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Attachment and the Body in Suicidal Adolescents: A Pilot Study

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ABSTRACT

There is a relative dearth of studies in the field of adolescent attachment despite the potential impact of such developmental changes on the organization of attachment systems. This omission is even more acute among clinical populations, although adolescence is notable for dramatic increases in specific psychopathologies, e.g. eating disorders, delinquency, and suicide and self-harm. This article attempts to address the shortfall using a mixed quantitative/qualitative research design. First, it examines the association between attachment styles and suicidality by comparing two groups of adolescent participants attending a psychotherapy clinic. Second, it explores the phenomenology of different presentations of suicidality in adolescence from a psychodynamically informed attachment theory perspective. The clinical and research implications from these findings are discussed.

KEYWORDS

adolescents, attachment, body, psychotherapy, suicide

THERE IS A relative dearth of studies in the field of adolescent attachment despite the potential impact of such developmental changes on the organization of attachment systems (Scott-Brown & Wright, 2001). To quote an authoritative summary

In some ways we know a great deal about attachment in adolescence, yet in other respects we know disconcertingly little. As at other stages of development, attachment strategies of adolescents are related to numerous aspects of psychosocial functioning . . . attempts to assess attachment in adolescence inevitably must confront the question of what attachment becomes and what function it serves during this stage of the lifespan. (Allen & Land, 1999)

A review of recent studies suggests that researchers are beginning to build up some details of adolescent attachment characteristics from different aspects of a biopsychosocial model of development. For example, Jacobsen, Edelstein, and Hofmann (1994) found evidence of a relationship between attachment and cognitive functioning at adolescence on Piagetian tasks assessing both concrete and formal operational reasoning. Those with insecure-disorganized attachments were disadvantaged on deductive reasoning, whereas those with a secure attachment had the most cognitively mature approach to the tasks. Findings such as these support the view that young people's affective states exert a strong influence on their ability and willingness to explore and acquire knowledge about their environment. Similarly, the contribution of attachment to social development in adolescence is based on the quality of current parental relationships. As opposed to 'classic' views of adolescent-parent struggles over independence, Bowlby (1973) argued for the importance of parent-adolescent attachment for the growth of the sense of self-reliance and social competence. Attachment to parents during adolescence thus differs from earlier ages because it emphasizes emotional autonomy while maximizing levels of support (Schneider & Younger, 1996). Research using different measures of attachment quality has supported this view (Batgos & Leadbeater, 1994; Resnick, 1991). Finally, biological maturation is also a hallmark of reorganizing adolescent attachments, adding reproduction and sexuality to the attachment equation. During adolescence the process of clarifying 'who am I in relation to you' is focused on how to combine sexual needs with safety needs, both within the individual and interpersonally (Crittenden, 1997; Kobak & Duemmler, 1994).

While evidence is accumulating to support the link between security of attachment and psychosocial functioning, research clinicians have also turned to examining the clinical implications of such findings. There is, however, a lack of studies in this area, although adolescence is notable for dramatic increases in specific psychopathologies, e.g. eating disorders, delinquency, suicide and self-harm. Scott Brown and Wright (2001) in summarizing some notable exceptions in recent studies note that attachment patterns link to psychopathology during adolescence in ways that parallel earlier developmental periods, such as characteristic affect regulation strategies. Specifically, the authors found empirical evidence for hyperactivating and deactivating strategies of affect regulation linked to attachment classifications during adolescence (Scott Brown & Wright, 2003). This concept is derived from Kobak, Cole, Ferenz-Gillies, Fleming, and Gamble's (1993) 'control theory', which explains specific links between the

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development of 'secondary' attachment strategies in the light of perceived insensitive or unavailable primary caregiving. Broadly speaking, if the attachment figure is experienced as rejecting or threatening, a deactivating strategy may be employed, diverting attention from attachment cues and thus minimizing distress (Cole-Detke & Kobak, 1996). This strategy typifies the avoidant attachment pattern and contrasts with a 'hyperactivating' strategy, which functions to maximize contact and increase consistency. It involves focusing excessively on attachment-related information and exaggerating distress cues, both of which typify ambivalent attachment patterns. Thus, according to the theory, symptoms reflect the individual's attempts to process and regulate aspects of their attachments.

Deliberate self-harm (DSH) and suicide by young people is an area that requires more research in order to effectively direct treatment and resources (Crouch & Wright, 2004). Recent interest and concern has led to the establishment of the National Inquiry into Young People and Self-harm. Evidence to this Inquiry already shows that the prevalence of self-harm is high – approximately 1 in 10 young people self-harm – and more than 24,000 young people are admitted to hospital each year after deliberately harming themselves (McLoughlin, 2004). This level of involvement in DSH is similar to earlier reporting. For example, a national British survey of 16–24-year-olds revealed that, in the week before responding, 3.8% of young men and 6.8% of young women said that they had deliberately harmed themselves without suicidal intent (Meltzer, Harrington, Goodman, & Jenkins, 2001). Self-harm is also an important indicator of the increasing mental health difficulties faced by young people today (Hagell, 2004).

Research into self-harm is directly relevant to suicide prevention, because the risk of suicide following self-harm is considerable. Hawton, Zahl, and Weatherall (2003) point out that 40–50% of people who die by suicide have a previous history of self-harm. Raising the profile of such issues has led to the realization that the relationship between incidence, risk factors and reasons for self-harm and suicide is extremely complex and varied (National Institute for Health and Clinical Excellence [NICE], 2004). It remains an extremely difficult task for the clinician, faced with a potentially self-harming or suicidal young person, to assess the presence and level of risks for the individual.¹

Few studies have examined the potential links between self-harm, suicide and attachment status, although depression during adolescence has been linked to maternal attachment insecurity (Hofmann, 1997; cited in Allen & Land, 1999). Furthermore, Adam, Sheldon-Keller, and West (1996) found that adolescents who reported high levels of suicidality were significantly more likely to be preoccupied and unresolved in their attachment status. Taken together, these findings suggest a potentially important link between hopelessness in adolescence, specific attachment organizations and risk of suicide.

From a psychodynamic perspective it has been postulated that suicidal behaviour arises through a split between mind and body (Campbell & Hale, 1991). The body becomes the location of, or is identified with, aspects of internal relationships, and a life-or-death struggle can result. Aspects of the self (or other) identified with the body are attacked or felt to be dispensable (Laufer & Laufer, 1984; Perret-Catipovic & Ladame, 1998). Understanding body and sexual puberty transformations and their impact on perceptions of self and others may be a potentially useful link for understanding the increase in self-harm and suicide during adolescence. For instance, attachments may become entangled with and psychodynamized by bodily issues around the assimilation or appropriation of meaning around puberty, the ownership of the sexual adult body, and the differentiation of own needs from significant caregivers (Briggs, 2002). Thus the adolescent's potentially conflictual relationship with the body in the context of

reorganizing affiliative attachment relationships and the transformations of puberty are theorized as having a central role in suicidality.

Clinically, it seems to the authors that adolescents at risk of suicide often seem to defy simple models of categorization. Some are painfully depressed, bothered about their depression and desperate to communicate about emotions, whereas others seem to find this very goal their greatest difficulty. Some adolescents seem to present as extremely preoccupied with ideas about death and dying, instilling in the worker an anxiety often focused around times of separations such as ends of sessions or routine holiday breaks. In contrast, other adolescents appear to show no sign of depression, but rather act impulsively often to the surprise of those in contact with them. It appears these young people are unaware of violent or depressive feelings and the creation of an under-reaction in the therapist is a danger.

In summary, it is with a combination of both these research and clinical experiences in mind that the current authors embarked on an exploration of the clinical utility of an attachment framework for understanding suicidal phenomena in adolescence with two broad aims. First, we examine the association between attachment styles and suicidality by comparing two groups of adolescent participants undergoing assessment for psychotherapy. Second, we explore the phenomenology of different presentations of suicidality in adolescence from a psychodynamically informed attachment theory perspective.

Method

Participants

Thirty-five adolescents (23 female, 12 male), aged between 15–20 years participated in the study on a voluntary basis. Twenty-five were recruited from a clinical population undergoing assessment for, or recently engaged in, weekly psychotherapy. These participants were divided into two groups – high-suicidal risk (HSR) and low-suicidal risk (LSR) – using the Pfeffer Child Suicide Scale (Pfeffer, 1986) by a rater blind to the study using full clinical case notes. This method has previously established reliability and validity (Pfeffer et al., 1993). A score of 3 and above was used to identify the HSR group. A third control group was used for comparative purposes, drawn from a previous study (Scott Brown & Wright, 2003) that was recruited from local schools and colleges. Results are listed in Table 1.

Measures

The Adolescent Separation Anxiety Interview The Adolescent Separation Anxiety Interview (ASAI) is an adaptation of the Separation Anxiety Test (SAT), a semi-projective measure of attachment that assesses young people's responses to photographs depicting separation scenes (Richard, Fonagy, Smith, Wright, & Binney, 1998). There is growing evidence for the reliability and validity of the SAT as a measure of attachment security

Table 1. Age and gender across the three comparison groups

	Average age (years)	Male	Female
HSR	16.9	4	6
LSR	17.5	5	10
Control	17.1	3	7

HSR, high-suicidal risk; LSR, low-suicidal risk.

in both clinical and non-clinical groups of children and adolescents (Scott Brown & Wright, 2003). The ASAI is an adaptation of the SAT specifically for use with adolescents, in that it uses photographs that depict more age-appropriate separation scenes, taking account of gender and ethnicity. The tool also employs an open-ended interview format that includes an exploratory conversation in which the adolescent is asked about him/her self and their experiences with significant caregivers. For more details about the method see Scott Brown and Wright (2003). For this study an additional question about the adolescents' perceptions of the meaning of bodily changes during puberty was added, i.e. 'can you tell me about how you remember your body when you were a child and how you think about it now'.

In the present study, transcripts were checked for accuracy and then coded using Resnick's (1993) coding system. The system is modelled on the AAI coding, and has shown reasonable reliability and validity (Freeman & Brown, 2001; Goldwyn, Stanley, Smith, & Green, 2000; Scott Brown & Wright, 2003). Using Resnick's system, responses to each picture were rated on nine subscales (on 9-point scales) and an overall attachment classification given based on the ratings together with additional information derived from the interview as a whole.

In addition to the ASAI the participants also completed two self-report forms. The Inventory of Interpersonal Problems measures interpersonal problems and is thus directly relevant to aspects of attachment organization, and the Youth Self-Report Form is a more general measure of well-being.

Inventory of Interpersonal Problems This short version of the Inventory of Interpersonal Problems (IIP-32; Barkham, Hardy, & Startup, 1996) was used to measure difficulties experienced by adolescents in their interpersonal relationships. The IIP-32 consists of statements reflecting things that the person finds 'too hard' to do (e.g. socialize) or things that the person does 'too much' (e.g. arguing). Each statement asks the extent to which the respondent is distressed by the problem, and responses are rated on a 5-point scale, ranging from 'not at all' to 'extremely'. Higher scores indicate more problems. Responses can be organized into a 'Full score' and eight subscales. The instrument has satisfactory reliability and validity (Barkham et al., 1996; Horowitz, Rosenberg, Baer, Ureno, & Villasenor, 1988) and has previously been reliability administered to adolescent populations (see Scott Brown & Wright, 2003)

Youth Self-Report Form The Youth Self-Report Form (YSR; Achenbach, 1991) was designed as a symptom inventory for adolescents. The YSR consists of 118 statements, which are rated according to whether the adolescent considers the statement to be 'not true', 'sometimes true' or 'often true'. Higher scores indicate a greater level of psychopathology. The measure identifies a 'total problem score', four 'competence' scales ('activities', 'social', 'academic performance' and 'total competence'), and 'internalizing' and 'externalizing' scores. The YSR also identifies eight syndrome scales. These subscales are merged to produce the 'internalizing' score and 'externalizing' score, as well as the total problem score. The YSR is a highly reliable and valid measure for assessing adolescent psychopathology (Achenbach, 1991).

Procedure

The interview and self-report items formed part of the psychotherapy clinic's overall assessment procedure, and was administered in a single meeting. All participants were informed of the nature and purpose of the project and written consent was obtained.

Data analysis

The data was analysed through a distinctive combination of quantitative and qualitative methods, in which the quantitative analysis was undertaken in order to provide a framework for further exploratory reading of the data. Non-parametric quantitative analyses were undertaken using chi-squared and Kruskal–Wallis tests.

Results

Quantitative analysis

Attachment and suicidal status Table 2 shows a potentially important difference between attachment classifications across the three groups, with a highly significant level of association ($\chi^2(4) = 17.2, p < .01$). Specifically, the HSR group included a majority of adolescents who gave enmeshed/preoccupied attachment narratives and no secure narratives. In contrast, the LSR group were more diversely spread across the three main attachment narrative patterns, and the control sample predictably over-represented within the secure category.

Two exemplars are given, later, to illustrate some of these differences as they present in the interview narratives. Both are responses to the question ‘Can you orientate me to your background and family?’, which is a first opportunity for the young person to describe themselves.

The first exemplar is from a transcript rated secure. This shows the subject providing a detailed, evidenced answer, and also the capacity to differentiate between what he does and does not know.

Transcript classified secure

Well I was born in London and then we moved to Cambridge . . . this is me and both my parents to live in a house in Cambridge because, . . . because um I don't know why, . . . but but my dad commuted back and forth so I spent most of my first year with my mum and then we moved back to London and stayed in a house in Muswell Hill for 5 years then we finally moved to our new house where we've been ever since (continues for two further lines before interview probes further).

In contrast, in the following exemplar, the subject was rated insecure–preoccupied. The quality of events reported and the experience of them is much more anxious than in the secure exemplar.

Transcript classified preoccupied

What? The date I was born in hospital?, . . . well I was born on the 12 November 1982 at I think Hammersmith . . . er, . . . I was brought up with my mum and dad

Table 2. Attachment classifications of high- and low-risk suicidal groups

Group	Attachment classification		
	Secure	Enmeshed/Preoccupied	Avoidant
HSR	0	6	4
LSR	5	2	8
Control	7	1	2

HSR, high-suicidal risk; LSR, low-suicidal risk.

but I think I don't know my mum, . . . when I was born like my mum was asleep I think for a long time so I was my dad looked after me for a bit and then or my nan looked after me most times cause my mum was out or ill or something erm, . . . I think, . . . that my dad was an alcoholic still is so up about 1989 that's when they divorced and my mum cause of dad drinking and not being there and stuff she had erm an affair so she had got an ectopic pregnancy . . . so my dad walked out (continues for another 30 lines unbroken).

These examples, of course, do not show the full range of differences in the narratives rated secure and insecure, but they do indicate some of the key quality of these differences.

Suicidal status and self report data Across group comparisons were conducted on the two self-report measures. Eight (80%) of the HSR, 13 (87%) of the LSR, and all 10 of the control participants completed the forms. Results of Kruskal–Wallis tests indicated that there was a significant difference between the groups on both the YSRF ($\chi^2(2) = 15.38$, $p < .001$) and the IIP ($\chi^2(2) = 6.49$, $p < .05$), with the HSR group reporting greater difficulties on both 'symptom-near' and 'symptom-distant' measures.

Attachment rating scales and suicidal status Differences in attachment styles in the sample were further investigated by comparing the range of scores allocated on each of Resnick's coding scales (Table 3).

The results of Kruskal–Wallis tests indicated that there was a significant difference between the groups on the four principal scales used to differentiate secure from insecure narratives (as opposed to differentiating insecure categories). Specifically, the suicidal group's scores were lowest on Emotional Openness, Optimism, Coherence and Solutions. Each of these significant differences was investigated further using Tukey's Honestly Significant Difference (HSD) test ($p < .05$) for post hoc multiple comparisons. Results showed the differences were due to the high-risk suicidal adolescents having significantly different scores on each of the scales than the other two groups.

Qualitative analysis

The quantitative results, despite the small sample size, demonstrate potentially important differences that could aid clinical assessments. However, they do not capture the rich qualitative content of the interviews' thematically coded differences, which provides a rich source of material from which to develop attachment-based formulations and hence guide therapy. In the next section we hope to elucidate some of these aspects with quotes taken from a number of different participants' interviews.

Stark references to suicide in questionnaires Perhaps one of the striking impressions of the high-risk group was the often unexpectedly stark references to suicide and mental disturbance during the assessments. Despite the rather static nature of the self-report forms (YSF, IIP) young people spontaneously added comments including

I can't stop thinking about cutting wrists.
I'm not a hoarder.
I think about killing myself, being killed by my girlfriend.
Hurting my mother.
I hear and see the devil.
I scratch till I bleed.

These quotes graphically illustrate something of the violent internal world the

Table 3. Descriptive statistics and non-parametric analysis of the relationship between Resnick (1993) attachment subscale ratings and participant group

Subscale	Clinical N = 15 a(b)	Suicidal N = 10 a(b)	Control N = 10 a(b)	Kruskal–Wallis χ^2	p	Tukey HSD
Emotional openness	5 (5)	3 (2.25)	7 (2.25)	12.17	.002**	Sui. < Clin. = Cont.
Resistance	5 (4)	4 (6)	3 (4)	5.59	.061	
Dismissing	3 (4)	4 (3.5)	2 (1.5)	5.07	.079	
Displacement	7 (4)	6.5 (4.5)	7 (1)	3.48	.176	
Preoccupied anger	7 (3)	6.5 (4)	7 (1.25)	1.05	.592	
Self blame	6 (1)	5.5 (1.75)	6 (2)	3.19	.203	Sui. < Clin. = Cont.
Optimism	5 (3)	3.5 (1.25)	5.5 (2)	10.12	.006**	
Coherence	5 (3)	2.5 (2.25)	6.5 (1.5)	15.35	.001***	
Solutions	6 (4)	5.5 (1)	7 (1)	10.19	.006**	Sui. < Cont.

* $p < .05$, ** $p < .01$, $p < .001$.

a = median, b = interquartile range.

adolescents were faced with and the conflict described by Bell (2000) as 'who is killing what or whom?'

Story-stem content

Material from the story-stem photographs were characterized by bizarre features and themes that often lay at the extremes of, or were unclassifiable using, Resnick's coding system.

Frightening/fearful themes related to death in inanimate objects

Interviewer: The young person is going on a school trip and here they are saying goodbye to their parents.

She goes she doesn't come back. The car looks like a coffin to me . . . See that car there . . . I don't know . . . I don't know.

Another participant commented

Interviewer: In the next picture Mum is going in to hospital, if that were you and your mum how would you be feeling?

Of course I'd be worried she's going to have an operation she could die they could cut her stomach up stick a knife in there, scissors in there and forget to take them out.

Interviewer: Would you feel anything else?

Scared still. . . Because she's going to have a serious operation . . . unless she likes having operations but I doubt that very much and the scissors are about to cut her stomach open . . .

Direct references to a suicide solution

Interviewer: In this picture the father has been arrested . . . what might the young person do?

Walk the streets . . . become a druggie I don't know she could become anything she's got no parents and no-one else there to look after her . . . even go kill herself.

In this example there is bleakness to the story including no sense of a reunion episode or available attachment figures, however, rather than a more typical insecure move into unrealistic self-reliance, there is escalating self-destructiveness as a consequence.

Interviewer: [In the picture] Mum is going in to hospital, what do you think would happen in the end?

Don't know . . . (*Interviewer:* any ideas?) No . . . ideally mum would die, so I would have a perfect excuse to kill myself, and everybody would be happy . . . including me.

Unresolved issues around death One young person said:

I saw my gran that time . . . dead . . . like a blue face . . . I'm trying not to cry.

Interviewer: Why shouldn't you cry?

Because it's a waste of time isn't it and you don't want me crying in the recorder.

Another told us:

They were screaming at him . . . apparently his mother's grave had been disturbed and an heirloom that she'd been buried disappeared and they knew it was my dad . . . I'm afraid he kicked his father's headstone into a couple of pieces.

Other features around coding transcripts There was a range of behaviours as if the young person's state of mind in relation to an attachment figure was transferred onto the interviewer. In these instances the young person's behaviour and potential feelings elicited in the interviewer became as much a focus of understanding the communication as the verbal content of the stories.

For example,

Interviewer: Dad's leaving home after an argument/we've had that before haven't we? I've had enough now (stands up, grabs coat and runs out of room).

In the second example of the transferred feelings theme below, the young person's difficulties around affect regulation directly enter the interview and need to be managed in the here-and-now:

Interviewer: Can you think of a time with your parents and you felt angry?

No. . . .

Interviewer: No you can't or don't want to?

Don't want to.

Interviewer: Can I ask what it is about angry feelings that you don't want to think about them?

Because if I do I'll end up punching you like everyone else.

Coding language within a cultural context We were also mindful of the fact that there are important aspects of youth culture involving specific linguistic features, which could be miscoded if taken out of context. For example, it was common for the adolescents we interviewed to say (e.g. 'don't know'), and to slip in and out of present tense when describing past events (e.g. 'she was like that innit'). However, we felt that these should not necessarily be taken as markers of avoidance or unresolved states of mind unless clearly related to some specific organizing function of an attachment-based narrative.

These lapses and changes were in stark contrast to more confused accounts, which lacked any sustained ability to focus on attachment-related thoughts in a coherent way.

For example:

Interviewer: Can you orientate me to your background . . . who brought you up things like that . . .

I was brought up by my mum and dad but I don't think I know my mum. . . . When I was born my mum was asleep and so my dad and nan looked after me cause my mum was out or something . . . my dad was an alcoholic . . . Oh God I forgot to tell you my er cousin murdered her boyfriend she stabbed him five times in the throat.

Narratives about the body The final part of the study we would like to report is the young people's responses to the question about experiences linked to bodily changes. These included preoccupations with how peers might view them, with control and regulation of the body, and liking and disliking changes in the body. The HSR group tended to be preoccupied with negative peer relationships and conformity to gender stereotypes around appearance and strength.

For example, one female participant said

I'm fixated on my own looks. I'm fixated on everyone else's looks. I meet someone and I study how they look, erm, and it's something that's very defining for me.

While a male participant commented

I don't know, I didn't used to think about my body at all . . . When I was younger, but now I worry cos, erm . . . I worry if I'm too skinny or err . . . err . . . I always want to change something about it (body) and it's easier not to change anything.

Interviewer: what would that be?

Err . . . like I should do more exercising and stuff. Err but I just can't be bothered.

In a variety of ways the HSR adolescents were characterized by experiences of their body as something out of control, that the attempt to exert control was overwhelming, and in the face of this difficulty submission and despair crept in.

Size and looks were salient in the narratives with references to outputs and inputs (e.g. food, weight and height). In contrast, the other two groups' participants demonstrated an increased quality of achievement around symbolic thinking about their body. It was also striking how the attachment classifications complimented the participants' 'hyper-activating/deactivating' themes of describing their body and bodily changes. The adolescents with dismissing attachment narratives repeatedly insisted that they did not think about their bodies.

For example, a male participant said

When I was a child I probably didn't care about it. I didn't think about it at all. It was just like 'it's my body'.

Similarly, embodied affective themes were introduced through negation, for example,

I mean looking at yourself and thinking, you know, is there something, is there something wrong with you there? I hope not you know, am I still developing in the right way? I'm still changing a little bit and, you know, I don't think I'm quite it. You know, hormones kicked in still quite recently . . . erm . . . I don't hate it but you know, there's always bits you don't like and there's always this 'that's a bit odd, and that's a bit funny, and that's a bit wonky'.

In contrast, adolescents with enmeshed/preoccupied attachment styles talked anxiously and at great length about aspects of their development. These accounts often impacted powerfully on the interviewer. For example, one female participant spoke for several minutes building up an account with a great sense of worry until she provided a picture of being completely trapped by her body, her lack of capacity to control it, and her fear of negative peer judgements. Typically, these accounts were characterized by high degrees in incoherence. For example,

Erm, I was more self conscious about I was always y-y-younger erm, probably from about nine. I was always very thin, erm, my mother wasn't and my sister wasn't, erm, and I always saw that when I get, got older my tendency would be to be . . . rather . . . like that which I worried about.

Interviewer: Sorry, to be?

Larger like them. And I worried about them. Which I worried about, but I shouldn't (looking embarrassed). And . . . and . . . erm . . . I was very tall. Erm, I've only grown an inch since I was ten or eleven. But I was five, five by that age, which was quite tall for that age. And when I first grew it was all, I was all like, my legs grew and then my body. And . . . I liked that . . . I got my period just after my eleventh birthday. And . . . and . . . I wasn't the first in my year for that, but I was one of the first . . . erm . . . But I was worried about my weight, and especially when I went up to senior school when I was eleven, twelve. And erm . . . There were an awful lot of thin pretty girls in the year, and you don't notice them change the same way as when you meet someone for the first time.

This quote exemplifies how the preoccupied/enmeshed participants appeared to be contending with a predicament of having 'the body in the mind', of being constantly involved in managing, controlling or containing these experiences.

Discussion

The aims of this article were to report on a pilot exploratory study of adolescents' characteristic attachment styles and body narratives as potentially useful areas for understanding suicidality in this age group. We started with a speculative theoretical proposition derived from attachment and psychodynamic theories that the adolescent's potentially conflictual relationship with the body in the context of reorganizing affiliative attachment relationships and the transformations of puberty has a central role in suicidality.

Results from the study suggest that suicidal adolescents are likely to be insecurely attached, in both dismissing and preoccupied ways. This finding corresponds with more general attachment research which has concluded that although clinical participants show highly deviating distributions of attachment classifications, with a strong overrepresentation of insecure types, systematic relations between diagnostic categories and type of insecurity are absent (van IJzendoorn & Bakermans-Kranenburg, 1996).

Our results also showed consistency with attachment theory's description of the characteristic narrative patterns found in each of the insecure attachment categories, including narratives evidencing the hyperactivating/deactivating aspect of attachment organization. We found that characteristics of the young person's attachment pattern guided how they communicated about their involvement with suicidality. So the narratives of suicidality for the preoccupied-insecure group were characterized by being trapped within a great sense of worry, and by having high degrees of incoherence. These young people were judged to be intensely preoccupied with hopelessness and deathly thoughts. The other insecure group, the dismissing group downplayed or understated their suicidality to the extent that it seemed they were unable to communicate about their feelings so that their involvement in suicidality was hidden from others.

By taking a close look at the quality of narratives provided by these young people in their interviews we found that we could make use of the distinction between preoccupied and dismissing insecure narrative patterns to distinguish different ways in which young people, at high and low risk of suicide, talked about their relatedness to their body. In general, adolescents with either dismissing or preoccupied attachment patterns, through deactivating and hyperactivating strategies, conveyed a sense of defending themselves against embodied distress and threats to self concept situated within the context of family and peer relations.

When we compared the suicidal and non-suicidal groups we found some interesting differences between the two groups that should be a focus for further study. We found that suicidal and non-suicidal subjects differed in that the suicidal group gave attachment-narratives that were less emotionally open, more pessimistic in content, characterized by (self-)destructive solutions to separation anxieties, and which showed the highest degree of incoherence. When we looked closely at the narratives, we were struck by the way that HSR adolescents' narratives were, first, studded with images of death, violence and murder, and, second, by feeling utterly overwhelmed and fearful of losing control. This kind of content and the outcome for the attachment organization – pessimism, incoherence, destructive solutions to separation anxieties – are possibly linked in the production of suicidality in young people.

We are mindful of both the relatively small sample size and the ad hoc qualitative

methodology employed here in discussing these results. One recommendation would be that the study should be replicated on a larger scale with the emphasis on reproducing the quantitative findings and undertaking a more systematic qualitative analysis. However, by emphasizing the emerging sense of similarities and differences in terms of the narratives of these young people, as discussed in the preceding paragraph, it can be argued that future studies should aim to go beyond coding into attachment categories, and thus to address some of the new kinds of association which are suggested here; for example, between feeling overwhelmed, fearing losing control, preoccupied with violence, death and murderousness, as well as expecting that separation anxieties will be resolved through self destructive action. The suggestion that young people's narratives of their bodies differ according to their attachment patterns is an intriguing one, which seems to offer the possibility of further understanding how and in what circumstances young people treat their bodies self-destructively. These associations may be uncovered by getting beyond coding into the broad attachment categories, developing some fine-grained distinctions and finding which of these relate to greater risk of suicide.

Finally, we can assess the clinical relevance of this study. We have shown that the two narrative patterns of insecure attachment, the hyperactivating and deactivating strategies, are both relevant to assessing suicide risks. These patterns map on to the kinds of clinical experience we have discussed earlier in this article, explain why clinicians experience these diverse responses and provide a focus for clinical assessment of suicidal risk. The narrative patterns provide clinicians with a framework for understanding different ways in which young people defend against emotionality, especially that connected with suicidal thoughts and feelings.

In conclusion, this is an exploratory study, but one which potentially opens up some new lines of enquiry which may particularly benefit the clinician's difficult task in assessing the presence and level of suicidal risks in adolescents.

Note

1. It is estimated that there are currently 150,000–170,000 attendances at Accident and Emergency departments year following self-harm. Self-harm resulted in 68,716 hospital admissions in 2001/2002 (NICE, 2004).

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