L. (2001) Child and young adolescent suicide in New Zealand. *Australian & New Zealand Journal of Psychiatry*, 35(5), 647-653.

Beck, A.T. (1986) Hopelessness as a predictor of eventual suicide. In J.J. Mann & M. Stanley (eds) *Psychology and suicidal behavior*, Vol. 487. Annals of the New York Academy of Sciences. New York, NY: The New York Academ of Sciences. (pp. 90-96)

Bedrosian, R. C., & Beck, A.T. (1979) Cognitive aspects of suicidal behaviour. *Suicide and Life Threatening Behavior*, 9(2), 87-96.

Bell, D. (2008) 'Who is Killing What or Whom? Some Notes on the Internal Phenomenology of Suicide', in Briggs, S. Lemma, A., Crouch, W. (eds.) *Relating to self-harm and suicide: psychoanalytic perspectives on theory, practice and prevention.* London: Routledge.

Bellis, M. A., Lowey, H., Lekenby, N., Hughes, K., Harrison, D. (2014). Adverse childhood experiences: retrospective study to determine their impact on adult health behaviours and health outcomes in a UK population. *Journal of Public Health,* 36 (1), 81-91.

Bellis, M.A., Ashtoni, K., Hughes, K., Ford, K., Bishop, J., Paranjothy, S. (2016) Welsh Adverse Childhood Experiences (ACE) and their impact on health-harming behaviours in the Welsh adult population. Public Health Wales.

Bender, L. (1953) *Aggression, Hostility and Anxiety in Children.* Springfield. Illinois: Charles C Thomas.

Bender, L., Fabian, A.A. (1947) Head injuries in Children, Predisposing Factors. *American Journal of Orthopsychiatry*, 17, 68-79.

Bender, L., Schilder, P. (1937) Suicidal pre-occupations and attempts in children*. American Journal of Orthopsychiatry*. 7, 225–34.

Bender, L., & Silver, A.A. (1951) Problems with Community Planning for Disturbed Children as Suggested by Hospital Experience. *The Journal of Educational Sociology*, 24(9), 528-533.

Berthod, C., Giraud, C,. Gansel, Y., Fourneret, P., Desombre, H. (2013) Suicide attempts of 48 children aged 6-12 years. *Archives Pediatrics*, 20 (12), 1296-305.

Bettelheim, B. *The Empty Fortress: Infantile Autism and the Birth of the Self.* New York: Free Press, 1967.

Biermann, T., Estel, D., Sperling, W., Bleich, S., Kornhuber, J., Reulbach, U. (2005) Influence of lunar phases on suicide: the end of the myth? A population-based study. *Chronobiology International*, 22 (6), 1137-43.

Bion, W.R. (1957) Differentiation of the psychotic from non-psychotic parts of the personalities. *The International Journal of Psychoanalysis*, 38, 266-275.

Bion, W.R. (1961) *Experiences in Groups and Other papers*. London: Tavistock Publications Limited.

Bion, W. R. (1967). *Notes on Memory and Desir*e. In R. Lang (Ed.), Classics in Psychoanalytic Technique. New York and London Jason Aronson, Inc.

Blos., P. (1985). *Son and Father – Before and Beyond the Oedipus Complex*. New York. The Free Press.

Bolter, J.D. (2016) Posthumanism in K.B. Jenson & R.T. Craig (eds) *The International Encyclopedia of Communication Theory and Philosophy. Oxford:* John Wiley & Sons, p.1556-1562.

Bolton, G. (2010) *Reflective practice: writing & professional development*. London: Sage.

Bonomie, C. (2018) *The Cut and the Building of Psychoanalysis II*. London: Routledge.

Boris, H.N. (1976) On hope: Its nature and psychotherapy. International Review of PsychoAnalysis, 3, 139-150.

Bostwick, M.J., Pabbati, C., Geske, J.R., McKean, A.J. (2016) Suicide Attempt as a Risk Factor for Completed Suicide: Even More Lethal Than We Knew*. The American Journal of Psychiatry.*
https://doi.org/10.1176/appi.ajp.2016.15070854

Bowlby, J. (1969) *Attachment. Attachment and loss: Vol.1. Loss*. New York: Basic Books.

Bowlby (1973) Attachment and Loss. Vol II. Separation Anxiety and Anger. New York: Basic Books.

Boyatzis, R.E. (1998) *Transforming Qualitative Information: Thematic Analysis and Code Development.* Thousand Oaks, CA: Sage.

Braun, V., & Clarke, V. (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3 (2), 77-101.

Braun, V., Clarke, V., Rance, N. (2014) How to use thematic analysis with interview data. In A. Vossler, & N. Moller (Eds), *The counselling & psychotherapy research handbook*. London: Sage. 183-197.

Brent, D.A. (1986) Overrepresentation of Epileptics in a Consecutive Series of Suicide Attempters Seen at a Children's Hospital, 1978-1983. *Journal of the American Academy of Child Psychiatry*, 25(2), 242-246.

Brent, D.A., Melhem, N. (2008) Familial transmission of suicidal behavior. *Psychiatric Clinics of North America*. 31, 157–177.

Brierre de Boismont. (1856) *Du suicide et de la folie suicide.* Paris: Bailliere.

Briggs, S., Maltsberger, J.T., Goldblatt, M., Lindner, R., Fiedler, G. (2006) Assessing and engaging suicidal teenagers in psychoanalytic psychotherapy. *Archives for Suicide Research*,10 (4), 1-15

Briggs, S., Lemma, A., Crouch, W. (2008) *Relating to Self-Harm and Suicide. Psychoanalytic Perspectives on Practice, Theory and Prevention.* London: Routledge

Briggs, S., Goldblatt, M. J., Lindner, R., Maltsberger, J. T., & Fiedler, G. (2012): Suicide and trauma: A case discussion, Psychoanalytic Psychotherapy, 26:1,13-33.

Briggs, S., Netuveli, G., Gould, N., Gkaravella, A., Gluckman, N.S., Kangogyere, P., Farr, R., Goldblatt, M.J., Lindner, R. (2019) The effectiveness of psychoanalytic/ psychodynamic psychotherapy for reducing suicide attempts and self-harm: systematic review and meta-analysis. *The British Journal of Psychiatry,* 214(6), 1-9 (2019)

Brill, A.A. (1939) The concept of psychic suicide. *International Journal of Psychoanalysis,* 20, 246-251.

British Humanist Association (2017) *Healthy, happy, safe? an investigation into how PSHE and SRE are inspected in English schools*. On line: https://humanism.org.uk/wp-content/uploads/2017-01-25-FINAL-Healthy-Happy-safe.pdf. Accessed. 29.01.20.

British Journal of School Nursing. (2018) More than 55 000 refused mental health treatment as CAMHS rejects one in four. *British Journal of School Nursing*, 13(9):422–423.

Britton, R., O'Shaughnessy, E., Feldman, M., & Steiner, J. [Editors] (1989). *The Oedipus Complex Today*. London. Routledge. 2018.

Brix, N., Ernst, A., Ramlau-Hansen. (2019) Timing of puberty in boys and girls: A population-based study. *Paediatric and Perinatal Epidemiology*, 33 (1), 70-78.

Brodsky, B.S., Mann, J.J., Stanley, B., Tin, A., Oquendo, M., Biraher, B., Greenhill, L., Kolko, D., Zelazny, J., Burke, A.K., Melhem, N.M., Brent, D.

(2008) Familial transmission of suicidal behaviour: factors mediating the relationship between childhood abuse and offspring suicide attempts. *Journal of Clinical Psychiatry*, 69(4), 584-96.

Browne, C. (1860) Psychical Disease of Early Life. *Journal of Mental Science*, 6(33), 284-320.

Brownwell, C.A., Nichols, S.R., Svetlova, M., Zerwas, S., Ramani, G. (2010) The Head Bone's Connected to the Neck Bone: When do Toddlers Represent Their Own Body Topography? *Child Development*, 81(3), 797-810.

Bruffaerts, R., Demyttenaere, K., Borges, G., Haro, J. M., Chiu, W. T., Hwang, I., Karam, E. G., Kessler, R. C., Sampson, N., Alonso, J., Andrade, L. H., Angermeyer, M., Benjet, C., Bromet, E., de Girolamo, G., de Graaf, R., Florescu, S., Gureje, O., Horiguchi, I., Hu, C., … Nock, M. K. (2010). Childhood adversities as risk factors for onset and persistence of suicidal behaviour. *The British Journal of Psychiatry : the journal of mental science*, 197(1), 20–27. https://doi.org/10.1192/bjp.bp.109.074716.

Bush, E.G., Pargament, K.I. (1994) A quantitative and qualitative analysis of suicidal preadolescent children and their families. *Child Psychiatry and Human Dev*elopment, 25(4), 241-52.

Butler, J. (2009) *Frames of War: When is Life Grievable?* New York: Verso

Campbell, D. (2008) The father transference during a presuicide state in Briggs, S. Lemma, A., Crouch, W. (eds.) *Relating to self-harm and suicide: psychoanalytic perspectives on theory, practice and prevention*. London, Routledge.

Carlson, G.A., Asarnow, J.R., Orbach, I. (1994) Developmental aspects of suicidal behavior in children and developmentally delayed adolescents. *New Directions in Child Development*, 64, 93-107.

Cartwright, D. (2004) The Psychoanalytic Research Interview: Preliminary Suggestions. *Journal of the American Psychoanalytic Association* , 52 (1), 209-24.

Cheng, Q., Kwok, Yip, P.S.F. (2015) Suicide Communication on Social Media and Its Psychological Mechanisms: An Examination of Chinese Microblog Users. *International Journal of Environmental Research and Public Health*, 12(9), 11506-11527.

Childline (2014) On the edge, ChlidLine spotlight: suicide.
https://letterfromsanta.nspcc.org.uk/globalassets/documents/research-reports/on-the-edge-childline-suicide-report.pdf

ChildrenEngland (May. 2017) www.childrenengland.org.uk › children-and-social-work-act-2017

Child Poverty Action Group (2019) www.cpag.org.uk

Cholbi, M. J. (2002) “Suicide Intervention and Non-Ideal Kantian Theory.” *Journal of Applied Philosophy* 19(3), 245-259.

Cipriano, A., Cella, S., & Cotrufo, P. (2017) (2017) Nonsuicidal Self-injury: A Systematic Review. *Frontiers in Psychology*, 8, 1946.

Clarke, V & Braun, V. (2018) Using thematic analysis in counselling and psychotherapy research: A critical reflection. *Counselling & Psychotherapy Research*, 18 (2), 107-110.

Cohen, Y. (1993). Suicidal Acts among Latency-Age Children as an Expression of Internal Object-Relations. *British Journal of Psychotherapy*, 9 (4), 405-413.

Collins, C., & McCartney, G. (2011) The Impact of the Neoliberal “Political Attack” on Health: The Case of the “Scottish Effect”. *International Journal of Health Services*, 41(3), 501-23.

Colquhoun. F. (2009) Child Maltreatment, Sexual Abuse and Suicide Attempts. London: NSPCC

Connelly, L.M., Peltzer, J.N. (2016) Underdeveloped themes in qualitative research: Relationships with interviews and analysis. *Clinical Nurse Specialist*, 30, 51-57.

Corbin, J., Morse, J.M. (2003) The Unstructured Interactive Interview: Issues of Reciprocity and Risks when Dealing with Sensitive Topics. *Qualitative Inquiry*, 9 (3), 335-354.

Cukrowicz K, Smith P, Poindexter E (2010) The effect of participating in suicide research: Does participating in a research protocol on suicide and psychiatric symptoms increase suicide ideation and attempts? *Suicide and Life-Threatening Behaviour,* 40, 535-543.

Damasio, A.R. (1999) Emotions as viewed by psychoanalysis and neuroscience. Neuropsychoanalysis 1(1), 38-39.

D’Attillio, J.P., Campbell, B.M., Lubold, P., Jacobsen, T., Richard, J.A. (1992) et al., 1992 Social support and suicide potential: Preliminary findings for adolescent populations. *Psychological Reports*, 70(1), 76-78.

Dazzi, T., Gribble, R., Wessely, S., Fear N.T. (2014) Does asking about suicide and related behaviours induce suicidal ideation? What is the evidence? *Psychological Medicine.* 44 (16), 3361-3.

De Kernier, N. (2012) Suicide attempt during adolescence: A way of killing the “infans” and a quest for individuation-separation. *Crisis: The Journal of Crisis Intervention and Suicide Prevention*, 33(5), 290-300.

De Kernier, N. (2013) Killing the dead: evolution of melancholic identifications underlying suicide attempts in adolescence. *Journal of Child Psychotherapy*, 39(2), 206-227.

De Maat, S., de Jonghe, F., Schoevers, R., Dekker, J. (2009) The effectiveness of long-term psychoanalytic therapy: a systematic review of empirical studies. *Harvard Review of Psychiatry*, 17, 11-23.

Denzin, N. and Lincoln, Y. (2000). The Discipline and Practice of Qualitative Research. In: Denzin, N.K. and Lincoln, Y.S., Eds., Handbook of Qualitative Research, Sage, Thousand Oaks, 1-32.

Department of Health and Social Care (1999) *Saving Lives: Our Healthier Nation.* https://www.gov.uk/government/publications/saving-lives-our-healthier-nation.

Department for Work and Pensions (2019) *Households Below Average Income. Statistics on the number and percentage of people living in low income households for financial years 1994/95 to 2017/18. Tables 4a and 4b.* London. UK Gov.

De Sousa, G.S., dos Santos, M.S.P., da Silva, A.T.P., Perrelli, J.G.A., Sougey, E.B. (2017). Suicide in childhood: a literature review, Ciência & Sadúe Coletia, 22(9), 1678-4561.

Despert, J. L. (1952) Suicide and depression in children. *The Nervous Child*, 9, 378-389.

Devaney, J., Bunting, L., Davidson, G., Hayes, D., Lazenbatt, A., Spratt. (2012) *Still Vulnerable: The Impact of Early Childhood Experiences on Adolescent Suicide and Accidental Death.* NSPCC. Northern Ireland & Queen’s University. Belfast. Commissioned by the Northern Ireland Commissioner for Children and Young People (NICCY).

Devereux, G. (1967) *From Anxiety to Method in the Behavioural Sciences.* The Hague, Paris: Mouton.

Døme, P., Kapitány, B., Ignits, G., Rihmer, Z. (2010) Season of birth is significantly associated with the risk of completed suicide, *Biological Psychiatry,* https://doi.org/10.1016/j.biopsych.2010.03.005.

Donaldson, G. (2015) *Successful Futures: Independent review of Curriculum and Assessment Arrangements in Wales.* Gov. UK.

Dong, M., Dube, S.R., Giles, W.H., Felitti, V., & Anda, R. F. (2004). Adverse childhood experiences and self-reported liver disease: New insights into the causal pathway. *Archives of Internal Medicine*, 164(4), 460–461.

Dorpat, T. & Ripley, H.S. (1960) A Study in Suicide in the Seattle Area. *Comprehensive Psychiatry,* 1, 349-359.

Douglas, J.D. (1967) *The Social Meanings of Suicide.* New Jersey: Princeton University Press.

Dowling, M. (2006) Approaches to Reflexivity in Qualitative Research. *Nurse Researcher*, 13 (3), 7-21.

Dublin, L.I., Bunzel, B. (1933) *To Be or Not to Be: A Story of Suicide.* New York: Random House. 1933.

Duncan, S. (2016) *Shakespeare's Women and the Fin de Sciéle*. Oxford: Oxford University Press.

Dupont, J. (ed) (1995) *The clinical diary of Sandor Ferenczi*. New Yok: Harvard University Press

Durand-Fardell, M. (1855). Étude sur le suicide chez les enfants [Study on suicide in children]. *Annales Médíco-psychologiques*, 61: 60–79.

Durkheim, E. (1897) *Le Suicide*. Chicago: Chicago University Press.

Dyregrov, K. (2004) Bereaved parents' experience of research participation. *Social Science & Medicine,* 58, 391–400.

Easterlin, D.C. (1976) The conflict between aspirations and resources. *Population and Development Review*, 2, 417-425.

Elkind, D. (1891) *The Hurried Child*, Reading, Mass: Addison-Wesley Pub. Co.

Elliot, R., Fischer, C.T., Rennie, D.L. (1999) Evolving guidelines for publication of qualitative research. *British Journal of Qualitative Research, 38, 215-229.*

Emminghause, H. (1887) *"The Psychic Disorders of Childhood"*
Verlag der Laupp'schen Buchhandlung, Tubingen.

Endo, K., Ando, S., Shimodera, S., Yamasaki, S., Usami, S., Okazaki, Y., Sasaki, T., Richards, M., Hatch, S., Nishida, A. (2017) Preference for Solitude, Social Isolation, Suicidal Ideation, and Self-Harm in Adolescents. *Journal of Adolescent Health*, 61(2), 187-191.

Farberow, N & Sneidman, E.S. (1961) *The Cry for Help.* New York. MacGraw-Hill

Fedden, H.R. (1938) *Suicide*. London: Peter Davies Limited.

Feinstein, L., & Sabates, R. (2006) *Predicting adult life outcomes from earlier signals: identifying those at risk.* Report for the Prime Minister's Strategy Unit. London: Institute of Education: University of London.

Felitti, V.J., Anda, F.F., Nordenberg, D., Williamson, D.F., Spitz, A.M., Edwards, V., Koss, M.P., Marks, J.S. (1998) Relationships of childhood abuse and household dysfuction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine*, 14 (4), 245-258.

Ferenczi, S. (1929) The Unwelcome Child and his Death-Instinct. *International Journal of Psycho-Analysis*, 10, 125-129.

Finkelhor, D. (1994) Current information on the scope and nature of child sexual abuse. The Future of Children. *Sexual Abuse of Children*, 4(2), 31-53.

Finkelhor, D., Shattuck, A., Turner, H., Hamby, S. (2013) Improving the adverse childhood experiences study scale. *JAMA Pediatric*, 167(1), 70-5.

Fonagy, P. (2003) Psychoanalysis today. World Psychiatry, 2(2), 73.

Fonagy, P., Rost, F., Carlyle, J., McPherson, S., Thomas, R., R.M Pasco-Fearon., Goldberg, D., Taylor, D. (2015) Pragmatic randomized controlled trial of long-term psychoanalytic psychotherapy for treatment-resistant depression: the Tavistock Adult Depression Study (TADS).

Fowler, C. (1943) Suicide as a symptom of Neurotic Conflict in Children. *Smith College Studies in Social Work,* 19(2), XIX (1949), 136-37.

Fox, N.J. & Alldred, P. (2018) New Materialism. In: Atkinson, P.A., Delamont, S., Hardy, M.A. & Williams, M. (eds) *The SAGE Encyclopedia of Research Methods.* London: Sage.

Franklin, J.C., Ribeiro J.D., Fox ,K.R, et al. (2016) Risk factors for suicidal thoughts and behaviors: A meta-analysis of 50 years of research. *Psychological Bulletin,* 143(2), 187-232.

Freuchen, A., Kjelsberg. E., Lundervold, A. J., Groholt B. (2012) Differences between children and adolescents who commit suicide and their peers: A psychological autopsy of suicide victims compared to accident victims and a community sample. *Child and Adolescent Psychiatry and Mental Health,* 6(1) 37-42.

Freud, A. (1963) The concept of developmental lines. *Psychoanalytic Study of the Child,* 18, 245-265.

Freud, S. & Breuer, J. (1895). Studies on Hysteria. Standard Edition, 2. London: Hogarth Press, 1955.

Freud, S. (1896). The Aetiology of Hysteria. *SE.* III.

Freud, S. (1898) The psychical mechanism of forgetfulness. *SE*. III

Freud, S (1901) The psychopathology of everyday life. *SE*. VI

Freud, S. (1909) Analysis of a phobia in a five year old boy. *SE*. X.

Freud, S. (1910) Symposium on Suicide. With Particular Reference to Suicide among Young Students. Discussions of the Vienna Psychoanalytic Society. In Friedman. *On Suicide* (1967) New York. International Universities Press Inc.

Freud, S (1913) Totem and taboo. *SE*. XIII.

Freud, S. (1915b) 'Thoughts for the times on war and death'. *SE*. XIV.

Freud, S. (1917) Mourning and melancholia. *SE.*XIV

Freud, S. (1920). The psychogenesis of a case of homosexuality in a woman. *SE.* XVIII*.*

Freud, S. (1920a) Beyond the pleasure principle. *SE.* XVIII*.*

Freud, S. (1923) The Ego and the Id. *SE.* XVIV.

Freud, S. (1924) The economic problem of masochism. *SE.* XIX.

Freud, S. (1925) An Autobiographical Study. Eastford. Ct: Martino Publishing. 2010.

Freud, S. (1930) Civilisation and its discontents. *SE.* XXI.

Friedlander, K. (1940) On the 'Longing to Die'. *International Journal of Psychoanalysis,* 21, 416-426.

Friedman, P. (1967) *On suicide.* New York. International Universities Press Inc.

Friedman, R.C., Corn, R. (1985) Follow-up five years after attempted suicide at age 7. *American Journal of Psychotherapy,* 39(1), 108-113.

Frith & Gleeson (2004) Clothing and embodiment: men managing body image and appearance. *Psychology of Men & Masculinity*, 5(1), 40-48.

Furman, E. (1984) Some difficulties in assessing depression and suicide in childhood. In H. Sudak., A.B. Ford., & N.B. Rushforth (eds), *Suicide in the Young*. Boston: John Wright/PSG Inc, p. 245-258.

Gabbard, G.O. (2005) Psychodynamics of Suicide in G.O Gabbard *Psychodynamic Psychiatry in Clinical Practice*. Washington, DC: American Psychiatric Association Publishing Inc. p. 221-227.

Galton, M., & McBeath, J. (2015) *Inclusion*: *statements of intent.* Cambridge: Cambridge University Press.

Garland, C. (2002) Understanding trauma: A psychoanalytic approach. London: Karnac Books/Tavistock Clinic series.

Garland, C. (2004) Traumatic events and their impact on symbolic functioning. In S. Levy & A. Lemma (eds). The peversion of loss: Psychoanalytic perspectives on trauma London: Whurr.

Garth, J.M., & Lester, D. (1978) The moon and suicide. *Psychological Reports*, 43(2), 678. https:// https://doi.org/10.2466/pr0.1978.43.2.678.

Gavin, A.R., Nurius, P., Long-Greene, P. (2012) Mediators o Adverse Birth Outcomes Among Socially Disadvantaged Women. *Journal of Women's Health*, 21(6), 634-642.

Gay, P. (1988) *Freud - a Life for Our Time.* New York. Anchor Books. 1989.

Gay, P. (1995) *The Freud Reader*. London: Vintage.

Gerisch, B. (2008) Suicidality in women: obsession and the use of the body. In Briggs, S. Lemma, A., Crouch, W. (eds.) Relating to self-harm and suicide: psychoanalytic perspectives on theory, practice and prevention. London: Routledge

Gherovici, P., & Christian, C. (2018) *Psychoanalysis in the Barrios: Race, Class, and the Unconscious*. New York: Routledge.

Gjertsen, F. (2000) Head on into the mountainside–accident or suicide? About the reliability of suicide statistics. *Suicidologi.* 25, 18-21.

Glasser, B.G., & Strauss, A. (1965) *Awareness of dying*. Chicago: Aldine Publishing.

Glasser, M. (1979) 'Some aspects of the role of aggression in perversions', in I. Rosen (ed). *The Pathology and Treatment of Sexual Deviations*. Oxford: Oxford University Press.

Glenn, C., Franklin, J.C., Nock, M.K. (2015) Evidence-Based psychosocial Treatments for Self-injurous Thoughts and Behaviours in Youth. *Journal of Child & Adolescent Psychology*, 44(1),1-29.

Goldblatt, M.J & Maltsberger, J.T. (2009) Countertransference in the treatment of suicidal patients. In D. Wasserman and C Wasserman. *Oxford Textbook of Suicidology and Suicide Prevention*. Oxford: Oxford University Press.

Goldblatt, M.J., Briggs, S., Lindner, R. (2015) Destructive Groups: The Role of Projective Identification in Suicidal Groups of Young People. *British Journal of Psychotherapy*, 31(1), 38-53.

Goldblatt, M.J., Briggs, S., Lindner, R., Schecter, M., Ronningstam, E. (2015) Psychodynamic psychotherapy with suicidal adolescents. *Psychoanalytic Psychotherapy,* 29(1), 20-37.

Goldblatt, M. (2017) The psychodynamics of hope in suicidal despair. *Scandinavian Psychoanalytic Review*, 40(1), 54-62.

Goldney, R.D. (2010) A note on the reliability and validity of suicide statistics. *Psychiatry, Psychology and Law.* 17 (1), 52-56.

Gorin, S. (2008) Ethical challenges in conducting research with hard to reach families, *Child Abuse Review,* 17 (4), 275-287.

Gould, M.S., Marrocco, F.A.,Kleinman, M., Thomas, J.G., Mostkoff, A., Cote, J., Davies, M. (2005) Evaluating iatrogenic risk of youth suicide screening programs: a randomized controlled trial. *JAMA,* 293, 13, 1635-43.

Gov.UK. (2017) Self harm and suicidal thoughts and attempts. Ethnicity facts and figures. October. 2017 ethnicity-facts-figures.www.service.gov.uk ›

Grandclerc, S., De Labrouhe, D., Spodenkiewicz, M., Lachal, J., & Moro, M. R. (2016). Relations between Nonsuicidal Self-Injury and Suicidal Behavior in Adolescence: A Systematic Review. PloS one, 11(4), e0153760.

Green, A. (1978a) Psychopathology of abused children. *Journal of the American Academy of Child & Adolescent Psychiatry,* 17(1), 92-103.

Green, A. (1978b) Self-destructive behaviour in battered children. *The American Journal of Psychiatry*, 135(5), 579-582.

Greene, M. J. (2014). On the inside looking in: methodological insights and challenges in conducting qualitative insider research. *The Qualitative Report*, 19 (29), 1-13.

Gutierrcz-Garcia, J .M., Tusell, F. (l997). Suicides and the lunar cycle. *Psychology Repository,* 80, 243-250.

Haim, A. (1975) *Adolescent Suicide*. London: Tavistock Publications Ltd

Halbwachs, M. (1930) *The Causes of suicide*. London Routeledge & Keegan Paul

Hale, R. 2008 Psychoanalysis and Suicide; Process and Typology in Briggs, S. Lemma, A., Crouch, W. (eds.) Relating to self-harm and suicide: psychoanalytic perspectives on theory, practice and prevention. London: Routledge.

Hamilton, J. (2002) Freud and the suicide of Pauline Silberstein. *Psychoanalytic Review,* 89, 889-909.

Hammersley, M., (2005) Ethnography: potential, practice, and problems. *Qualitative Research Methodology Seminar Series*, sponsored by the ESRC National Centre for Research Methods, University of Southampton.

Haraway, D. (1997) *Modest_Witness@Second_Millenium_FemaleMan Meets_OncoMouse: Feminism and Technoscience*. New York: Routledge

Harker, L., Jütte, S., Murphy, T., Bentley, H., Miller, P., Fitch, K. (2013) *How safe are our children*? London: NSPCC

Harman, J & de Coverly Veale, C. (2017) *Healthy, happy, safe? An investigation into how PSHE and SRE are inspected in English schools.* London. British Humanist Association.

Hawton., K & Fagg, J. (1988) Suicide and other causes of death following attempted suicide. *British Journal of Psychiatry*, 152, 259-266.

Hawton, K., Fagg, J., and Marsack, P. (1980) Association between epilepsy and attempted suicide**.** *Journal of Neurolology, Neurosurgery and Psychiatry.* 43, 63–170.

Hawton, K., & Van Heeringen, K. (2000) *Suicide and Attempted Suicide*. Chichester: Wiley,

Hawton, K., & Harriss, L. (2008). Deliberate self-harm by under-15-year-olds: characteristics, trends and outcome. *Journal of Child Psychological Psychiatry.* 49 (4), 441-448.

Hawton, K., Witt, K. G., Salisbury, T. L. T., Arensman, E., Gunnell, D., Towsend, E., van Heeringen, K., Hazell, P. (2015). Interventions for self-harm in children and adolescents*, Cochrane Database of Systematic Reviews,* 12

Hazell, L., King, R. (1996) Arguments for and against teaching suicide prevention in schools. *Australian and New Zealand Journal of Psychiatry. 30, 633-642.*

Heidegger, M. (1927) *Being and Time*. New York: Harper & Row. 1962

Hendin, H. (1964) *Suicide in Scandinavia*. New York: Grune & Stratton.

Hendin, H. (1969) *Black Suicide*. New York: Basic Books.

Hendin, H. (1975) *The Age of Sensation*: New York: W.W. Norton.

Hendin, H. (1978) Suicide: The Psychosocial Dimension. *Suicide and Life-Threatening Behaviour*, 17(2)

Hendin, H. (1982) *Suicide in America.* New York: W.W. Norton.

Hendin, H. (1987) Youth Suicide: A Psychosocial Perspective. Suicide and Life-Threatening Behaviour, 17(2)

Hendin, H., Maltsberger, J.T., Pollinger Haas, A., Szanto, K., Rabinowicz. (2004) Desperation and Other Affective States in Suicidal Patients. *Suicide and Life-Threatening Behaviour*, (34), 386-394.

Hendrick, I. (1940) Suicide as Wish Fulfillment. *Psychiatric Quarterly*, 14, 30-42.

Hesdorffer, D.C., Ishihara, L., Mynepalli, L., Webb, D.J. (2012) Epilepsy, suicidality, and psychiatric disorders: A bidirectional association. *Annals of Neurology,* 72 (2), 184-191.

Hinshelwood, R. (1987) What Happens in Groups: Psychoanalysis, the Individual and the Community. London: Free Association Books.

Hinshelwood, R. (2013) *Research on the couch*. London: Routledge

Hinshelwood, R. (2018) Psychoanalytic Research: Personal Reflections. *British Journal of Psychotherapy*, 34 (4), 539-548.

Hollway, W. & Jefferson, T. (2000) *Doing qualitative research differently: free. association, narrative and the interview method*. London. Sage.

Hollway, W. & Jefferson, T. (2001) ‘Free Association, narrative analysis and the defended subject: the case of Ivy’. *Narrative Inquiry*, 11 (1) 103-22.

Holman-Jones, S. (2005). Auto Ethnography: Making the Personal Political. In: Denzin, N.K. and Lincoln, Y.S., Eds., Handbook of Qualitative Research, Sage, Thousand Oaks, 763-791.

Hom, M. A., Stanley, I. H., Rogers, M. L., Gallyer, A. J., Dougherty, S. P., Davis, L., & Joiner, T. E. (2018). Investigating the iatrogenic effects of repeated suicidal ideation screening on suicidal and depression symptoms: A staggered sequential study. *Journal of affective disorders*, 232, 139–142. https://doi.org/10.1016/j.jad.2018.02.022

Hunt, S.A. (2009) Fathers involvement in family life. In S.A Hunt (ed) *Family Trends: British families since the 1950s*. London: Family and Parenting Institute.

Hutchings, M. (2016) Exam factories? *The Impact of Accountability Measures on Children and Young People*. London. NUT (National Union of Teachers)

Ialongo, N.S., Edelsohn, G., Kellam, A., Sheppard, G. (2001) A Further Look at the Prognostic Power of Young Children's Reports of Depressed Mood and Feelings. *Child Development*, 72 (3) 736-47.

Ialongo, Nicholas S., Koenig-McNaught, Amy L. Wagner, B.M., Pearson, J., McCreary, B.K., Poduska, J., Kellam, A., Sheppard, G. (2004) African American Children's Reports of Depressed Mood, Hopelessness, and Suicidal Ideation and Later Suicide Attempts. *Suicide and Life-Threatening Behavior*, 34 (4), 395-407.

Institute of Fiscal Studies (2019) *Living standards, poverty and inequality in the UK: 2017-18 to 2021-22.* The Institute of Fiscal studies. London.

Jacobnizer, H. (1960) Attempted suicide in children. *Journal of Pediatrics*, 56: 519-523.

Jacobsen, L.K., Rabinowitz, I., Popper, M.S. (1994). Interviewing pre-pubertal children about suicidal ideation and behavior. *Journal of the American Academy of Child and Adolescent Psychiatry,* 33, 439-452.

Jensen, V.W., Petty, T.A. (1958) The fantasy of being rescued in suicide. *Psychoanalytic Quarterly*. 27(3), 327-39.

Johnsen, T. J., & Friborg, O. (2015). The effects of cognitive behavioral therapy as an anti-depressive treatment is falling: A meta-analysis. Psychological bulletin, 141(4), 747–768. https://doi.org/10.1037/bul0000015

Joiner, T.E. (2005). *Why people die by suicide.* Cambridge, MA: Harvard University Press.

Jones, E. (1911) On dying together. In: *Essays on applied psychoanalysis*. London. Hogarth. 1951.

Jones, P., Gunnell, D., Platt, S., Scourfield, J., Lloyd, K. (2013). Identifying Probable Suicide Clusters in Wales Using National Mortality Data. *PLoS ONE*, *8*, 8, e71713. doi:10.1371/journal.pone.0071713

Kairys, S.W., Johnson, C.F., the Committee on Child Abuse and Neglect. (2002) The Psychological Maltreatment of Children-Technical Report. *American Academy of Pediatrics*. Pediatrics, 109 (4), 1-3.

Kanner, L. (1957*) Child Psychiatry*. Springfield Ill: Charles C Thomas.

Katz, C., Bolton, S.-L., Katz, L.Y., Isaak, C., Tilston-Jones, T. and Sareen, J. (2013), A Systematic review of school based suicide prevention programs. *Depression and Anxiety*, 30: 1030-1045.

Kautz & Piotrowski (2019) Reconsidering Graduate Training and Clinical Practice: The Importance of Psychodynamic Thinking. Psychoanalytic Social Work, 26(2), 106-141.

Kelly-Irving, M., Lepage, B., Dedieu, D., Bartley, M., Blane, D., Grosclaude, P. (2013) Adverse childhood experiences and premature all-cause mortality. *European Journal Epidemiology* 28, 721-734.

Kelly-Irving, K., Delpierre, C. (2019) A Critique of the Adverse Childhood Experiences Framework in Epidemiology and Public Health: Uses and Misuses. *Social Policy and Society*, 18(3), 445-456.

Khan, M. (1963) The concept of cumulative trauma. *The psychoanalytic study of the child*, 18, 286-306.

Klein, M. (1933) *The Psychoanalysis of Children*. London: Virago Press. 1989.

Klein, M. (1935) A contribution to the psychogenesis of manic-depressive states' in M. Klein. *Love, Guilt and Reparation and Other Works*, 1921-1945 London: Virago Press. p. 262-289.

Kleinmann, A. (2017) "Intra-actions" (Interview of Karen Barad by Adam Kleinmann) https://www.academia.edu/1857617/_Intra-actions_Interview_of_Karen_Barad_by_Adam_Kleinmann_

Klonsky, E. D., Victor, S. E., & Saffer, B. Y. (2014). Nonsuicidal self-injury: what we know, and what we need to know. *Canadian journal of psychiatry*. 59(11), 565–568. https://doi.org/10.1177/070674371405901101

Kobler, A.L., & Stotland, E. (1964) *The End of Hope.* London: Macmillan.

Kofman, Y. B., & Garfin, D. R. (2020). Home is not always a haven: The domestic violence crisis amid the COVID-19 pandemic. *Psychological Trauma: Theory, Research, Practice, and Policy,* 12(S1), S199-S201. http://dx.doi.org/10.1037/tra0000866

Kosky, R. (1983) Childhood suicidal behavior. *Journal of Child Psychology & Psychiatry.* 24, 457–68.

Kolves, K., & De Leo, D. (2015) Child, Adolescent and Young Adult Suicides: A Comparison Based on the Queensland Suicide Registry. *Journal of Child and Adolescent Behaviour*, 3: 209-215..

Krall, V. (1953) "Personality Characteristics of accident Repeating Children." *Journal of Abnormal and Social Psychology*, 218, 99-107.

Kuntz, A.M., & Presnall, M.M. (2012) Wandering the Tactical: From Interview to Intraview. *Qualitative Inquiry,* 18 (9)*,* 732-744.

Kvale, S. (2007) *Doing Interviews*. London: Sage.

Laplanche, J. (1976) *Life and Death in Psychoanalysis.* New York: The John Hopkins University Press.

Larkin, H., Shields, J., Anda, R.F.(2012) The Health and Social Consequences of Adverse Childhood Experiences (ACE) Across the Lifespan: An Introduction to Prevention and Intervention in the Community. *Journal of Prevention & Intervention Community*, 40(4), 263-70.

Latour. B. (2005) *Reassembling the Social*. Oxford: Oxford University Press

Laufer, M. (1968) The Body Image, the Function of Masturbation, and Adolescence. *Psychoanalytic Study of the Child*, 23, 114-137.

Laufer, M. (1995) *The Suicidal Adolescent*. London: Routledge.

Lee, R.M. (1993) *Doing research on sensitive topics*. London: Sage.

Leenaars, A.A., & Wenckstern, S. (1991) *Suicide Prevention in Schools*. New York:Hemisphere.

Leenaars, A.A., & Wenckstern, S. (1999) Suicide prevention in schools: The art, the issues and the pitfalls. *Crisis: Journal of Crisis Intervention & Suicide*, 20, 132-142.

Leitch, L. (2017) Action steps using ACEs and trauma-informed care: a resilience model. Health Justice, 5(1), 5. doi: 10.1186/s40352-017-0050-5.

Lester, D., Gunn III, J.F. (2012) Perceived Burdensomeness and Thwarted Belonging: An Investigation of The Interpersonal Theory of Suicide, *Clinical Neuropsychiatry*, 9 (6) 221-224.

Leuzinger-Bohbleber, M., Hautzinger, M., Fieldler, G., Keller, W., Bahrke, U., Kallenbach, L., Kaufhold, J., Ernst, M., Neglee, A., Schoett, M., Küchenhoff, H., Günther, F., Rüger, B, Beutel, M. (2018) Outcome of Psychoanalytic and Cognitive Behavioural Long-Term Therapy with Chronically Depressed Patients: A controlled Trial with Preferential and Randomized Allocation. The *Canadian Journal of Psychiatry*, 64(1), 47-58.

Levy, S., & Lemma, A. (Eds.). (2004). The perversion of loss: Psychoanalytic perspectives on trauma. Whurr Publishers.

Lewin, R. A., & Schulz, C. G. (1992). *Losing and fusing: Borderline transitional object and self relation*s. New York: Jason Aronson.

Liamputtong, P. (2006) *Researching the vulnerable: a guide to sensitive research methods*. London: Sage.

Liebermann, L.P. (1953) Three Cases of Attempted Suicide in Children. *Journal of the American Academy of Child Psychiatry,* 8 (2), 272–285.

Litman, R.E. (1970) Sigmund Freud on Suicide. In, Sneidman, Farberow & Litman *The Psychology of Suicide*. New York: Science House.

Locke,J. (1689) *Two Treatises of Government.* On line: https://oll.libertyfund.org/titles/locke-the-enhanced-edition-of-the-two-treatises-of-government-1689.

Lomanowska, A.M., Boivin, M., Hertzman, C., Fleming, A (2017) Parenting Begets Parenting: A Neurobiological Perspective on early Adversity and the Transmission of Parenting Styles across Generations. *Neuroscience*, 342. DOI: 10.1016/j.neuroscience.2015.09.029

Liu, X., Agerbo, E., Ingstrup, K.G., Musliner, K., Meltzer-Brody, S., Bergink, V., Munk-Olsen. (2017) Antidepressant use during pregnancy and psychiatric disorders in offspring: Danish nationwide register based cohort study. *BMJ* 358:j3668

Lynch, M. (2000) Against Reflexivity as an Academic Virtue and Source of Privileged Knowledge. *Theory, Culture and Society*, 17 (3), 26-54.

MacDonald, A. (1907) “Statistics of child suicide,” *American Statistical Association*, 260-264.

Main, M., & Soloman, J. (1986) Discovery of a new insecure-disorganized/disoriented attachment pattern. In M. Yogman & T.B. Brazelton (eds), Affective development in infancy. NJ: Ablex. 95-124

Mahler, M. (1963) Thoughts about development and individuation. *Psychoanalytic Study of the Child*, 18, 307-324.

Mahler, M., & Furer, M. (1968) *On Human Symbiosis and the Vicissitudes of Individuation: Infantile Psychosis.* New York: International Universities Press, Inc.

Mahler, M. S. (1972). On the first three subphases of the separation-individuation process. *The International Journal of Psychoanalysis*, 53(3), 333–338.

Major, L.E & Machin, S. (2018) *Social Mobility And Its Enemies*. Harmondsworth: Penguin.

Maltsberger, J.T. (1988) “Suicide Danger: Clinical Estimation and Decision.” *Suicide and Life Threatening Behaviour*, 18, 47-54.

Maltsberger, J.T. (1993) Confusions of the Body, the Self, and Others in Suicidal States. In A. Leenaars (ed) *Suicidology: Essays in Honour of Edwin S. Shneidman*. Northvale, N.J: Jason Aronson.

Maltsberger, J.T. (2003a) Scott Ames: A Man Giving Up on Himself. *Suicide and Life-Threatening Behaviour,* 33(3), 331-337.

Maltsberger, J.T, Hendin, H., Haas, A. Pollinger, & Lipschitz, A. (2003b). Determination of Precipitating events in the suicide of psychiatric patients. *Suicide and Life Threatening Behavior, 33(2),* 111–119.

Maltsberger, J.T. (2004) The descent into suicide. *International Journal of Psychoanalysis*, 85, 653-667.

Maltsberger, J.T., Pompili, M., Taterello, R. (2006) Sandro Morselli: Schizophrenic Solitude, Suicide, and Psychotherapy. *Suicide and Life-Threatening Behaviour*, 36(5), 591-600.

Maltsberger, J.T., Goldblatt, M.J., Ronningstam, E., Weinberg, I., Schecter, M. (2011) Traumatic Subjective Experience Invite Suicide. *Journal of the American Academy and Dynamic Psychiatry*, 39(4), 671-693.

Marcinko, D., Skocić, M., Sarić, M., Popović-Knapić, V., Tentor, B., Rudan, V. (2008) Countertransference in the therapy of suicidal patients-an important part of integrative treatment. *Psychiatr Danub*, 20(3), 402-5.

Marsh, I. (2011) *Suicide: Foucault, History and Truth.* Cambridge: Cambridge University Press.

Maslow, A. (1943) “A Theory of Human Motivation.” *Psychological Review 50(4), 370-96.*

Masson, J.M. (1984) *The assault on truth: Freud’s suppression of the seduction theory.* New York. Farrar, Straus and Giroux.

Maudsley, H. (1886) *Heredity in Health and Disease*. *Fortnightly Review* 45 (old series), 648–659.

Maudsley, H. (1892) Suicide in simple melancholy. *Medical Magazine of London*, 1, 45-56.

McIntire, M.S. & Angle, C.R. (1973) Psychological “Biopsy” in Self-Poisoning of Children and Adolescents. *American Journal of Disabled Children*, 126 (1), 42-46.

McIntire, M.S., & Angle, C.R. (1981) The taxonomy of suicide and self-poisoning-A pediatric perspective, In Wells C.F, Stuart, I.R (Eds) *Self-Destructive Behaviour in Children and Adolescents* New York, Van Nostrand Reinhold Co. p. 224-250.

McLennan, J.D., MacMillan, H.L., Afifi, T.O. (2020) Questioning the use of adverse childhood experience (ACEs) questionnaires. *Child Abuse & Neglect,* 10. Hhttps://doi.org/10.1016/j.chiabu.2019.104331.

McNeil, E.B. (1960) Psychology and aggression. *Conflict Resolution*. III (3), 195-294.

Menninger, K.A. (1933) Psychoanalytic Aspects of Suicide. *International Journal of Psychoanalysis,* 14, 376-390.

Menninger, K. (1938) *Man against himself.* New Haven: Yale University Press.

Menzies-Lyth, I. (1960) A Case-Study in the Functioning of Social Systems as a Defence against Anxiety. *Human Relations,* 13(2), *95-121.*

Mercer, J. (2007) The Challenges of insider research in educational institutions: wielding a double-edged sword and resolving delicate dilemmas, *Oxford Review of Education,* 33 (1), 1- 17.

Merril, J. & Owens, J. (1988) Self-poisoning among four immigrant groups. *Acta Psychiatrica Scandinavica*, 77, 77–80.

Midgeley, N, Target., M, & Smith., J.A. (2009). The outcome of child psychoanalysis from the patient's point of view: a qualitative analysis of a long-term follow-up study. *Psychology and Psychotherapy: Theory, Research and Practice*, *79*, 2, 257–69.

Mishna, F., Van Wert, M., Asakura, K. (2013) The Best Kept Secret in Social Work: Empirical Support for Contemporary Psychodynamic Social Work Practice, Journal of Social Work practice, 27(3) DOI: 10.1080/026505333.2013.818944.

Moore, C. (1790) *A Full Inquiry Into The Subject of Suicide (against God*). London: J.F & C. Rivington.

Morselli, H. (1881) *Suicide: An Essay on Comparative Moral Statistics.* New York: D. Appleton & Company.1882.

Moss, L.M & Hamilton, D.M (1957) Psychotherapy of the Suicidal Patient In E. Shneidman and N.L Farberow *Clues to Suicide*. New York: McGraw-Hill. p. 99-110.

Murphy, T.R. (1986) “Woeful Childe of Parents Rage”: Suicide of Children and Adolescents in Early Modern England, 1507-1710, *The Sixteenth Century Journal*, 17(3), 259-270.

Neeleman, J. (2001). A continuum of premature death. Meta-analysis of competing mortality in the psychosocially vulnerable. *International Journal of Epidemiology,* 30 (1), 154-162.

Norris, N. (2015) Democratic evaluation: The work and ideas of Barry MacDonald. *Evaluation*, 21(2), 135-142.

Novick, J. (1984) Attempted Suicide in Adolescence: The Suicide Sequence. In H. Sudak, A.B. Ford and N.B, Rushforth (eds) *Suicide in the Young*. Boston: John Wright/PSG Inc, 115-137.

Noy, C. (2006) Sampling Knowledge: The Hermeneutics of Snowball Sampling in Qualitative Research. *International Journal of Social Research Methodology,* 11 (4), 327-344.

NSPCC (2015) *Research with children: ethics, safety and avoiding harm.* London: NSPCC.

NSPCC (2018) *Childline annual review*. On line: https://learning.nspcc.org.uk/research-resources/childline-annual-review/?_ga=2.34106081.1745441734.1580582526-1946032458.1576439281

Nurius, P.S., Logan-Greene, P., & Green, S. (2012) *Journal of Prevention & intervention in the community 40(4), 278-290*

Obholzer, A., & Roberts, V.Z (eds) 1994 *The Unconscious at Work: Individual and Organisational Stress in the Human Services. London: Routeledge*

O’Connor, R., & Pirkis, J. (Eds) The International Handbook of Suicide Prevention. Oxford: John Wiley & Sons Ltd.

Ogden, T. H. (1994). The analytic third: Working with intersubjective clinical facts. *International Journal of Psychoanalysis*, 75(1), 3–19.

O'Carroll, P.W., Berman, A.L., Maris, R.W., Moscicki, E.K., Tanney, B.L., Silverman, M.M (1996). Beyond the Tower of Babel: a nomenclature for suicidology. *Suicide Life & Threat Behaviour*, 26(3), 237–252.

ONS (Office for National Statistics) (2016) Teacher’s suicide rates in the UK broken down in gender and ages from 2007 to 2012. webarchive.nationalarchives.gov.uk.

ONS (2017) Who is most at risk of suicide? https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarri

ages/deaths/articles/whoismostatriskofsuicide/2017-09-07. Accessed: 30/01/2020

Orbach, I. (1978a) Unique characteristics in children's suicidal behavior. In Aalberg V. (Ed.), *Proceedings Ninth International Congress on Suicide Prevention and Crisis Intervention,* Mikkeli, Finland: Finnish Association for Mental Health.

Orbach, I. (1988) *Children who don't want to live.* San Francisco: Jossey-Bass.

Orbach, I (2007a) Self-destructive processes and suicide. *Israeli Journal of Psychiatry* 44(4), 266-79.

Orbach, I. (2007b) From abandonment to symbiosis: A developmental reversal in suicidal adolescents. *Psychoanalytic Psychology*, 24(1), 150-166.

Orbach I., Glaubman, H. (1978) Suicidal, aggressive and normal children's perception of personal and impersonal death. *Journal of Clinical Psychology*, 34, 850-857.

Orbach, I & Glaubman, H (1979) The Concept of Death and Suicidal Behavior in Young Children. Three Case Studies. *Journal of the American Academy of Child Psychiatry*, VIII, 668-678.

Orbach I., Gross Y., Glaubman, H. (1981) Some Common Characteristics of Latency Age Suicidal Children: A tentative Model based on a Case Study analysis.

Otto, U. (1964) Suicidal attempts made by children and adolescents because of school problems. *Acta Pediatrica Scandinavica,* 54, 348–356.

Overholser, J., Athey, A., Beale, E., Dieter, L., Stockmeier, C. (2018) "How Could This Happen?" Psychosis or Depression as a Factor in Death by Suicide. *Schizophrenia Bulletin*, 44(Issue Suppl 1), S374-S375.

Owen, G., Belam, J., Lambert, H., Donovan, J., Rapport, F., Owens, C. (2012) Suicide communication events: lay interpretation of the communication of suicidal ideation and intent. *Social Science Medecine.* 75, 419–28.

Parker, I. (2010) The place of transference in psychosocial research. *Journal of Theoretical & Philosophical Psychology*, 30 (1), 17–31.

Parkinson, J., Minton, J., Lewsey, J., Boutell, J., McCartney, G. (2016) Recent cohort effects in suicide in Scotland: a legacy of the 1980s. *Journal of Epidemiology & Community Health,* 71 (2), 1-15.

Persier, E. (1899) Le suicide chez l'enfant et l'adolescent. *Annals de Medecine et de L'Enfant*.

Patros, P.G., Shamoo, T.K. (1990) *I want to kill myself: Helping your child cope with depression and suicidal thoughts*. Lexington, MA: Lexington Books.

Peterson, K.S. (2014) Interviews as Intraviews: A hand puppet approach to studying processes of inclusion and exclusion among children in kindergarten. *Reconceptualiing Educational research methodology,* 5 (1), 32-45.

Peuchet, J. (1838) “On Suicide and Its Causes.” Trans. Karl Marx. In *Marx on Suicide*. Ed. Eric A. Plaut and Kevin Andersen, 43-75. Evanston: Northwestern University Press, 1999.

Pfeffer, C.R. (1978) Psychiatric hospital treatment of latency age suicidal children, *Suicide & Life-Threatening Behaviour,* 8, 150-160.

Pfeffer C.R. (1980) Unanswered questions about childhood suicidal behavior: perspectives for the practicing physician. *Journal of Developmental & Behavioural Pediatrics*, 1 (1), 11-4.

Pfeffer, C.R. (1981a) Suicidal behavior of children: a review with implications for research and practices*. American Journal of Psychiatry.* 138, 154–9.

Pfeffer C.R. (1981b) The family system of suicidal children. *American Journal of Psychotherapy*. 35, 330–41. 59.

Pfeffer, C.R. (1985a) Suicidal fantasies in normal children. *Journal of Nervous Mental Disorders*. 173, 78–84.

Pfeffer, C.R. (1985b) Observations of Ego Functioning of Suicidal latency-Age Children. In M.L Peck., N.L Farberow., R.E Litman (eds) *Youth Suicide*. p38-35. New York: Springer Publishing Company.

Pfeffer, C,R. (1986) *The Suicidal Child*. New York: Guilford.

Pfeffer C.R. (1990a) Clinical perspectives on treatment of suicidal behavior among children and adolescents. 60. *Psychiatric Annals,* 20, 143–50.

Pfeffer, C.R. (1990b) Suicidal Behaviour in Children and Adolescents: A Clinical and Research Perspective. *The Yale Journal of Biology and Medicine*, 63, 325-332.

Pfeffer, C.R. (2003) Assessing suicidal behaviour in children and adolescents in R.A King & A. Apter, *Suicide in Children and Adolescents*. Cambridge: Cambridge University Press.

Pfeffer C.R., Conte H.R., Plutchik R., Jerrett, I. (1979) Suicidal behavior in latency-age children: An empirical study*. Journal of the American Academy of Child Psychiatry*, 18, 679–92.

Pfeffer C.R., Conte H.R., Plutchik R., Jerrett, I. (1980) Suicidal behavior in latency-age children: an outpatient population. *Journal of the American Academy of Child Psychiatry*, 19, 703–10.

Pfeffer, C., Hurt, S.W., Penkin, J.R., Ciefker, C.A. (1995) Suicidal Children Grow Up: Ego Functions Associated with Suicide Attempts. *Journal of the American Academy of Child & Adolescent Psychiatry,* 34(10), 1318-1325.

Pierce, M & Hardy, R. (2012) Commentary: The decreasing age of puberty-as much a psychosocial as biological problem?. *International Journal of Epidemiology*, 41 (1), 300-302.

Pokorny, A.D. (1964) Suicide Rates in Various Psychiatric Disorders. *Journal of Nervous Mental Disorders*, 139, 499-506.

Prudhomme, C. (1938) The Problem of Suicide in the American Negro. *The Psychoanalytic Review.* 25, 372-391.

Raleigh, S. V., & Balarajan, R. Suicide among immigrants from the Indian sub-continent. *British Journal of Psychiatry*,156:46–50.

Ramzy, I. (1963) Research aspects of psychoanalysis. *Psychoanalytic Quarterly*, 32, 58-76.

Razinsky. L. (2012) *Freud, psychoanalysis and death*. Cambridge: Cambridge University Press.

Rees, T.J. (2010) Is Personal Insecurity a Cause of Cross-National Difference in the Intensity of Religious Belief? *Nordic Journal Of Religion and Society*, 11.

Renshaw, D. (1974) Suicide and Depression in children. *Journal of School Health,* 44, 487-489.

Richman, J. (1978) Symbiosis, empathy, suicidal behaviour and the family. *Suicide and Life-Threatening Behaviour*, 8(3), 88-96.

Richman, J., Rosenbaum, M. (1970) A Clinical Study of the Role of Hostility and Death Wishes by the Family and Society on Suicidal Attempts. *Israel Annals of Psychiatry and Related Disciplines*, 8, 213-231.

Ridge, T. (2013) ‘We are All in This Together? The Hidden Costs of Poverty, Recession and Austerity Policies on Britain’s Poorest Children. *Children & Society*, 27(5), 406-417.

Rigby, K., & Slee, P. (1999) Suicidal ideation among adolescent school children, involvement in bully-victim problems, and perceived social support. *Suicide & Life-Threatening Behaviour,* 29(2), 119-30.

Ringel, E. (1976) The Presuicidal Syndrome. *Suicide and Life-Threatening Behaviour, 6(3), 131-149.*

Riordan, D.V., Selvaraj, S., Stark, C., Gilbert, J.S.E. (2006) Perinatal circumstances and risk of offspring suicide. *British Journal of Psychiatry*, 189, 502-507.

Risq, R. (2008) The research couple: a psychoanalytic perspective on dilemmas in the qualitative research interview. *European Journal of Psychotherapy & Counselling*, 10 (1), 39-53.

Roazen, P. (1974). *Freud and His Followers*. London. Allen Lane

Robins, E., Gassner, S., Kayes, S., Wilkinson, R.H., Murphy, G.E. (1959) The Communication of Suicidal Intent: A Study of 134 Consecutive Cases of Successful (Completed) Suicide. *American Journal of Psychiatry,* 115, 724-733.

Robinson, O. C. (2014) Sampling in Interview-Based Qualitative Research: A Theoretical and Practical Guide. *Qualitative Research in Psychology*, 11 (1), 25-41.

Ronningstam, E.F. & Maltsberger, J.T. (2010) Pathological Narcissism and Sudden Suicide-Related Collapse. *Suicide and Life-Threatening Behaviour*, 28(3), 261-271.

Ronningstam, E., Weinberg, I., Goldblatt, M., Schecter, M., Herbstman, B. (2018) Suicide and Self-Regulation in Narcissistic Personality Disorder, *Psychodynamic Psychiatry,* 46(4), 491-510.

Royal Society for the Prevention of Accidents. (2018) www.rospa.com ›

Rustin, M. (1997) The generation of psychoanalytic knowledge, sociological and clinical perspectives-'Give me a consulting room…', *The British Journal of Psychotherapy,* 13 (4), 527-541.

Rustin, M. (2006) Infant observation research: What have we learned so far? Infant Observation. 9 (1), 35-52.

Sabbath, J. C. (1969) The suicidal adolescent: the expendable child. *Journal of the American Academy of Child Psychiatry*, 8: 272–28987.

Sadger, I. (1910) *Heinreich von Kleist. Eine pathographisch-psychologische studie*. Berlin: Bergman.

Sadger, I. (1929) "Ein Beitrag zum Problem des Selbstmords', *Z. Psychoanal. Päd,* 3, 423.

Sainsbury, P. (1955) *Suicide in London: An Ecological Study*. London: Institute of Psychiatry/Chapman & Hall.

Salib, E & Cortina-Borja, M. (2006) Effect of month of birth on the risk of suicide. *British Journal of Psychiatry,* 188 (5), 416-422.

Samaritans (2017) *Dying from Inequality: Socioeconomic disadvantage and suicidal behaviour.* London: Samaritans.

Samaritans (2017) *Suicide Statistic Report*. London: Samaritans.

Samaritans (2019) https://www.samaritans.org/news/samaritans-believes-reducing-self-harm-key-suicide-prevention/

Sandler, J., & Joffe, W.G. (1965) Notes of childhood depression. *International Journal of Psychoanalysis*, 46, 88-96.

Schacter, J. (1999) The paradox of suicide: issues of identity and separateness. In R. Perelberg (ed) Psychoanalytic Understanding of Violence and Suicide, 147-158. London: Routledge.

Schecter, M.D. (1957) The recognition and treatment of suicide in children. In *Clues to Suicide,* E, Shneidman., N, Farberow (eds) New York: McGraw-Hill Book Company, Inc. Blakiston Division.

Schilder, P., Wechsler, D.J. (1934) The Attitudes of Children Toward Death. *Journal of Genetic Psychology,* 45, 406-451.

Schimek, J. G. (1987). Fact and fantasy in the seduction theory: A historical review. *Journal of the American Psychoanalytic Association*, 35(4), 937–965.

Schmideberg, M. (1936) A note on Suicide. *The International Journal of Psycho-Analysis*,17 (1), 17-30.

Schneer, H.I., Kay, P., Brozovsky, M. (1961) Events and Conscious Ideation Leading to Suicidal Behaviour in Adolescence. *Psychiatric Quarterly,* 35:507-515.

Serin, S. (1927) Les suicides d'enfants. *L'hygiene Mentale* ,22, 33-37.

Shaffer, D. (1990) Adolescent suicide attempters. Response to suicide-prevention programs. *Journal of the American Medical Association*, 264 (24), 3151-5.

Sharma, S., & Fowler, J.C. (2018) Restoring Hope for the Future: Mentalization-Based Therapy in the treatment of the Suicidal Adolescent. *The Psychoanalytic Study of the Child*, 71, 55-75.

Sharma, T., Guski, L.S., Freund, N., Gøtzche, P.C. (2016) Suicidality and aggression during antidepressant treatment: systematic review and meta-amalyses based on clinical study reports. *BMJ* 2016;352:i65

Shamoo, T.K., Patros, P.G. (1992) *Helping your child cope with depression and suicidal thoughts.* San Francisco: Jossey-Bass Publishers.

Shaw, M., Dorling, D., Smith, G.D. (2002) Mortality and political climate: how suicide rates have risen during periods of Conservative government, 1901-2000, *Journal of Epidemiology & Community Health,* 56 (10), 723-725.

Shedler, J. (2010) The efficacy of psychodynamic psychotherapy. *American Psychologist,* 65(2), 98.

Shedler, J. (2015) Where is the evidence for ‘evidence-based therapy? *Psychiatric Clinics of North America*, 41, 319-329.

Sher, L. (2020) The impact of the COVID-19 pandemic on suicide rates*. QJM: An international Journal of Medicine*, 113(10), 707-712.

Shneidman, E. (1971) Perturbation and lethality as precursors of suicide in a gifted group. *Suicide and Life Threatening Behaviour* 1, 23-45.

Shneidman, E.S. (1993) Suicide as Psychache. *Journal of Nervous and Mental Disease*, 181, 147-149.

Shneidman, E. S. (1996). *The suicidal mind*. Oxford. University Press.

Sharma, S., & Fowler, J.C. (2018) Restoring Hope for the Future: Mentalization-Based Therapy in the treatment of the Suicidal Adolescent. *The Psychoanalytic Study of the Child*, 71, 55-75.

Shaw, M., Dorling, D., Smith, G.D. (2002) Mortality and political climate: how suicide rates have risen during periods of Conservative government, 1901-2000, *Journal of Epidemiology & Community Health,* 56 (10), 723-725.

Shuey, E.A., Levethal, T (2017) Pathways of risk and resilience between neighbourhood socioeconomic conditions and parenting, *Children & Youth Services Review,* 72, 52-59.

Shuttleworth, S. (2010) *The mind of the child: child development in literature, science and medicine, 1840–1900*. Oxford: Oxford University Press.

Simm, R., Roen K., Daiches, A. (2008) Educational professionals’ experiences of self- harm in primary school children: ‘You don’t really believe, unless you see it’. *Oxford Review of Education*, 34, 253–69.

Simm, R., Roen, K., Daiches, A. (2010) Primary School Children and Self-Harm: The Emotional Impact upon Education Professionals, and Their Understandings of Why Children Self Harm and How This Is Managed. *Oxford Review of Education*, 36, 677–92.

Skånfors, L. (2009) Ethics in child research: children’s agency and researchers’ ‘ethical radar’, *Childhoods Today*, 3(1), 1-22.

Skerrett, D.M., Kolves, K., De Leo, D. (2015) Are LGBT Populations at a Higher Risk for Suicidal Behaviours in Australia? Research Findings and Implications.. *Journal of Homosexuality*, 62(7), 883-901.

Smith, J.A., Flowers, P. & Larkin, M. (2009*). Interpretative Phenomenological Analysis: Theory, Method and Research*. London: Sage.

Solms, M.L. (2018) The Neurological Underpinnings of Psychoanalytic Theory and Therapy. Frontiers in Behavioural Neuroscience, 12: 294. Doi:10.33389/fnbeh.2018.00294

Speechley, M., Stavraky, K.M. (1991) The adequacy of suicide statistics for use in epidemiology and public health. *Canadian Journal of Public Health*, 82(1), 38-42.

Stack-Sullivan, H. (1953) *Interpersonal Theory of Psychiatry*. New York: W.W. Norton & Company, Inc.

Stack-Sullivan, H. (1956) *Clinical Studies in Psychiatry.* New York: W.W. Norton & Company, Inc.

Stack Sullivan, H. (1964) *The Fusion of Psychiatry and Social Science*. New York: W.W. Norton.

Stainton-Rogers, W. (2001) *The psychology of gender and sexuality.* Buckingham: Open University Press.

Steinberg. M.D. (2011) *Petersberg Fin de Sciecle*. New York: Yale University Press.

Steiner, J. (1993) *Psychic Retreats: Pathological Organizations in Psychotic, Neurotic and Borderline Patients*. London: Routeledge.

Steinert, C., Munder, T., Rbung, S., Hoyer, J., Leichsenring, F. (2017) Psychodynamic therapy: as efficacious as other empirically supported treatments? A meta-analysis testing equivalence of outcomes. *American Journal of Psychiatry*, 943-953.

Stekel, W. (1910) Symposium on Suicide. With Particular Reference to Suicide among Young Students. Discussions of the Vienna Psychoanalytic Society. In Friedman *On Suicide* (1967) New York. International Universities Press Inc.

Stengel, E. (1956) The Social Effects of Attempted Suicide. *Canadian Medical Association* , 116-119.

Stengel, E. (1964) *Suicide and Attempted Suicide*. Baltimore: Penguin.

Stone, M. (1999) Suicide: An Essential Guide for Helping Professionals and Educators. Are Teachers of Children and Young Adolescents Responsive to Suicide Prevention Training Modules? Yes. *Death Studies*, 23 (1), 6-67.

Stone, M., Laughren, T., Jones, M.L., Levenseon, M., Holland, C., Hughes, A., Hammand, T.A., Temple, R., Rochester, G. (2009) Risk of suicidality in clinical tials of antidepressants in adults: analysis of propriety data submitted to US Food and Drug Administration. *BMJ* 2009;339:b2880.

Straker, N., Bieber, P. (1977) Journal of the American Academy of Child Psychiatry. XVI, 1977: Asthma and the Vicissitudes of Aggression. Two Case Reports of Childhood Asthma, 132-139. *Psychoanalytic Quarterly*, 47, 479-480.

Strand, S. (2014) Moderators of the FSM achievement gap: being more able or poor in an affluent school. Paper presented at the British Educational Research association conference, university of Oxford on Wednesday 24 September

Strahan, S.A.K. (1893) Suicide and Insanity: A Physiological and Sociological Study BY S.A.K Strahan, M.D. Barrister-at-Law. London: Swan, Sonnenschien, and Co. *Journal of Mental Science*, 40(170), 433-436.

Sun, F.K & Long, A. (2013) A suicidal recovery theory to guide individuals on their healing and recovering process following a suicide attempt. *Journal of Advanced Nursing*, 69 (9), 2030-2040.

Szasz, T.S. (1998) *Fatal Freedom: The Ethics and Politics of Suicide.* Greenwood Publishing Group.

Taylor, D. (2010) Psychoanalytic approaches and outcome research: Negative capability or irritable reaching after fact and reason? *Psychoanalytic Psychotherapy*, 24(4), 398-416.

Taylor, S. (1982) *Durkheim and the Study of Suicide.* London: MacMillan.

The Sutton Trust (2017) *The State of Social Mobility in the UK*. Boston Consulting Group.

Thomas, L.(2016) *The Suicide Attempt of a Seven Year Old Boy An Exploration of Precipitating and Protective Factors.* A thesis submitted in partial fulfilment of the requirements of the University of East London for the degree of Professional Doctorate.

Thompson, M.P. Kaslow, N.J., Short, L.M., Wyckoff, S. (2002) The Mediating Roles of Perceived Social Support and Resources in the Self-Efficacy-Suicide Attempts Relation Among African Abused Women. *Journal Of Consulting and Clinical Psychology*, 70(4), 942-949.

Thompson, M.P., Kingree, J.B., Lamis, D. (2019) Associations of adverse

childhood experiences and suicidal behaviours in adulthood in a U.S. nationally representative sample. *Child Care & Health Development*, 45(1), 121-128.

Tillman,J.G., Clemence, J.A., Stevens, J.L (2011) Mixed Methods Research Design for Pragmatic Psychoanalytic Studies. *Journal of the American Psychoanalytic Association*, 59 (5),1023-1040.

Tishler, C.L. (1980) Intentional self-destructive behaviour in children under age ten. *Clinical Pediatrics,*19, 451–3.

Tisdall, K., Davis, J.M., Gallagher, M. (2008) *Researching with Children and Young People: Research Design, Methods and Analysis.* London: Sage.

Tøllefsen IM, Helweg-Larsen K, Thiblin I., Hem, E., Kastrup, C., Nyberg, U., Rogde, S., Zahl, P-H., Østevold, G., Ekeberg, Ø. (2015). Are suicide deaths under-reported? Nationwide re-evaluations of 1800 deaths in Scandinavia. *BMJ Open* 2015;5:e009120. doi:10.1136/bmjopen-2015- 009120

Tomassini, C., Juel, K., Holm, N.V., Skythhe, A., Christensen, K. (2003) *BMJ*, 327(7411), 373-374

Tomlinson, M. (2012). War, Peace and Suicide: The Case of Northern Island. *International Journal of Sociology*, 27, 4, 464-482.

Toolan, J.M. (1962) Suicide and Suicidal Attempts in Children and Adolescents. *American Journal of Psychiatry*. CXVIII, Adolescents. James M. Toolan. 719-724. *Psychoanalytic. Quarterly*, 32, 607.

Toolan, J.M.(1975) Suicide in children and adolescents. *American Journal of Psychotherapy.* 29(3), 339-44.

Tsirigotis, K., Gruszcynski, W., & Tsirigotis, M. (2011) Gender differentiation in methods of suicide attempts. Medical Science Monitor: *International Medical Journal of Experimental and Clinical Research*, 17(8), 65-70.

Tullis, R.A., Owen, J.A., Mcrae, C; Vitale, I. (2009) Truth troubles. *Qualitative Inquiry*, 15(1), 178-200.

Tustin, F. (1982) *Autistic States in Children*. London: Routeledge.

Udry, J. R., Li, R.M., Hendrickson-Smith, J. (2003) Health and Behaviour Risks of Adolescents with Mixed Race Identity. *American Journal of Public Health* 93(11), 1865-1870.

Unluer, S. (2012) Being an Insider Researcher While Conducting Case Study Research. *The Qualitative Report*, 17 (29), 1-14.

Värnik, P., Sisask, M., Värnik, A., Arensman,E., Van Audenhove, C., van der Feltz-Cornelis, C.M., Hegerl, U. (2012) Validity of suicide statistics in Europe

in relation to undetermined deaths: developing the 2-20 benchmark. *Injury Prevention,* 18 (5), 321-5.

Van Orden, K.A., Witte, T.K., Cukrowicz, K.C., Braithwaite, S.R., Selby, A.A., Joiner, T.E Jr. 2010, The Interpersonal Theory of Suicide*, Psychology Review*, 117(2), 575-600.

Vinas, F., Canals, J., Gras, E., Domenaech-Llaber, E. (2002) Psychological and Family Factors Associated with Suicidal Ideation in Pre-Adolescents. *The Spanish Journal of Psychology*, 5(1), 20-8.

Wasserman, D. (2020) *Oxford Textbook of Suicidology and Suicide Prevention.* Oxford: Oxford University Press.

Wasserman, D., Thanh, H.T.T., Minh, D.P.T., Goldstein, M., Nordenskiold, A., Wasserman, C. (2008) Suicidal process, suicidal communication and psychosocial situation of young suicide attempters in a rural Vietmanese community. *World Psychiatry*, 7 (1), 47-53.

Wasserman, D., Hoven, C.W., Wasserman, C., Wall, M., Eisenberg, R., Hadlaczky, G., Kelleher, I., Sarchiapone, M., Apter, A., Balazs, J., Bobes, J., Brunner, R., Corcoran, P., Cosman, D. et al (2015) School-based suicide prevention programmes: the SEYLE cluster-randomised, controlled trial. *Lancet.* S0140-6736(14)61213-7. doi: 10.1016/S0140-6736(14)61213-7. [Epub ahead of print]

Waters, J. (2015) Snowball sampling: a cautionary tale involving a study of older drug users. *International Journal of Social Research Methodology,* 18 (4), 367-380.

Watkins, J., Wulaningsih, W., Da Zhou, C., Marshall, D., Sylianteng, G.D.C., Dela Rosa, G., Miguel, V.A., Raine, R., King, L.P., Maruthappu, M. (2017) effects of health and social care spending constraints on mortality in England: a time trend analysis, *BMJ Open*, 7 (11), online: https://bmjopen.bmj.com/content/7/11/e017722 (accessed 20.01.2020)

Weick, K.E. (2002) Essai: real-time reflexivity: prods to reflection. *Organization Studies*, 23 (6), 893–898.

Westcott, W.W. (1885) *Suicide; its history, literature, jurisprudence, causation, and prevention*. London: H.K. Lewis.

White, R.A., Azrael, D., Papadopoulos, F.C., Lambert, G.W., Miller, M. (2015) Does suicide have a stronger association with seasonality than sunlight? *BMJ Open*. Hhttp://dx.doi.org/10.1136/bmjopen-2014-007403corr1.

Whalen, D.J., Dixon-Gordon, K., Belden, A.C., Barch, D., Luby, J.L. (2015) Correlates and Consequences of Suicidal Cognitions and Behaviours in Children Ages 3-7 Years. *Journal of the American Academy of Child & Adolescent Psychiatry,* 54(11), 926-937.

Whitlock, J., & Knox, K.L. (2007). The Relationship Between Self-injurious Behavior and Suicide in a Young Adult Population, *Archives of Pediatric Adolescent Medicine*, 161(7), 634–640. doi:10.1001/archpedi.161.7.634

Wigenfeld, K., Schäfer, I., Terfeher, K., Grabski, H., Driessen, M., Grabe, H., Löwe, B., Spitzer, C. (2011) The reliable, valid and economic assessment of early traumatization: first psychometric characteristics of the German version of the Adverse Childhood Experiences Questionnaire. *Psychotherapy Psychosomatic Medical Psychology*, 61(1):e10-14. Doi: 10. 1055/s-0030-1263161

Winn, D. & Halla, R. (1966) Observations of children who threaten to kill themselves. *Canadian Psychiatric Association Journal*, 11, 283-94.

Winnicott, D. W. (1958) The capacity to be alone. *The International Journal of Psychoanalysis*, 39, 416–420

Winnicott, D.W. (1960) The Theory of the Parent-Infant Relationship. *The International of Journal of Psychoanalysis*, 41:585-595. (1960).

Winnicott, D.W. (1965) The maturational processes and the facilitating environment. London: Routledge

Winslow, F.B. (1840) *The Anatomy of Suicide.* London: Renshaw.

Wohlfahrt-Veje, C., Mouritsen, A., Hagen, C.P., Tinggaard, J., Mieritz, M.G., Boas, M., Petersen, J.H., Skakkebaek, N.E., Main, K.M. (2016) Pubertal Onset in Boys and Girls Is Influenced by Pubertal Timing of Both Parents. *The Journal of Clinical Endocrinology & Metabolism*, 101(7), 2667-2674.

Wolk-Wasserman, D. (1986). Suicidal communication of persons attempting suicide and responses of significant others. *Acta Psychiatrica Scandinavica,* 73 (5), 481-499.

Woo, J-M, Okusaga, O., Postolache, T.T. (2012) Seasonality of Suicidal Behaviour. *International Journal of Environmental Research & Public Health*, 9 (2), 531-547.

WHO. WHO Methods and Data Sources for Country-Level Causes of Death 2000-2015. World Health Organization; Geneva, Switzerland: 2017. p. 56. Global Health Estimates Technical Paper (WHO/HIS/IER/GHE/2016.3.

Yardley, L. (2000) Dilemmas in qualitative health research, *Psychology & Health*, 15:2, 215-228, DOI: 10.1080/08870440008400302

Zaretsky. S. (2000) The Psychoanalytic Treatment of a Homicidal, Suicidal, latency Age Child. *Modern Psychoanalysis*, 25(2), 249-258.

Zilboorg, G. (1936a) “Differential Diagnostic Types of Suicide.” *Archives of General Psychiatry*, 35, 270-291.

Zilboorg, G. (1936b). Suicide among Civilized and Primitive Races. *American Journal of Psychiatry*, 92, 1347-1369.

Zilboorg, G. (1937) “Considerations on Suicide, with Particular Reference to That of the Young.” *American Journal of Orthopsychiatry,* 7, 15-31.

Zilboorg, G. (1938/75) Some Aspects of Suicide. *Suicide and Life Threatening Behaviour, 5, 131-139.*

Zilboorg, G. (1939) Sociology and the Psychoanalytic Method. *American Journal of Sociology*, XLV, 341.

Zirin, R.A. (2006) Reflections on Suicidal Children. *International Journal of Psychoanalytic Self Psychology,* 1, (4), 389-411.

Appendix A

Participant Letters and Ethical Paperwork

UNIVERSITY OF EXETER

PARTICIPANT INFORMATION SHEET

You are being invited to contribute to a research project as part of the University of Exeter's Clinical Doctoral programme in the School of Psychology entitled: **Encounters with primary school children who express suicidal thoughts and behaviours: Are teachers and pastoral staff equipped?**

The research takes the form of an interview which might take anywhere between 45-90 minutes to complete. The interview will be conducted in a private setting to be agreed. The interview will be based on a semi-structured format (see attached) with already existing questions alongside a responsiveness to whatever the interviewee brings. The interview will be audio recorded and subsequently transcribed.

The data collected will be processed, analysed and written up as part of a Doctoral Thesis and presented to a small audience of teaching staff and Doctoral students in the School of Psychology at the University of Exeter in the first place. The research may then be published and the findings publicly presented and disseminated.

Your participation is entirely voluntary and anonymous. You may withdraw your consent at any time. If you chose you withdraw all your data will be removed from the study and then destroyed.

If there are any unresolved safeguarding issues which become identified during the interview process the researcher would support the interviewee to resolve these or might need to pursue these concerns independently through the necessary channels to ensure that the individual concerned is safeguarded.

If you have any questions or queries then please contact me on: shelley.macdonald@btinternet.com

If there are any concerns regarding the research then please contact Lisa Leaver, l.a.leaver@ex.ac.uk).

Thank you for your time.

Shelley MacDonald

UNIVERSITY OF EXETER
PARTICIPANT CONSENT SHEET

I………………………………………………………………….. (NAME) consent to being interviewed for the research study entitled; "**Encounters with primary school children who express suicidal thoughts and behaviours: Are teachers and pastoral staff equipped**?"
The study has been reviewed and approved by the Ethics Committee at the University of Exeter.
I agree to the interview being audio recorded, transcribed and used for purposes of data analysis.

I understand that my anonymity will be preserved.

I understand that I can withdraw my participation at any point.

I understand that the study might be published, presented in public and disseminated. I agree to my contribution being part of that study.

If I have any concerns regarding the study I can contact the Chair of the Ethics Committee at the University of Exeter (Lisa Leaver, l.a.leaver@ex.ac.uk).

…………………………………………………(SIGNATURE)…………(DATE)

UNIVERSITY OF EXETER

Encounters with young children who express suicidal ideas and behaviours.

Request for consent to use limited, non-identifying, information concerning children who have expressed suicidal ideas and behaviours.

This research will not make mention of the following:
Name of school
The city and county in which the school is located.
The names of any children.
The names of any staff.
Any unique identifying information.

The research will use the following:
The age of the child expressing suicidal ideas and behaviours.
The gender
The birth order
The family situation (ie, living with biological mother and step father)
Cultural background
Faith
The suicidal comment or behaviour the child expressed.
Whether the child is entitled to free school meals.
Whether or not there has been any Social Care intervention
The socio-economic data about the school catchment

Please confirm consent below.

……………………………………………….(Signature)

If there are any concerns about the research or any need for further clarification please contact J.Smithson@exeter.ac.uk

If there are any ethical concerns regarding the research please contact Lisa Leaver. l.a.leaver@ex.ac.uk.

Ethical Clearance Confirmation

From: Shelley macdonald <shelley.macdonald@btinternet.com>
Sent: 18 February 2016 21:59
To: Leaver, Lisa
Cc: Smithson, Janet
Subject: amendments

Hi Lisa,
Re: Ethical Approval for application (2016/17) Encounters with suicidal ideation and behaviours in primary school children: are teachers and pastoral staff equipped?
Attached are the amendments and clarifications requested.
I was unable to upload them onto the system as it is recorded as 'approved' and cannot be edited further.
Regards

ShelleyResponse to conditions for acceptance of ethics application

We have raised the following conditions that must be met for this application to meet the approval of the Ethics Committee:

1) There should be something in the information sheet/consent form about the detailed procedures to be followed if the researcher believes that a child is at risk, especially if the interviewee does not agree. The potential participant should be aware of this. Will the researcher follow up on these children without permission of the interviewee?

I have added the following information on the revised information sheet (attached)
"If there are any unresolved safeguarding issues which become identified during the interview process the researcher would support the interviewee to resolve these or might need to pursue these concerns independently, through the necessary channels, to ensure that the individual concerned is safeguarded."

2) Please clarify how the researcher would seek to safeguard independently? What exactly would they do, whom would they contact?

The researcher would pursue any safeguarding concerns independently if the practitioner/teacher concerned either did not wish to, or we disagreed on the level of risk. I would approach the school that the child attends with the concern and leave it with the school to decide what to do with it.
As I know all the people I am interviewing I think it unlikely that I would have to pursue a concern independently. I think it much more likely that I would support the staff member to take the concern further.
Part of the reason I can conduct the research on such a sensitive subject is because I have an established relationship with the people I'm interviewing.
But I do have scope to interview people I don't know so it's well worth considering the implications if there were to be a disagreement as to the seriousness of the concerns around a child or adult. As this scenario has now been included in the participant information sheet the interview will enter into the interview knowingly.

3) Please indicate whether the researcher is a school counsellor? Her professional status was unclear, although this would have a bearing on what they could do in the research situation.

The researcher is a school psychotherapist.

4) Please add to the consent form that the study has been reviewed and approved by the Ethics Committee at the University of Exeter, with contact information of the Chair (Lisa Leaver, l.a.leaver@ex.ac.uk) should they have any concerns.

I have added this information on the revised information sheet and the consent form (attached).

Appendix B

Domain Summaries

The following domain summaries are presented in chronological order of when they were conducted.

1. Antonia. Key Stage 2 Teacher. Year 6.
Experience: 6 years of working with socially deprived young children. **Age: 25-30.** **Ethnicity: White UK.** **Interview Duration: 01:10:16**
Antonia focused on two Year 6 boys although she spoke of a number of children with behaviours that would be described as disturbed and self-harming. One of the boys was hanging out with street gangs, using drugs such as weed and had been found collapsed unconscious on the pavement having to be attended by an ambulance. Whilst he had not explicitly expressed a S-C he was seen as posing a danger to himself which Antonia placed under the auspices of S-C. The second child Antonia brought was one who had run into traffic and had been playing on the railway track. Antonia also spoke about how staff engaged with S-C children and how external agencies such as Childline and CAMHS are not as helpful as they might be. Antonia referred to the different containing capacities of supply teachers as opposed to class teachers and the issue of staff who live in the community

bringing the culture of the community with them and how this impacts upon how they respond to S-C in children.

2. Sharon. School Based Counsellor
Experience: 7+ years of working with socially deprived young children. **Age: 55-60** **Ethnicity: White UK** **Interview Duration:1:01:09**
Sharon brought several children not all of whom had expressly articulated a S-C but to whom Sharon clearly had attached a 'suicide concern'. A year 6 girl who heard voices, and did not feel as if she was what her mother wanted. She spoke of wanting to die when alone. She wanted to die to see if anyone would miss her. This child had an older brother with mental health issues who was aggressive. She spoke both about wanting to be dead and wanting to be killed (but did not talk of killing herself). Part of her wished for a reunion with a dead neighbor with whom she had formed an attachment. The second child Sharon spoke of was a 9 year-old girl who had a benign brain tumour and she expressed a wish to be dead. Both her parents had alcohol dependency issues. The third child Sharon brought was an 8 year-old girl whose father had hung himself within a short time of a family friend completing suicide. This child was reported by a TA as having said she wanted to die. In the session she painted red paint on her hands and said it was blood. She said a bad man had put a bloody hand on her. Sharon realised during interview that S-C were typically made outside of the counselling room. The fourth child Sharon brought was a 10 year-old girl whose mother had Learning Difficulties and

younger brother had tried to kill himself. Sharon felt there to be a great deal of family disturbance which could not be spoken of and interpreted the child's play as requiring of her being rescued by emergency services as the character representing the child was dying. The fifth child Sharon spoke of as having a split personality with a father with Mental Health problems who came and went. There was also a history of domestic violence. This child did not express a S-C but Sharon felt that the level of disturbance displayed around the school in relation to sexualized behaviours, aloneness and aggression warranted inclusion. She spoke of this child also painting her and making pots of 'gloop'. Sharon's sixth child was a mixed race boy with an angry father and a mother who associated her son with the father and disliked him, perhaps because of this. The seventh child, a mixed race girl, Sharon spoke of had a very dependent relationship with mother and had experienced domestic violence at home. This child struggled with her peers, classroom behaviours and demonstrated self-harm by cutting and banging her head. She demonstrated S-C outside of school, such as running out on to the road. Sharon mentioned that she was yet another (the 4th) who painted her in the session. The eighth child brought was a boy where sexual abuse was suspected. Sharon interpreted his play as the child being in a precarious position between life and death. The ninth child was a 5 year-old girl from a family with a sexual abuse history. The child moved from her birth family to foster care during the therapy. Although she did not express a S-C Sharon was concerned about the level of fear in her play. The tenth child was a girl with a physical disability. Her father had been in prison and the child was removed from mother due to domestic violence and into Kinship Care with her

Grandmother. Sharon spoke of her having a lot of anger toward mother who was expecting another baby. Also the child came into therapy as things were breaking down at home with Grandmother. Also it had been noticed that the inclusion she had enjoyed throughout her primary years was changing as her peers were all bridging the prospect of secondary school. Further, her struggle with the limitations of her body were coming more to the fore. She had brought a game where all the characters died and also made mention of witches who had bloody reputations through history and Sharon expressed worry about future vulnerability. This last child, a Year 1 boy, also equated blood with paint and, again, put paint on Sharon's body. He was removed from home into foster care during the therapy. Abused by his older brother, Sharon worried about his future susceptibility to S-C.

Sharon mentioned the birth order of all the children. Three were first born, the remaining being middle children. Therefore all, potentially, had the experience of being usurped by the new sibling.

3. Paula. Primary School Counsellor

Experience: 11 years working with socially deprived young children.

Age: 50-55

Ethnicity: White UK

Interview Duration: 00:26:38

Paula spoke about a Year 5 boy she worked with whose mother had died some months previously. The family were religious and his concept of death was that mother was waiting for him so he had tried, on a number of occasions, to throw himself out of a top story window because he wanted to

die and be with her. After talking about his loss with the Paula he stopped wanting to die.

Paula spoke about self-harm, what constitutes self with autistic children and whether self is mother and mother is self in such cases. She also spoke of teachers and how it is possible to see the work in schools serving socially deprived communities as self-harm with teachers getting pregnant to avoid working in these schools.

4. Hayley: Primary School Counselling Service Manager

Experience: 3+ years of working with socially deprived young children.

Age: 30-35

Ethnicity: White UK

Interview Duration: 00:25:37

Hayley, seemed concerned about confidentiality and perhaps this was why it was difficult to carve out any clarity with most everything she said. Reading between the lines it would seem that her position in the school was somewhat dislocated and the counselling service was viewed as adjunct. She described herself as a ‘vessel’ through which information about concerning children passed but was dealt with elsewhere (shortly after the interview she left the school in which she worked. She did, however, bring one example of a child saying he would rather die than go home but she did not bring any further information about the child. Hayley also brought another child who explicitly stated that either she wanted to die or kill herself (Hayley could not recall the precise expression). She had a brother with a disability and her father was ashamed of him. The parent’s relationship was broken and Hayley felt that the

cultural background of the father informed the shaming response to the brother. The brother was attacking of the S-C girl. The Head Teacher became aware of the girl's home situation was referred to the school counselling service. She spoke about the children's artwork conveying dark, foreboding figures bearing down and burying in their play. Hayley also made connections with virtual reality where death was a prominent narrative and the realities of troubled children's lives using an example of an autistic Year 6 boy.

5. Barbara. Primary School Counselling Manager
Experience: 10+ years of working with young children. **Age: 50-55** **Ethnicity: White UK** **Interview Duration: 01:13:02**
Barbara, offered a detailed single case study of a Year 5/6 girl, older than her years but not mature, who came in to school one day and told a young TA, and a number of her peers, that she had tried to hang herself from the door hook the previous evening. Barbara charts the time from disclosure to the child leaving the school at the end of Year 6. Barbara saw the incident as an attempt to lever change in that she wished her mother's new partner to move out from the family home and dedicated some time and effort to trying to achieve this. However, Barbara also felt that this was a child who was struggling and needed attention paid. Mother was very reluctant to take the child's need seriously and, unusually, there was a move from an alleged suicide attempt 'down' to self-harming activities which Barbara, in part, saw as the child needing to 'evidence' her distress to others as talking about it was, in

some quarters, not being taken seriously. A referral to CAMHS was made but due to lack of parental engagement they closed before they began and the school counselling service and the school itself was left to manage. Barbara's continuing efforts to 'not to let it become normal', to keep acknowledging it and to keep bringing the family and staff together to think about the child were rewarded. Mother reluctantly came round to the idea that her daughter might need attention although on reflection, whilst mother engaged well with Barbara she wondered if it was more for appearances sake than genuine concern for her daughter. The self-harming reduced, a crisis point was reached in the family where the new partner was poised to move out then matters abated. However, the child entered into an unhealthy relationship with an older boy who Barbara saw as a continuation of worrying behaviours There was some speculation that the daughter, who had hitherto been recipient of the mother's exclusive attention, felt the loss of her mother to the new partner, almost as if she was a 'spurned lover'. Another of the child's 'solutions' was to get a partner for herself but as he was pressing her for a sexual relationship the possibility of her precipitously 'becoming' her mother might have been more of an example of 'working in' rather than 'working out'.

Barbara also spoke of the ubiquity of head banging in her school, scratching arms, self-tatooing, hair pulling, wall punching and face gouging, cutting. She spoke of a gender difference in relation to these behaviours allocating the more outwardly aggressive behaviours to boys and the girls self-harming as more 'secretive'(or one might suggest boys 'act out' and girls 'act in').

6. Tilly. Counsellor-in-training.
Experience: Less than a year of working with socially deprived young children. **Age: 20-25** **Ethnicity: White UK** **Interview Duration: 00:16:05**
Tilly spoke of an 8 year-old girl whose sand tray lay alerted her to possible suicide communication from a child she was working with in therapy. The girl killed the character in the play that represented her saying that she was going to get a knife and kill herself. This was the only known Muslim child in the study and her suicide communications came after returning from the Christmas break and she was understood to be very anti Christmas. The comments were not taken out of the room as they belonged to the play and the counsellor and her supervisor did not think them sufficiently concerning to extend confidentiality. Tilly wondered about the impact of social media, her struggling brother and depressed mother who was experiencing suicidal thoughts upon the child's S-C.

7. Pearle. Special Needs TA.
Experience: 20+ years working with socially deprived young children. **Age: 50-55** **Ethnicity: White UK** **Interview Duration: 00:14:16**
Pearle spoke, specifically, about 2 children whom she understood to have expressed a suicide communication in recent years and she also spoke, more

generally, about a number ('over 10') of S-C children from Year 2 - Year 6, over a twenty-year period. Pearle noticed that S-C in children, although rare, was becoming more prevalent. She also noted that, increasingly, children are bringing these communications on more of a sustained basis with them mentioning suicide on a number of occasions whereas previously there had just been one off comments. She noted that young children rarely had a plan but every now and then a child would suggest tying a ligature around their neck. Pearle had enquired into S-Cs and concluded that these children did not understand that dead means forever and that they will not see their families again. She saw these communications as efforts to get attention but also she noted that all had 'difficult backgrounds'. Pearle used the first half of the phrase, *Between the Devil and the Deep Blue Sea,* when talking about how you respond to a child S-C, which suggested whatever option she chose, neither were desirable. Both not responding to a child S-C would hold one liable for not adhering to safeguarding policy and practice but responding to children put an adult under the child's control. Pearle also identified that S-C children are bright and articulate. She thought S-C more prevalent in children diagnosed with ASD. She noted perfectionism and how quickly some of these children move from getting something wrong to issuing a S-C.. In terms of intent and risk Pearle identified one Year 3 child who had searched suicide on the internet and she found this worrying. Pearle proposed the possibility that his S-C might be related to excessive use of video games but this child had a diagnosis of ASD and was socially dislocated. Further, Pearle noted that S-C children were often very sad, possibly depressed, without friends. She both understood and minimised the seriousness of child S-C for while a child might

not wish to die they, in all likelihood are in deep distress. She acknowledged there might be future suicide risk for a least two of the young children she currently supported.

8. Rebecca. Pupil & Family Support Worker and Safeguarding Lead
Experience: 7 years of working with socially deprived young children. **Age: 35-40** **Ethnicity: Dual Heritage.** **Interview Duration: 00:29:46**
Rebecca spoke in great detail about a Year 5 boy who had said he wanted to kill himself the previous year and was thought to have gender identity issues. Rebecca also spoke about a Year 2 child who was reported by mum to have said that he wanted to kill himself from the age of 5. She spoke about how difficult family life was and how unresponsive CAMHS were saying that they were unable to help as he did not have Mental Health problems. Child experienced domestic violence. Father was in prison and had a difficult childhood himself.

9. James. Child & Adolescent Psychotherapist
Experience: Over 40 years of working with vulnerable adolescents. 10 years as a Clinical Lead for a School Counselling Organisation working in Primary Schools. **Age: 70-75** **Ethnicity: White UK** **Interview Duration: 00:57:47**

James did not draw on specific examples of socially deprived S-C children but he did talk of one S-C middle class child who stood on his desk in the middle of his class and announced that he wanted to kill himself. James placed an emphasis on S-C in the form of attempts and completed suicide as an attack on the body, a body that has been subject to a revolution in puberty. He saw puberty as onsetting earlier and earlier for various reasons. He spoke about young children across the country expressing S-C and yet not a great deal of acknowledgement from Childline and NSPCC. James spoke about how necessary it was to pay attention to young children in family therapy as they are often the ones who will reveal tensions concealed by the rest of the family. James felt that young children had good cause to question whether or not they wanted to be in the world as there were so many horrific things happening such as domestic violence, sexual and physical abuse. He spoke about the denigration of children and the lack of sensitivity to their awareness of what is happening in and around them. He was surprised how few people killed themselves relative to the appalling experiences they endure. He felt that the understanding of death's permanence was within a young child's grasp. James said he was not a great fan of safeguarding as it breached the trust that was necessary to get the work done and make the child less suicidal. He suggested that if working clinically with a suicidal client that at the end of the session the counsellor should say, 'I don't want you to do it.' James expressed the advice would be the same for young children and adolescents. He spoke about the contempt professionals have for those who attempt suicide and the NHS resources old people are using.

10. Melissa: Counsellor-in-training.
Experience: Under 1 year of working with socially deprived young children. **Age: 25-30** **Ethnicity: White UK** **Interview Duration: 01:05:18**
Melissa spoke about an 8 year-old boy she had been working with for some months. He was during a session he climbed up on a table, stood at its edge, looked out of the window and took the blind chord and, briefly wrapped it around his neck, at which point he turned to Melissa and said he wanted to die. Melissa 'remained calm' and suggested that they should think about what this might mean. In spite of Melissa attempting to return to the S-C on numerous occasions subsequently the child did not refer to it again.

11. Verity. Key Stage 1 Teacher. Class 2.
Experience: 25+ years of working with young children. **Age: 45-50** **Ethnicity: White UK** **Interview Duration: 00:58:09**
Verity spoke of only encountering child S-C more recently. She mentioned not having the time to deal with the S-C in the child several times throughout the interview. She appeared to be in a state of ambivalence as to whether the children really meant what they said. Was it just something they had heard? Were they using it to shock and elicit a response, or was there something profoundly wrong? Verity did not speak to the children directly about their S-

Cs but she did pass on that they had made them to the parent/carer. She spoke about not feeling equipped to respond to such communication, not just from children, but anyone. Verity was also the only participant to talk about death and to suggest that it might be helpful for children to be given a space to talk about death. However talking about death would have to manage belief systems which believed in an afterlife and this might prove sensitive. As the catchment community had low maternal age it was discussed that many of the children had grandparents in their 30s and might encounter death later in life, however, many children had experienced premature death in the extended family and as such death was less attached to a natural process and this might be a further obstacle to broaching the subject.

12. Kate. Safeguarding Lead
Experience: 7 years of working with socially deprived young children. **Age: 30-35** **Ethnicity: Other UK** **Interview Duration: 00:45:20**
Kate spoke of several S-C children and brought with her into the interview a record of all the child S-Cs in the school from 2013-2015 and after interview in July 2017 she shared further records of S-C. There were 23 separate incidents encompassing 21 different children from Year 2 to Year 6 in this period. Only five involved 'suicide gestures' with no accompanying words. As the person in the school with safeguarding responsibility for all the suicide communicating children and all vulnerable children she held an invaluable overview. She spoke of a Year 5 boy who had a serious illness saying he

wanted to kill himself and that no one liked him. The S-C stopped when his mum agreed for him to move schools. She spoke of a Year 6 boy who tied a jumper around his neck, pulled it tight and when a teacher asked him to stop he refused. He also moved schools after a period of homelessness. She also spoke of a Year 3 child with 3 logs of her saying she wanted to kill herself, saying to a teacher not to look for her the next morning as she would not be there. Kate was critical of some staff's handling of children, particularly those who saw S-C children as attention seeking and those who were dismissive of troubled children in general. She was also critical of outside services. She emphasized the importance of knowing, understanding and working with the families. Kate felt that some staff and professionals could not bear to know the realities of some children's lives and the greater receptivity staff had toward bearing to hear what troubled children the more likely they were to bring there troubles to them. She also advocated child development training and support for staff. All the children she brought had troubled home lives, some characterised by parental illness, loss, domestic violence, sexual abuse, prison. Kate was interested in where the distinction lay between self-harm, dangerous behaviours and S-C, drawing attention to several examples one of which was a girl refusing to eat.

13. Edith. Counsellor.
Experience: Three years working with socially deprived young children. **Age: 25-30** **Ethnicity: Dual Heritage** **Interview Duration: 00:43:33**

Edith spoke of one client, a Year 2 girl who was in Kinship Care and had a period of being Looked After. It had been reported to her by a TA that the child had said she wanted to kill herself on a number of occasions. Edith was shocked to hear this as she was so contained in sessions and it made her question her relationship with her and whether or not she was able to bring these thoughts and feelings to her. She also recognised that the child wanted to keep the therapy room as somewhere that she could play and be her age. Further, there was the recognition that if a child said something that was really painful or hard to bear in their session there would be the remainder of that session where the counselor might focus in on it. Edith did not feel the child would be a suicide risk as her life had thrown up so many challenges that she has an ‘inner fight’ and that she sees a future with some measure of hope. Lastly, Edith spoke, briefly about a Year 1 girl who head banged every night and about a Year 6 boy who she only saw for a few sessions but felt a level of threat, violence and danger with. He spoke about no one caring about him and being in a burning building from which he rescued himself. He was a firesetter, played on the train track, went to a gun range, hung out with gangs, had a dominant grandmother and had some contact with a father who had drug problems and had been in prison.

14. Jess. Primary School Based Counsellor
Experience: 10+ years of working with socially deprived young children. **Age: 50-55** **Ethnicity: White UK** **Interview Duration: 00:25:57**

Jess spoke of two-brothers, one who had expressed a suicide-communication verbally and one who had significant self-harming behaviours. Both had experienced difficult home lives and were having to accommodate mother's new partner. There were times during the interview when Jess appeared flippant, as if suffering from 'compassion fatigue' and yet her efforts to try to talk realistically to the children about their lives was searching and her openness about how she was left feeling in relation to the work. She spoke about how 'horrible' the work was and the realities of the children's lives. She spoke about a S-C child who wanted her life not his. She spoke about the difference between self-harm and S-C finding that self-harm was more about coping with life and S-C felt like an attack, it was furious, hopeless, without choice. Jess also brought a dream about the challenges of working in counselling and child protection which suggested that whatever way one intervened as a professional in the lives of vulnerable families there was death and the 'shit' continued.

15. May. Key Stage 2 Teacher.

Experience: 25+ years of working with socially deprived young children.

Age: 50-55

Ethnicity: White UK

Interview Duration: 00:33:57

May spoke of a child who threw a rope around a tree in the school field and threatened to hang himself. As there were a number of staff involved May thought this was why nobody logged the incident. She also spoke about a very deprived boy whose grandmother dragged him away from Santa's Grotto

at the School Fair and how she responded by writing him a letter from Santa. May also chose to focus on the non-S-C, depressed, children she was concerned about alongside a child who very clearly made a SC. May had always worked across schools serving socially-deprived catchments and so she had a particular perspective over time. She spoke about the teacher having less one-to-one time with the children and this, in turn, meant they have less time to spend in listening to the child about matters non-curricular. She compared the increasing academic pressures on young children to planting sweetpeas too early and they subsequently die so there appeared to be a life and death anxiety about the fate of the children. May noticed that there were very few 1-2-1 opportunities for teachers to sit with children. Further, she talked about the impact on children's physical health, both the pressure on families to work all hours, but also the 'attendance pressure' coming from schools to bring children in to school irrespective of their health and how family distress can become somatised. May recognised Ofsted were little interested in the pastoral aspects of her work and there was only the avoidance of a major safeguarding situation which operated as a background threat. There was no acknowledgement from Ofsted of the emotional work her day as a teacher brought. She spoke of the pressures of social media and the impact of parental work patterns on family life. May also spoke of how early primary school staff note concerns about children, although there was great variance between teachers, they document these but at the end of the day the resourcing to meet the noticing is not there. She also spoke of employing strategies to enlist support for vulnerable children as having unwelcome side effects, not least exclusion from the mainstream and pathologising struggling

behaviours. She spoke about a light bulb moment when a child who lay on a blind bend, in the middle of a road, and up until this point she had not considered this sort of behaviour as a S-C but now she did.

16. Lucy. Key Stage 1 Teaching Assistant (TA)
Experience: 7 years working with socially deprived children. **Age: 25-30** **Ethnicity: White UK** **Interview Duration: 00:29:06**
Lucy worked with some of the youngest children in the school. She spoke about 5 S-C children in total. Her responses were often 'psycho-educational' in that she would explore the child's understanding of what they had said. With one child when she explained that there was no returning from death the child retracted the S-C. The other child she brought had been to church the previous day and spoke about wanting to go to God and ask him something. Worried that he might piece together that you had to kill yourself to meet God she had a conversation with him about this. She spoke about how troubled the home lives were of the S-C children. She also felt some expressed a S-C for attention. Lucy spoke of one child who she described as being in an, 'altered state' and that his S-C was not relationship-seeking, as in he did not appear to be looking for something from Lucy.

Appendix C

Data Items and Initial Codes

Antonia

Initial Codes

Semantic: Troubled Family Life. Relationship between dangerous behaviour, self-harm and suicide communications. School Moves. Bereavement. Drug Use. Outside agencies who are supposed to help, hindering. The problem of having staff who live in the community carrying 'community culture' into the school. Staff not taking child suicide communication seriously. How to manage feeling states being modeled by parents who struggle to manage their own feeling states (Transgenerational Transmission). The importance of knowing and having a relationship with vulnerable children which allows for containment when they are distressed. Trauma. Loss. The necessity for emotional wellbeing training as part of teacher training. Safeguarding Systems. Distressed child outside of class. Breaking skin. Scraping arm. Anger. Head Banging. Scab Picking. Scratched Face. Link between Homicidality and Suicidality. Clumsy children.

Latent: Absent Fathers. Generational Inversion (Son-Father)/Oedipal Anxieties. Class. Strengths and weaknesses of continuity of relationship and rupture. Belonging. Outside/r/Inside/r. Unconscious. Machine (car/train/ambulance).

Sharon

Initial Codes

Semantic: Poor physical health. Sibling mental ill health. Parental mental health problems. Absent and intermittent fathers. Daughter trying to be what mother wished her to be. Death. Loss. Bereavement. Reunion. Hormonal change/puberty. Aloneness. Parental alcohol use/abuse. Hearing voices. The need for order. Creativity. Stabbing. Being watched. Being left out. Damaged cars. Scary Films. Aggressive, older, male sibling. Anxiety. Working with mother to stabilize child. Friendship issues. Child as Carer for father. Large families. Children as support for mother. Guilt of child whose father completed suicide. Blended Family. Maternal Learning Difficulties. Irregular School Attendance. Interpretation of Play. Ambulance and Police Car. Ghosts. What is known and understood between child and therapist. Sibling suicide attempt. Subsequent disclosures. Social Care involvement. Safeguarding Systems. Splitting. Disruptive Classroom Behaviours. Domestic Abuse. Sexualised Behaviours. Aggression. Manipulation. Friendship issues. Anger. Extremes of mood. ADHD. Medication. Voided child due to ADHD medication. Mixed Race. Angry Father. Dislike of female staff. Mother's dislike of son. Gender. Yearning for mother. Unmanageable child behaviour in the therapy room. Vulnerability. Self-portrait work. Sexual Abuse. Physical Abuse. Parental Separation. Father with a Care Background. Boundary confusion. Inbetween. Future vulnerability. Moving (Schools, family, residence). Hide 'n seek. Sibling disclosure. Academic Intelligence. Physical Disability. Pregnant Mother. Father in jail. Child living with Grandmother. Young parents. Sibling Abuse

Latent: Generational Inversion (Oedipal anxieties). Outsiderliness. Boundary

Bleed. What cannot be spoken of. Taboo of incest. Medicating the son as a way of controlling a violent father by proxy. 'Killing off' of child due to medication to control behaviours which are a response to a threatening environment. Identity issues of Mixed Race children. Space. Isolation, integration. Fusion. Unstable Father. Mother-too close/too far.

Paula

Initial Codes

Semantic: Understanding of death. Afterlife. Reunion. Religion. Culture. Family prohibition around talking about death. Safeguarding Systems. Social Care involvement. Emotional demands of working with suicide communicating children who are grieving. Therapeutic touch. Mourning and the importance of saying goodbye. Bereavement. Pain passing. The importance of talking about loss. Demands of working in schools serving socially deprived catchments. Body boundary and self/other concepts in autistic states. Pregnancy as a defence against working with the realities of some children's lives. Not being missed. Not being noticed

Latent: Absent father. Children as commodities. Continuity of being/rupture. Outsider/Insider dynamics. Identity Fusion/Confusion.

Hayley

Initial Codes

Semantic: Sibling Disability. Troubled family environment. Interpretation of children's play and artwork. Not wanting to go home. Shame. Bruising. Rough Play. Chinese Burns. Blind chords around neck. Skin mark-making activities.

Suicide-gesturing children thought of as too young to know what they are doing. Sharp intake of breath in relation to some of the children's concerning behaviour and then it is forgotten. Loss of maternal attention due to sibling in greater need. Humanistic Head Teacher. Empty vessel. S-C recipient freeze. Filing concerns. Death image. Social Care. Foreboding. Burying. No thought. Screaming. Child refusing to leave therapy room. Lack of containment. Boundary violation. Kicking tables. Going under tables. Autistic child. Outbursts. Frustration. Misunderstanding. Confusion. Death and dying in video games. Early intervention. Mixed Race.

Latent: Confidentiality. Body. Inside/r/Outside/r. Exclusion. Voided. Air. Lack of integrated working between school and counselling service. Unlinking. Transitioning between spaces and places.

Barbara

Initial Codes

Semantic: Inter agency working together or apart. Safeguarding. Parental receipt of child suicide communication. Child suicide communication as a lever for environmental change. Fused relationship between mother and child. The consternation around child suicide communication. The difficulty of maintaining interest in the troubled child without becoming 'immunised' against feeling and concern. Head banging. Scratching arms. Self-tatooing. Hair pulling. Face gouging. Cutting. Wall punching. Gender. Control. Friendship Issues. Drama. Social Care Involvement. Reluctant Mother. Circularity. Confusion. The need to produce physical evidence of distress. Razor blades. Elder sibling disturbance. Rebellion. School Exclusion.

Challenging. Rude. Swearing. Child humiliation of staff. Child bullying staff. Working through. Child blanking staff. Brilliant Teacher. Left Out. Ambivalence. Maternal Disguised Compliance. Gender and receptivity of Safeguarding Lead in school impacting on the safeguarding of the child in relation to boyfriend. Importance of working together. Child as spurned lover when mother entered into a new relationship. Mirroring. Chaos. Good academic performance. Suicide Talk. Sustained child distress and teacher numbing/indifference/fatigue. Discord. Fear. "If you leave me I'll kill myself'. Messy. Dangerous. Risk of rape. Continuity of information sharing between primary and secondary school. 'Wild fire-begins with a spark and grew and grew'. Lack of maternal engagement with services. Staff's struggle to accept self-harm as a term for younger children's behaviours where they hurt themselves. Pregnant Mother. Drawing disturbing images. Child struggle to accept warmth and positivity. Belief in an afterlife. Sibling talking his sister into doing dangerous acts. Integrated school counselling service kept in the loop. Teaching staff wanting to pass over disturbed children to the counselling service rather than wanting to get skilled up themselves. Staff surprise as to how much they can help a struggling child. CAMHS policies not managing to include distressed children whose parent does not take them to appointments. School fear of having outside services coming in and giving children ideas re self-harm. Adults not wanting to hear that little children do not want to be here. Increasing awareness of child distress. Mixed Race. Disturbance in older sibling.

Latent: Generational Inversion (Oedipal). Outside/Inside. Damaged Body. Acting Out/Acting In. Name Amnesia. Aloneness. Mother too near/too far.

Absent Father. Loss. Centre/Edge. Coercive Boyfriend. Suicide as noble.

Tilly

Initial Codes

Semantic: Mismatch between suicide communication and affect. Absent father. Depressed mother. Confidentiality. Difference between how children present in class and what emerges in the therapy room. Positive change in children after having therapy. What children might be exposed to on social media and whether this influences S-C. Maternal suicidality. Struggling older sibling (brother). Sibling school absenteeism. Parental difficulty in sustaining deprivations in response to modifying behaviour in child. Adult safeguarding. Difference between suicide communication in the play and direct suicide communication. Professional confidence that comes with experience. Death. Killing. Violent play. Metaphor. Safeguarding. Sadness. Lack of maternal engagement with services. Sustained exposure to You Tube and videos. Media as a possible source of S-C. Dislocation from siblings. Son in charge of mother.

Latent: Cultural Dislocation. Isolation. Aloneness. Generational Inversion. Young practitioner reliance on supervisor. Learning from experience.

Pearle

Initial Codes

Semantic: Intelligence of S-C children. Intent, child understanding of death? Sad, lonely children. Depression. Aggression. Environmental Contributory Factors. Familial Transmission. Social Dislocation. Gaming and Internet Use.

Perfectionism. Safeguarding Systems. Suicide Responses as behaviour management. Suicide Trajectory. Perfectionism and the intolerability of getting things wrong. Suicide planning and Method. Increase of S-C over the years. ASD.

Latent: Children should not be in control of adults. Suicide communication as a negative behaviour that needs to be managed in an effort to neutralize and prevent it. Attention as reward. Ambivalence. Not rewarding 'negative behaviours' as child S-C is seen as demanding of a response. Relationship with reality. Outsiderliness. Void/Space

Rebecca

Initial Codes

Semantic: Depressed child**.** Child S-C as a way of possibly managing unwanted gender. Child S-C as compliance with maternal will. Child S-C as a product of family disturbance. Transgenerational Disturbance. How adult agendas can shape children. How school safeguarding systems have changed. How child voice is taken more seriously than previously. CAMHS not seeing child S-C as coming within their remit as it is not seen as a mental health problem. Domestic Violence. Paternal Violence. Absent fathers. Other children being scared of S-C children due to outbursts. Long-term physical illness in the family. How influential adults can be in shaping how a child frames and understands their distress. Staff's disbelief that young children might attempt suicide. How a change of gender can be a way of killing off a previous self and life. S-C children struggle with their emotions. Social Care involvement with the families of S-C children. Depression. Child Protection

Plan. Hospital Stay. Criminal Father. Empathic Child. Working with mother. Maternal Guilt. Mother blaming child. Asthma attack. How professionals shut distressed children up. Part-time timetable. Child violent outbursts. Failure to log. Escaping out of windows. Angry child. School Move. Dad with drinking problem. Aggression.

Latent: Outside/inside. Expertise is outside of school. Disappointment in external agencies. Transgender politics.

James

Initial Codes

Semantic: Puberty as a revolution. Existential Crises. The body as a site to express suicide communication. Domestic Violence. Sibling with physical illness. Sexual Abuse. Physical Abuse. Adult's insensitivity toward children and underestimation of their complexity. Recipient responses to the suicidal. Recipients not wanting to hear what the suicidal child has to say due to the labour involved in reporting it. Society's responses to those who completed suicide through history. Depression. Differences between child and adolescent suicide communication. Poorly qualified people working with Looked After children. The impact of poverty and the fear of poverty upon emotional wellbeing. Politics. Maternal ambivalence to sons of fathers who have abused them. Feminism's prohibition on being critical of mother. Class, suicide is not just a working class phenomenon. The covering up of children's distress by adults. Why more do not kill themselves. Children's vulnerability, lack of defence. The unpredictability of suicide. Stepfathers and undertoes of sexual tension. Attachment Theory. Holding one's nerve working with suicidal

clients. Conduct Disorders. Therapist panic when receiving a S-C.

Latent: Social hierarchy and maintenance of the status quo. Class. Competition for resources.

Melissa

Initial Codes

Semantic: Confidentiality. Parental Separation. Absent Fathers. Boundaries. Difficult Family Life. Stepfathers. Gaming. Playing on 18 certificate games. Exploring Child Suicide Communication in a psychotherapy session. Safeguarding Systems. School Moves. Boisterous. Rude. Edges. Therapist Worry. Wanting to Die. Therapist Calm. Thinking and linking. Living with Grandfather. Confidentiality. Numb. Projection. Reporting to Head Teacher. Precocious Child. Family's financial situation.

Latent: Generational Inversion/child-adult. Taking information out of a session. Time.

Verity

Initial Codes

Semantic: Insufficient Time to deal with child suicide communication. Having to gloss over child S-C. Not knowing how to manage child S-C. Child S-C as shock tactic. Children being given choice and struggling with this. Intelligence of S-children. Death. Afterlife. Link between troubled families and child S-C. Absent Fathers. Lack of faith in safeguarding systems. Intent of S-C in children. Pressure of Academic Expectation. What does child S-C mean? Pressure of Social Media. Child S-C as a 'cry for help'. S-C children as

profoundly sad. Children's feeling overriding their capacity to think and learn. Children's problems worsening over time. Not being able to help. Limitation of young children's emotional vocabulary. Learning emotional responses from parents who struggle with their own emotional responses. Change in children being asked about their feelings. PSHE & teaching children about their emotions. Are there more children who might express a S-C but they are unable to articulate it? Children talking to peers about their feelings. Informing parents about child S-C and how they don't know what to do with it. How little death is spoken about in schools and how much children are interested in it. Schools teach sex but not death. Children bringing concerns about S-C peers to teachers. Dealing with negative comments from children about themselves. Sadness. Despair. Not Knowing. Feeling Overwhelmed

Latent: Anxiety. The Titanic as a metaphor for the conscious and unconscious. The Titanic as an exploration of class and how social hierarchy, as metaphor for man vs nature and nature winning, as an exploration of story as fiction and story as fact. What is real and not. Being interviewed by someone who is known to be interested in the unconscious. Time. Distance.

Kate

Initial Codes

Semantic: Psychiatric labels acting against safeguarding vulnerable children. Adversity Load. Self-harm. The difference between S-C children and non-S-C vulnerable children. Staff's handing of child S-C. School Culture either working for or against staff working well with S-C. The relationship between being unsafe near the road, and accident prone children and suicide

communication. Staff being dismissive of children who are suicide communicating. Domestic Violence. Parental separation. Sexual Abuse. The need for child development training for all primary school staff. How multiple involvement in a suicide communication safeguarding incident can get in the way of logging. Giving attention-seeking children the attention they need. How staff become anaesthetized against communications from troubled children. How the traumatised child needs managing in school. The importance of thinking the unthinkable. Working together with other agencies to safeguard children. S-C children being academically able. Transgenerational Trauma. Social Care Involvement. Trauma in the womb. Staff not taking S-C in children seriously. Extremism. Breaking glasses. Anger. CAMHS giving distressed children self-harming techniques that are self-harming. Missing mother. What constitutes self-harm. Labels preventing thinking into children's wellbeing. Top Dog. Fighting. Trying to maintain peer respect. Stabbing. Failing Body. Not being liked by peers. Mum working at school. Moving schools. Bereavement. Loss of Grandparent. School Counselling Service as an integrated part of the school being a valuable resource for S-C children. Society. Prediction of a worsening situation regarding children's distress. Bearing it. Listening.

Latent: PREVENT as an anti-suicide strategy. Absent fathers. Inside/Out. Contaminating Outside.

Edith

Initial Codes

Semantic: Kinship Care. Loss. What the purpose of therapy can be for a distressed child: preservation of a good, safe space. Maternal BPD. Paternal

Mental Health. Religion: conversion to Islam. Stepfather. In utero disturbance. Continuity between uterine environment and post-natal environment. Paternal illicit drug use. Dominant paternal grandmother. Control. If a S-C child does not bring the S-C into therapy does this say something 'bad' about the therapist. Loss. Mother's poor choice of partner. Family's compromised ability to safeguard children. Twins. Pregnant mother. Blended Family. Social Care. Family Breakdown. Sibling Loss. Mother Loss. Fire.

Latent: In and Outside of the Therapy Room**.** Romantic Love placed above maternal love. Transition. Borders. Multiple Loss. Absent Father.

Jess

Initial Codes

Semantic: Dysfunctional Families. Domestic Violence. Absent father. Child having to accommodate mother's new partner. Fury. Theories about suicide, self-harm and the difference between. The experience of working with such sad and damaged young children. Safeguarding Systems. Neglect. Child anxieties about death. How easy it is to overlook the well-behaved S-C child as opposed to the acting out violent child. BPD. Sadness. Social Care. Safeguarding Speel. Crazy. Exhausting. Madhouse. Fear. Anxiety. Children desperate to talk. Young father substitute. Marked difference between behaviours at home and at school. Difference between Self-harm and S-C. Bright child. Elder male sibling violence to younger sibling. Whether to kill or be killed. Reassuring a S-C child that childhood is not forever. Childhood as something to escape from. A small thing snowballing into death. Staff unable to hold the rage of the S-C child. Survival capacity of troubled children. Pain.

Scars. Physical Strength of distressed child.

Latent: Absent Father. Generational Inversion (Oedipal Anxieties). Unconscious responses to working with suicide communicating children. Sibling disturbance. Counselling as frontline child protection. Humour as a defence against painful experience. Dismissive toward safeguarding mechanisms. Familial Transmission of disturbance. Fusion.

May

Initial Codes

Semantic: Education Systems, Safeguarding Systems. What is the point of logging S-C incidents if there isn't the infrastructure in place to respond. Society, Body. Physical Illness. Relationship between dangerous road behaviours and suicide states. Struggling Families. Economic Stress. Neglect. Parental Absence. Depression, Anxiety, Aggression, Exposure to suicide. Social isolation/peer dislocation/exclusion. Understanding of death. Time. Leftover milk. Anger. Volatility. Impulsivity. Connectivity between mental health and physical health. Concerning children who do not draw attention to themselves. Increase in troubled children over the years. Increased awareness of the lives of concerning children. Pressure. Pace and delivery. No flop down time. School as sanctuary. The value of good quality safeguarding training. Indefinable worries about children. Repeated concerns regarding some children shared with the Head Teacher. How school culture shapes relational exchange with children. The impoverishment of external support agencies. Disappearance of the voluntary sector. The difference of a school being an Academy and under Local Authority in terms of making a

decision that has financial implication when supporting a child is now more likely to be delayed until the child is incredibly disruptive. Senior staff governing schools not seeing safeguarding children as a school's job. Social Media.

Latent: Life and Death anxieties about the impact of education upon children. Conflation of time. Generational Inversion (Mother-Grandmother). Distress around working with neglected children. State as neglectful parent. Power and control (Prison Warden-Prisoner Dynamic). Outside/Inside. Corporatisation of Education. Being helpful/wanting to help.

Lucy

Initial Codes

Semantic: Attention Seeking. Afterlife. Understanding of Death. Future Risk. Intelligence of suicide communicating children. Safeguarding Systems. Calming Room. The children who express a S-C might be less vulnerable to subsequent suicide than those who do express a S-C. Instability. Troubled Family Life. Maternal Loss. Absent Fathers. Intent. Maternal Mental Health. Information Sharing. Imaginary Place. Authority. "In touch with how the world works." Love. Survival, "they've got to know their way around to survive, to be sure, to be alert." 'Learning' from behaviours at home. Children who experience turbulent home lives but don't issue S-Cs. "I'll stab myself". Tummy.

Latent: Relationship with reality. Relationship between interior and exterior space. Sticking to task. Exclusion. 'Off the top of my head'. "In the back of my mind'. Gut instinct.

Appendix D

Proposed VALE Inventory

No	VALE INVENTORY	SCORE
1	**Adoption**	
2	**ADHD Diagnosis**	
3	**ASD Diagnosis**	
4	**Bereavement of immediate family member (Recent +R)**	
5	**Birth Trauma**	
6	**Bullying (Perpetrator +P/Victim +V)**	
7	**Child Allegation of Abuse against Carer/Father/Mother**	
8	**Child Aggression**	
9	**Child Attachment Difficulties**	
10	**Child Substance Misuse + School Year Reported**	
11	**Child experience of Domestic Violence**	
12	**Child/Mother experienced Gestational Difficulties**	
13	**Child demonstrates sexualised behaviours**	
14	**Child experience of homophobia**	
15	**Child experience of multiple (>3) House Moves**	
16	**Child experience of sustained Emotional Abuse**	
17	**Child experience of Sustained Neglect**	
18	**Child experience of Physical Abuse**	
19	**Child experience of Racism**	
20	**Child experience of Sexual Abuse/Sexual Exploitation**	

21	**Child experience of (>2) School Moves**	
22	**Child experience of Trauma**	
23	**Child peer dislocation**	
24	**Child Suicide Communication+ Frequency**	
25	**Child inability to express overt anger**	
26	**Child medicated for DSM Diagnosis**	
27	**Child on or has been on Statutory Child Protection**	
28	**Child on or has been on Statutory Child in Need**	
29	**Child with a long-term Physical Health Problem/Disability**	
30	**Depression Diagnosis**	
31	**Community Concerns brought to school's attention**	
32	**Early Significant Rupture**	
33	**Exposure to Adult Criminal Behaviour**	
34	**Family experience of Homelessness**	
35	**Family (Non-parent/sibling) Member Suicide**	
36	**Family member with Long-Term Physical Illness/Disability**	
37	**Gender Consternation**	
38	**High Birth Order**	
39	**Immigration Stress**	
40	**Incubator Experience**	
41	**Loss of residing with Mother/Father/Sibling u16yrs**	
42	**Low Birth Weight (LBW)**	

43	**Low Educational Level**	
44	**Male**	
45	**Maternal Estrangement/Hostillty**	
46	**Maternal Low Educational Attainment Level**	
47	**Maternal Miscarriage History**	
48	**Maternal/Paternal Drug Use (Non-prescription)**	
49	**Maternal/Paternal Drug Use (Psychiatric)**	
50	**Maternal/Paternal/Sibling DSM Diagnosis**	
51	**Maternal/Paternal Problem Alcohol Use**	
52	**Maternal/Paternal/Sibling Suicide**	
53	**Maternal/Paternal/Sibling Suicide Communication**	
54	**Maternal Post-Natal Depression + Medication**	
55	**Maternal Separation Anxiety/Boundary Disturbance**	
56	**ODD Diagnosis**	
57	**Parental Prison Experience**	
58	**Precocious Puberty**	
59	**Prematurity**	
60	**Sexuality Consternation**	
61	**School Exclusion**	
62	**Social Disadvantage**	
63	**Spring Birth Month**	
64	**Trans-Generational Trauma**	
65	**Trauma**	