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Impact upon therapy and the therapist when working with suicidal patients: some transference and countertransference aspects

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ABSTRACT *The suicide, or attempted suicide, of a client/patient is something that a substantial number of counsellors and psychotherapists have encountered during their career. The literature indicates that this can be a cause of anxiety for many. In this paper the experience of psychotherapists working with suicidal patients is explored. One hundred psychotherapists were surveyed, by means of a postal questionnaire. Five follow-up interviews were conducted. The findings indicate that suicidal patients can evoke intense feelings within the therapist, and the meanings of this are discussed. The links with the concept of projective identification are particularly considered. It is noted how such feelings, experienced within the transference relationship and the therapist's own countertransference, can reflect the inner world of the patient concerned. The psychotherapists described how they felt themselves to have been affected by the work, both personally and professionally. Commonly mentioned responses included feelings of hopelessness and helplessness and a sense of failure. Finally, the respondents outlined measures that they believed to be vital for their own support. The importance of firm boundaries and staying in the therapeutic role is discussed.*

Introduction

This paper describes some of the effects upon the therapeutic process and upon the person of the counsellor or psychotherapist when working with patients [1] who commit or attempt suicide. These issues emerged as part of a study designed to explore the personal meanings of suicide. Some results relating to the patients' relationships in early life have already been published (Richards, 1999). There I described the themes of rejection, invasion and engulfment that became apparent in terms of these relationships, and links with an experience of abandonment were explored. It was found that incidents involving loss or rejection in a patient's present life could tend to re-activate these earlier internalised relationships. Also, feelings of worthlessness and intense rage were perceived to be very common amongst this group of patients.

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In this second paper from the study, I would like to focus upon the way in which these various aspects of the patients' experience were observed by the therapists in the transference relationship and in their own countertransference responses. I have taken an object relations model of human development and behaviour to underpin what is described here.

The essential concept in object relations theory is that the self and the object (other) are internalised in interaction with one another (Kernberg, 1988). This means that within the client there is a self-representation and an object representation, and an interaction between the two. The therapeutic relationship can be thought of as a stage upon which the dynamics of the patient's early relationships are once more acted out with another person. In this relationship the client brings pressure to bear on the therapist, sometimes very subtly, and sometimes with great force, to get the therapist to actually act out in accordance with either or both of these roles. Sandler (1988) refers to this as 'actualisation', whilst Joseph (1988) talks about the client unconsciously attempting to 'nudge' the counsellor into acting in a manner consistent with the client's projection. Bion (1955) describes it in this way: 'The analyst feels he is being manipulated so as to be playing a part, no matter how difficult to recognise, in somebody else's phantasy' (p. 446).

For some patients, because of their state of mind, there is an unconscious proclivity to rely heavily upon this method of validating their internal perceptions of the world. In this connection, the concept of projective identification may be helpful to our understanding of what takes place (Taiminen, 1992). Klein (1946) first introduced the term and believed it to be a mechanism of defence that operates from the earliest period of life. She understood it as being primarily to do with pressing unwanted feelings, sensations and associated parts out of the self and into the external object, primarily the mother. The idea of projective identification has since been developed and extended (Bion, 1967; Sandler, 1988). It is now also thought to be a means by which, unconsciously, some patients attempt to communicate their feelings and experiences to another person. In this way they may actually make the other feel and know what it is like inside their inner world. To some extent everyone will unconsciously employ this mechanism at times. However, suicidal patients are amongst those who rely heavily upon projective identification (Malin & Grotstein, 1966) both as a defence and as a means of communication. Thus they are able to arouse very intense emotions within their counsellor or therapist (Maltsberger, 1984–85). The therapist can, in this way, become a receptacle for the difficult feelings which are a part of the patient's inner world (Modestin, 1987). It is the effects upon the therapist of being on the receiving end of the patient's projections which are the focus for this paper.

The suicide of a patient is something that has been experienced by a substantial number of counsellors and therapists during their career. Menninger (1990, 1991) surveyed 88 practising psychotherapists about the causes of their anxiety. He discovered that the most cited reason was patient suicide. Menninger reported that a patient's suicide is most often experienced as a therapeutic failure, and it invariably has a profound impact on the therapist. The themes that therapists most commonly cited in describing their reactions were shock, sadness, anger, a sense of guilt,

anxiety and doubt about competence. Of the 41 therapists in the study who had experienced a patient suicide, 90% reported that they had dealt with the situation by discussing the matter with colleagues. Two-thirds of the therapists acknowledged that they had changed the way they practised as a result of the experience. One participant noted:

> 'I no longer expect myself to be able to know everything, to save everybody. My "narcissism" was bruised but made more realistic. I think, as a result, I do not convey omnipotence to my patients and they less intensely expect it of me.'

Other responses included: 'Expect to feel depressed, guilty, and angry'; 'Talk, feel, talk and don't blame yourself', and 'When suicidal patients have difficult times, stay as connected with them as possible'.

Chemtob *et al.* (1988) conducted a similar study examining the frequency and impact of patients' suicides on psychiatrists. A random sample of 643 psychiatrists from all over the USA was sent a postal questionnaire. This yielded a 46% response rate. The researchers surmise that this low rate may reflect some defensiveness amongst psychiatrists regarding the topic of patients' suicides. Of the 259 participants, 51% reported having had a patient who committed suicide. Psychiatrists reported feeling anger and guilt, experiencing loss of self-esteem, and having intrusive thoughts about the suicide. On an Impact of Event Scale, recalling their reactions in the weeks after a patient's suicide, 57% of participants had intrusion and avoidance scores which reflected levels of stress similar to those obtained in studies of individuals who had experienced the recent death of a parent (Horowitz *et al.*, 1979). Other studies have also concluded that professional helpers who are confronted with a patient's suicide often display the same emotional reactions and have to go through the same process of coming to terms with it as other relations (Little, 1992; Moritz *et al.*, 1989). Chemtob *et al.* (1988) discovered no relationship between the number of years a participant had practised and the probability that he or she would have had a patient who committed suicide. However, there was a negative relationship between years of practice and the impact of suicide. More years of practice at the time of a suicide were associated with smaller reactions in the areas of guilt, social withdrawal, loss of self-esteem and disruption of relationship with friends. Psychiatrists in this study also reported an increased use of collegial and peer consultation following the suicide of a patient. Chemtob *et al.* conclude that: 'An overriding impression derived from the survey is that a patient's suicide is not a rare event for psychiatrists. In fact, it can be considered a very real occupational hazard for psychiatrists involved in direct patient care' (p. 226).

It could be considered that counsellors might not, on the whole, have such a large number of very disturbed clients amongst their caseload as psychiatrists. However, I recently facilitated a workshop on suicide at a counselling conference, and a large number of delegates attended. When I asked around the group why they had chosen this particular workshop, they nearly all declared that they were there because they were either counselling a client who was threatening suicide or they were supervising a counsellor involved in such work.

Wolk-Wasserman (1987) interviewed 40 suicide attempt patients, members of their families and their therapists. He observed that patients were often aggressive and negative or ambivalent towards their treatment as a defence against a possible separation from the therapist and in order to avoid feeling hurt or rejected. Holidays or other interruptions in therapy were particularly problematic. According to Wolk-Wasserman, it emerged from the material that termination, or threatened termination, of therapy may have been one of the factors precipitating a new suicidal action in seven cases. The therapist was often confronted by the aggressive, provocative and demanding side of the patient. Their primitive defence mechanisms, such as denial of reality, idealisation, disparagement and projective identification were hard for the therapist to take. Wolk-Wasserman believes that in some of the patients studied, the suicide attempt clearly expressed aggression towards the therapist. Repeated threats of suicide could provoke fear or anger in the therapist, since such an action involved a failure in his or her work (p. 76).

Modestin (1987) concludes that patients with a higher suicidal risk generate more anxiety and more feelings of anger. Due to the suicidal patient's ability to project strong emotional feelings, he or she is particularly prone to provoke countertransference reactions within the therapist. The concept of countertransference refers to specific, emotional and at least to some extent, unconscious response of therapist to patient. If the therapist is able to take note and make sense of such responses, the countertransference can be a great aid in understanding the patient (Heimann, 1950). However, if it remains unrecognised and becomes acted out, for example, in angry retaliation, it is therapeutically undesirable and even dangerous. Modestin (1987) asserts: 'To minimise the danger of the occurrence of dangerous countertransference responses in the treatment of suicidal patients, periodical review of the treatment with a colleague and limitation of the number of seriously suicidal patients to be treated at the same time, have been recommended' (p. 384). Recognising the likelihood that the patient will evoke intense feelings will prepare and enable the therapist to take appropriate steps to support self and the patient.

Method

This investigation is a part of a larger study into suicide and internalised relationships (Richards, 1999).

The sample group consisted of 100 psychotherapists of a psychodynamic or psychoanalytic orientation. It was a stratified random sample, drawn from the UKCP National Register of Psychotherapists.

The first stage of the enquiry was conducted by means of a postal questionnaire. This was specifically designed for the purpose of the study. The items for the questionnaire emerged from the reading of the existing literature and were divided into four sections. Part 1 asked for biographical details about the psychotherapist, including how long they had been in practice; part 2 for biographical details about one suicidal patient with whom the psychotherapist had worked; part 3 for details about the patient's relationships with significant people in their lives; and part 4

asked for details about the patient–therapist relationship. It is the results obtained from this final part of the questionnaire that I report on in this paper. I shall therefore describe part 4 in more detail.

All of the questions in this section were semi-open-ended and left the participants free to describe these matters in their own words.

First, the psychotherapists were asked whether they considered the patient was able to make use of their link or connection to the therapist. They were next asked about the nature of the transference relationship with their patient. The next question asked what effect the patient's suicidal behaviour had upon the therapist. They were then asked to describe what support was available for themselves. The final question asked whether there were things that the therapist had learned from their experience that may be helpful to others.

At the end of the questionnaire, the therapists were asked whether they would be willing to participate in a follow-up interview. Five interviewees were selected. Two of these had worked with patients who had committed suicide and three had patients who had attempted suicide. The interviews were semi-open-ended. They lasted for approximately 50 minutes and, with the permission of the interviewees, were tape-recorded in order to assist the analysis of the qualitative data that ensued. A series of prompt questions was used for the interview. Two of these questions particularly addressed, in more depth, the nature of the transference relationship with the patient, and also, what the experience of working with a suicidal person was like for the therapist.

The data produced in response to the semi-open-ended questions within the questionnaire and the interviews were subjected to content analysis. This allowed for themes to be identified and grouped together. Quotations drawn from the data are presented as illustrations of the issues under discussion.

Results and discussion

A total of 58 of the 100 questionnaires were returned. Of this number, 35 (60.3%) psychotherapists had worked with a suicidal patient. Six (10.3%) participants reported having had a patient who committed suicide, and a further 29 (50%) reported having worked with a patient who had attempted suicide, either prior to or whilst in therapy. (This number includes two therapists whose patients did not attempt suicide but, throughout therapy, continually threatened it.)

All 35 of the participants answered the questions with regard to the nature of the transference relationship with their patient. The majority was also willing to share their experience in terms of what the effect had been upon themselves and what they had found to be helpful and supportive in this situation. I also found all five of the interviewees to be extremely open and willing to discuss these aspects.

The data collected in this section of the study revealed that the themes which emerged with reference to the patients' early relationships (Richards, 1999) also appeared in the transference relationship.

Attacks on the therapy: some transference aspects

Transference can be defined as a process within which a person's previous experiences, unconscious wishes, expectations and feelings regarding early significant objects are repeated and played out inappropriately towards a person in the present. They are inappropriate in that these old responses do not fit or belong to the new person or situation. Transference is particularly notable in the therapeutic relationship and, in the psychoanalytic tradition, it is utilised as a most important therapy tool (Sandler *et al.*, 1973).

In taking note of the feelings and behaviour that are brought into the therapy relationship in this way, the therapist has an opportunity to help the patient to work through difficult aspects which, in all probability, they have not had an opportunity to do previously.

Six (17%) of the participants spoke specifically of the way in which their patients had been able to make use of the therapist and the therapy process in order to contain and process their destructive feelings. Eleven therapists (31%) observed that the patient had developed considerable dependence within the therapeutic relationship, and seven (20%) described the patient's need and longing to be loved and valued. However, it was striking that many of these patients were described as also having a fear and a hatred of the dependent relationship upon the therapist. They could only perceive it as ending in abandonment, either in the form of rejection or engulfment. This reflected the way that many of the patients had been described as feeling in relationship to significant figures early in life.

Several participants described the ambivalence which they experienced in their patients:

> 'At the time of the suicide attempt the transference to me was almost wholly negative, e.g. feelings that her dependence on me could only lead to more pain, rejection and abuse.'

> 'She continues to try to abandon/leave me as a defence against dependency ... Lack of trust. Negative feelings, i.e. contempt (well hidden), envy, rage, which block the development of trust. Some positive feelings but withdraws when these are felt. Always trying to cope on her own.'

> 'He could experience me as the loving mother at times. Mostly it was the invasive mother or the indifferent one he found in me.'

Again, although 32 participants (91%) said that, to a greater or lesser degree, they did consider that their patient had been able to make use of the link or connection to them, nine of these (26%) described their patient also as attacking the therapy and attempting to sabotage the process. Some patients attempted to avoid reality in the therapeutic relationship by splitting and first of all idealising and then disparaging the therapy and the therapist. One interviewee said:

> 'Any influence I was having, or any closeness that I was getting to the transference, she would run away from. She would undermine by going to the pub first, coming in smelling of drink, arriving late. It felt like an attack

> on me really, always negating. And yet she'd always come. I just felt very angry that she didn't give me a chance.'

The results indicate that patients displayed both a desperate need and yet, at the same time, were very frightened by the closeness of the therapy relationship. This sometimes meant that patients attempted to destroy the therapy as well as showing signs of wanting it. The therapists tended to believe that the closeness with them simply felt too dangerous to these patients. One interviewee gave her impression of the patient's experience:

> 'There is this incredibly intrusive "witch mother" internal figure that I think makes any kind of intimacy really very frightening. So when we're trying to make a therapeutic alliance, I think it's all too terrifying. She risks being completely overwhelmed by this "witch mother".'

It seemed that the prospect of facing this inner threat and pain of annihilation was so terrifying for some patients that they could only find ways of avoiding it.

Two interviewees explained:

> 'She was always looking for escapes, something just to dull the pain, drink usually, and not survive it to the other side … She had an obsession with death and she wasn't eating.'

> 'She'll be very polite and listen to my interpretations and then go off down to the slot machine. And *that's* the relationship because she has an illusion of intercourse, an intimate experience with this machine.'

Some of the therapists felt the suicide attempt contained an aggressive message from the patient to them. One participant said:

> 'The way the attempt was announced to me was sadistic.'

Three of the participants had the news of their patients' suicides broken to them quite a while after therapy had ended. In one instance a close relative of the patient telephoned to say that he thought the therapist would want to know of the death and he wanted to express the family's gratitude for what the therapist had tried to do. The relative attributed blame towards the GP who was perceived as not having done what he should have. In the second case the parent attempted, much more directly, to project the blame on to the therapist. The therapist described the mother's voice on the telephone as harsh and accusing:

> 'Her mother said, "I thought you may like to know that (name) killed herself". And the implication was that I had failed her.'

This therapist certainly felt that the angry attack which the patient had made upon everyone by her suicide was clearly being passed on to her, even though at the time of the death she had not been seeing the patient for a very long time. The third participant said of the experience:

> 'I felt some feelings of lack of surprise, also countertransference feelings that it was a further attack on me.'

The data produced here were consistent with that from the study carried out by Wolk-Wasserman (1987). However, Wolk-Wasserman only discusses the patient's aggression towards the therapist in terms of wishing to avoid feeling rejection and separation. In the present study I believe that the participants are describing an emergence, in the transference relationship, of specific and explicit fears that are particular to the inner world of each patient.

Sometimes it may seem as if there is no escape from the painful and conflicting feelings, and most likely no way of communicating what these feelings are like, apart from destroying the self.

Attacks on the therapy: some countertransference aspects

Countertransference comprises the therapist's emotional response to the patient, both conscious and unconscious. As with transference, it can represent one of the most important tools for the therapist's work, providing insight into the patient's inner world. Countertransference has been described as one of the most powerful ways in which a patient's communications can impact upon the therapist (Heimann, 1950).

One participant described her own feelings during the time that she worked with her patient:

> 'I felt at times completely useless, hopeless as a therapist and a human being, always doing and saying the wrong thing. I also had strong feelings of her dependence and panic at the degree of it. Sometimes the feelings were acknowledged by her to be hers, at other times I carried them all.'

It is vital, however, that the therapist is aware of his or her countertransference reactions. If he or she is not, then these may become acted out and be destructive to the therapy. Maltsberger & Buie (1989) have described how different components of countertransference hate, particularly malice and aversion, may even play a part in promoting a suicidal outcome. They comment that countertransference struggles frequently repeat a significant part of the childhood of patients who later become suicide prone. They describe an example of a patient who had engaged in such a struggle with his therapist:

> 'In retrospect it seemed that the patient had needed to provoke a rejection from the therapist. Once satisfied that no one really understood or cared he could turn away from other people and destroy himself' (p. 286).

In this way the patient externally confirms his or her internal perception of how the world is.

The present study revealed various ways in which patients attempted to provoke or prod the therapist into acting upon their countertransference feelings. Several participants reported feeling angry or furious with the patient, even to the point of

considering whether to continue working with that patient. Other reactions included frustration and contempt. Some participants said that they felt helpless and wondered if the patient would be better off working with someone else. For example:

> 'She makes everybody feel helpless, totally … The GP and the psychiatrist have given up on her. I do feel a sense of despair sometimes. Do I say to her, "I can't help you, you'd better go and find somebody who can"? But again I think that's something to do with her despair, that's how she wants to make me feel, that's what it's like for her.'

Another reaction was to want to intrude upon the patient:

> 'I found myself pleading with her to have something to eat, some sustenance.'

> 'She makes me want to become invasive and overpowering. I think, "Right, give me your money. I'll keep all your money and give you pocket money and then we'll get you sorted out." I feel terrifically tempted to do this.'

One participant recounted being aware of countertransference in the wish to attack like the abusive parental object. Another interviewee described being overwhelmed by tiredness in the sessions with a suicidal patient:

> 'I have on occasions really thought I would fall off my chair with wanting to go to sleep, it's been so powerful. I'm convinced that it's something to do with the countertransference, it's something she's doing to me, she doesn't want me to be there or something. There's something mind numbing about what's going on, she's just wiping me out.'

The data demonstrate that it was a common experience for the therapists not only to be confronted with a high degree of despair, anxiety and aggression but also to find themselves invaded by such feelings. The patients could be both extremely demanding and disparaging. In the transference the patients would frequently attempt to make the therapist act in a way that accorded with their inner perception of self and other in relationship.

Under such pressure from the patient it is difficult, and yet vital, for the therapist to stay in touch with, and aware of, countertransference feelings and what this means in terms of the patient's experience. Otherwise there is a danger of being propelled into rejecting the patient, and perhaps prematurely ending the therapy, or inappropriately taking over responsibility for them.

The effect on the psychotherapist

The questionnaire enquired of the participants as to the effect upon themselves of the patient's suicidal behaviour. Most of the participants for whom this was relevant were prepared to share their experience. The themes that therapists most commonly mentioned in describing their reactions were: a lack of surprise; feelings of hopelessness and helplessness; a sense of failure; feeling upset, distressed and sad; anxiety in

the weeks that followed and increased concern about the patient's self-destructiveness. One participant explained:

> 'I experienced something of his desperation and feelings of helplessness and hopelessness.'

Another stated:

> 'I was extremely upset. I felt we had faced the anger and worked it through. In the last session she was much more relaxed and talking about the future.'

Several therapists felt angry with the patient and also angry with the referring psychiatrist or the psychiatric system. For many participants it had a profound personal effect causing self-doubt and a loss of confidence. For example:

> 'He presented with strong contempt for self, for other helpers, for psychiatry and for me. I probably would have felt some of his contempt.'

> 'I was initially angry with him, then sad. In subsequent months I experienced a loss of confidence as a therapist.'

Thirty per cent of these psychotherapists have been practising for over 15 years and a further 30% for 11–15 years. Some of them are recalling events that occurred quite a while ago and yet their descriptions reveal that the feelings, memories and effects have stayed with them and are still very vivid.

Responses also indicate that the impact upon psychotherapists was not restricted only to those whose patient had died, or even to those whose patient had attempted to take their life whilst actually in therapy.

The participants were asked what support had been available for them as therapists at the time of the patient's suicide or attempted suicide. They were encouraged to describe this support in their own words and therefore were free to include whatever and as many factors as they wished. Many of respondents referred to having support systems that included several different aspects. Fifteen therapists had personal clinical supervision; 11 had peer group support or supervision; five had team/colleague support; three mentioned support from the patient's GP and consultant psychiatrist, and three referred to their own therapy. The importance of back-up from the institution for which one is working was also mentioned. Two therapists reported that they had no support at all.

The final question enquired as to whether the psychotherapists believed there was anything that had come out of their experience that would be helpful to others. Again, most participants were willing to share from their own observations and understanding. Ten participants asserted that good supervision and support are essential in this kind of work. Nine therapists emphasised the need to work within a multidisciplinary team and for co-operation with other relevant professionals.

Several therapists stated their belief that it is preferable to see patients who have a tendency to put feelings into action rather than being able to talk about these, in the way of the suicidal patient, in an institutional setting rather than private practice.

This was seen as offering a more secure, containing environment for the patient and the therapist. Linked with this, the view was expressed that there are dangers for both parties if a therapist works with suicidal patients whilst still inexperienced.

Six participants felt that therapists should never duck the issue of suicidal feelings or threats and should always take them seriously, discussing them fully with the patient. Linked with this, three people particularly mentioned the need to work through and understand with patients their own destructiveness, and one person talked about the importance of understanding the specific internal meaning of the suicidal act to the patient.

Five people talked about the importance of holding the boundaries firm and containing the demands and pressures to come out of role. One person commented upon the importance of this for the therapist as well as for the patient:

> 'Containment and structure feels very important to one's own identity and to enable one to deal with very strong projections of the patient's persecutory internal world into one's own.'

Five therapists pointed out that it is important to keep things in perspective. They felt it necessary to accept that, in spite of all best efforts, suicide is a possibility. As one participant put it:

> 'Therapists must really believe that they are not omnipotent.'

Other learning points included the importance of the following:

> 'Keep good records, maybe involved with police and coroner.'
>
> 'Genuine listening, patience and loving support.'
>
> 'The most important thing is that you have to care, this contains the bad objects in an internal way, which vital interpretation alone cannot.'
>
> 'Suicide is often a temporary state of mind which, if contained, can be helped to shift.'
>
> 'Expect there to be longer term effects on the therapist.'
>
> 'Don't keep it to yourself.'

The effects upon therapists shown in the present study are comparable with those discovered by Menninger (1991). The data here support his conclusions that this is not by any means an unusual occurrence in the practice of psychotherapy and that practitioners can expect to be affected by the experience both professionally and personally.

One of the interviewees in the present study summed it up in this way:

> 'This is the month when it took place and I always remember the anniversary of it and this is 15 years ago. As you can tell I'm talking about it as if it happened very recently, the details don't need much dredging up. I think to be involved in something to that degree and then for something like this to happen, to me it's an indelible thing. I don't mean to say that I suffer

from it now but I don't forget her. Because I think that everybody, family or therapist, whoever, has to mourn that sort of death.'

Conclusion

The results of the present study indicate that it would be helpful for counsellors and psychotherapists to anticipate the likely effects upon themselves of working with a suicidal patient. The tendency to suicide indicates that such a person may be someone who will find it difficult to talk to the therapist about their distressing feelings and could be likely, unconsciously, to rely on projective mechanisms to communicate these. Respondents reported feeling pressured, within the transference, to take on roles that confirmed the patient's inner perception of others, particularly as rejecting or overwhelming. Some therapists also felt themselves, at times, to be a receptacle for the patient's unbearable feelings.

In the therapeutic relationship, suicidal patients were often felt to desire closeness and yet to be frightened of it. Many of the therapists experienced their patients as attacking them and the therapy in a variety of ways. These aspects were understood as revealing, in the transference, something of the patient's inner world and the relationships that exist within it.

The importance of being aware of countertransference responses was noted. When such feelings were recognised and understood, they were found to be a source of insight into the patient's experience. It was considered that the impulse to act out of the countertransference feelings, including shifting the boundaries of the therapeutic relationship, was to be avoided. There was some evidence that if this takes place it can be damaging to the therapy.

Several therapists pointed out the dangers of working with suicidal patients whilst still inexperienced or in isolation. Ideally, it would be best that an experienced assessor carries out an initial interview. This is not always possible, and the dangers cannot always be picked up in a brief assessment. However, the results here provide an argument for attempting to implement such a system.

Great value was placed upon support, supervision and on working in co-operation with other professionals. Some therapists felt it preferable to work with such patients within an institutional setting rather than in private practice. Firm boundaries were understood to be crucial for the well-being of the patient and the therapist.

The present study has demonstrated how therapeutic work with patients who tend to act out their distress in self-destructive ways is demanding in the extreme. Most therapists had been affected personally and professionally. Consideration of the demands of such work may hopefully enable the counsellor or psychotherapist to prepare themselves and to make provision for adequate support whilst engaged in this exacting task.

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Notes

[1] In this paper the word 'patient' will be used to refer to those receiving psychotherapy. It reflects the fact that the respondents in the study are psychotherapists of a psychoanalytic orientation.

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