Psychotherapy with Suicidal Patients

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It seems logical that before we consider what the psychotherapy of a suicidal person ought to be that we have some common understanding of the suicidal state itself. Of course, everybody agrees that suicide is an enormously complicated term, encompassing a wide variety (and different ranges) of dysphoria, disturbance, self-abnegation, resignation, terror-cum-pain—to mention but a few inner states that are involved. But perhaps nowhere is there as insightful a description of suicide in as few words as that found in the opening paragraph of Melville's *Moby-Dick*: "a damp and drizzly November in my soul." For that is what, metaphorically, most suicide is: a dreary and dismal wintry gale within the mind, where the vital issue that is being debated is whether to try to stay afloat in a stormy life or willfully to go under to nothingness.

Suicide is the human act of self-inflicted, self-intended cessation (i.e., the permanent stopping of consciousness). It is best understood as a bio-socio-psychologico-existential state of malaise. It is obviously not a disease and just as obviously a number of kinds of trained individuals other than physicians can help individuals who are in a suicidal state.

If we are to escape many of the current somewhat simplistic notions of suicide (especially those which totally equate a disease called suicide with a disease called depression), then we need to explicate what the suicidal state of mind is like. Our key source in this can be the ordinary dictionary—eschewing any nomenclature of technical and, especially, technically diagnostic terms. In the dictionary there are words, e.g., angered, anguished, cornered, dependent, frustrated, guilty, helpless, hopeless, hostile, rageful, shamed, that will help us in our understanding. For us, in this chapter, two less common (but ordinary) dictionary words—*perturbation* and *lethality*—will be the keystone words of our

understanding.

Perturbation refers to how upset (disturbed, agitated, sane-insane, discomposed) the individual is—rated, let's say, on a 1 to 9 scale. Lethality refers to how lethal the individual is, i.e., how likely it is that he will take his own life—also rated on a 1 to 9 scale.

At the outset, I need to indicate what kinds of suicidal states I am talking about in order to indicate what kinds of psychotherapy are appropriate for them. We can arbitrarily divide the seriousness (or risk, or lethality, or suicidality) of all suicidal efforts (actions, deeds, events, episodes)—whether verbalizations (ordinarily called threats) or behaviors (ordinarily called attempts)—into three rough commonsense groupings: low, medium and high. In this chapter, I shall focus on the suicidal events or deeds of *high* lethality, where the danger of self-inflicted death is realistically large and imminent; what one might ordinarily call high suicide risks. Of course, a suicide act (deed, occurrence, event, threat, attempt) *of whatever lethality* is always a genuine psychiatric situation and should be treated without any iatrogenic elements. Thus, in the treatment of the suicidal person there is almost never any place for the therapist's hostility, anger, sardonic attitudes, daring the patient, or pseudo-democratic indifference.

By focusing solely on the psychotherapeutic approaches to high suicide risks, it should be obvious at the beginning that this chapter is a moiety—omitting entirely (and advertently) the lively areas of treatment suicidal individuals receive by means of chemical, electrical or institutional modalities.

Theoretically, the treatment of an acutely highly suicidal person is quite simple: It consists, almost by definition, of lowering his lethality level; in practice, this is usually done by decreasing or mollifying his level of perturbation. In short, we defuse the situation (like getting the gun), we create activity of support and care around the person, and we make that person's temporarily unbearable life just enough better so that he or she can stop to think and reconsider. The way to

decrease lethality is by dramatically decreasing the felt perturbation.

Working intensively with a highly suicidal person—someone who might be assessed as 7, 8 or 9 on a 1 to 9 scale of lethality—as distinguished from someone of moderate or low lethality, is different from almost any other human encounter, with the possible exception of that of working intensively with a dying person—but that is another story. Psychotherapy with an intensely suicidal person is a special task; it demands a different kind of involvement. The goal is different—not that of increasing comfort, which is the goal of most ordinary psychotherapy, but the more primitive goal of simply keeping the person alive. The rules are therefore different, and it follows (or rather precedes) that the theoretical rationale is different.

At this juncture, I wish to make a distinction among *four* psychologically different kinds of human encounters: conversation (or "ordinary talk"); an hierarchical exchange; psychotherapy or a "professional exchange"; and, finally, clinical suicidology or working psychologically with a highly lethal person.

In ordinary talk or conversation, the focus is on the surface content (concrete events, specific dates, culinary details); on what is actually being said; on the obviously stated meanings; on the ordinary interesting (or uninteresting) details of life. Further, the social role between the two speakers is one in which the two participants are essentially equal. Each participant has the social right to ask the other the same questions which he or she has been asked by the other. The best example of ordinary talk is two friends conversing with one another.

In a hierarchical verbal exchange the two participants are socially, and hence psychologically, unequal. This difference may be imposed by the situation, such as the exchange between a military officer and an enlisted person, or it may be agreed to by the two involved parties, such as between a physician and a patient. In either instance, the two are not psychologically equal. For example, an officer or a physician can ask an enlisted person or a patient, respectively, certain

personal questions to which a rational response is expected, that the person of "lower status" could not ask the other person in return without appearing impertinent or aberrant. Yet most of the talk is still on the surface, concerning the real details of everyday life.

In a professional psychotherapeutic exchange the focus is on feelings, emotional content and unconscious meanings, rather than on what is apparently being said. The emphasis is on the latent (between-the-lines) significance of what is being said more than on the manifest and obvious content; on the unconscious meanings, including double-entendres, puns, and slips-of-the-tongue; on themes that run as common threads through the content, rather than on the concrete details for their own sake. Perhaps the most distinguishing aspect of the professional exchange (as opposed to ordinary talk) is the occurrence of transference, wherein the patient projects onto the therapist certain deep expectations and feelings. These transference reactions often stem from the patient's childhood and reflect neurotic patterns of reaction (of love, hate, dependency, suspicion, etc.) to whatever the therapist may or may not be doing. The therapist is often invested by the patient with almost magical healing powers, which, in fact, can serve as a self-fulfilling prophecy and thus help the interaction become therapeutic for the patient. In this paragraph, the use of the words therapist and patient already implies that, of the two parties, one has tacitly agreed to seek assistance and the other has agreed to try to give it. The roles of the two participants, unlike those in a conversation, are, in this respect, not co-equal. A therapist and a patient could not simply exchange roles.

In working as a clinical suicidologist with an individual who is highly suicidal, the focus is again different. In this situation, the attention is primarily on the lethality. Most importantly, what differentiates this modality of therapy from any other psychotherapy is the handling of the transference feelings. Specifically, the transference (from the patient to the therapist) and the countertransference (from the therapist to the patient)—especially those positive feelings of affection and concern—can legitimately be much more intense and more deep than would

be seemly or appropriate (or even ethical) in ordinary psychotherapy where time is assumed to be endless and where it is taken for granted that the patient will continue functioning in life.

Working with a highly suicidal person demands a different kind of involvement. There may be as important a conceptual difference between ordinary psychotherapy (with individuals where dying or living is not *the* issue) and psychotherapy with acutely suicidal persons as there is between ordinary psychotherapy and ordinary talk.

The main point of working with a lethally-oriented person—in the give-and-take of talk, the advice, the interpretations, the listening—is to increase that individual's psychological sense of possible choices and sense of being emotionally supported. Relatives, friends and colleagues should, after they are assessed to be on the life-side of the individual's ambivalence, be closely involved in the total treatment process. Suicide prevention is not best done as a solo practice. A combination of consultation, ancillary therapists and the use of all the interpersonal and community resources that one can involve is, in general, the best way of proceeding.

Recall that we are talking about psychotherapy with the highly suicidal persons—not one of low or even medium lethality. With this in mind—and keeping in mind also the four psychological components of the suicidal state of mind (heightened inimicality, elevated perturbation, conspicuous constriction of intellectual focus, and the idea of cessation as a solution)—then a relatively simple formula for treatment can be stated. That formulation concentrates on two of the four psychological components, specifically on the constriction and the perturbation. Simply put, the way to save a highly suicidal person is to decrease the constriction, that is, to widen the range of possible thoughts and fantasies *(from* the dichotomous two—either one specific outcome or death—*to* at least three or more possibilities for admittedly less-than-perfect solution), and, most importantly—without which the attempt to broaden the constriction will not

work—to decrease the individual's perturbation.

How does a psychotherapist decrease the elevated perturbation of a highly suicidal person? Answer: by doing anything and almost everything possible to cater to the infantile idiosyncrasies, the dependency needs, the sense of pressure and futility, the feelings of hopelessness and helplessness that the individual is experiencing. In order to help a highly lethal person, one should involve others; create activity around the person; do what he or she wants done—and, if that cannot be accomplished, at least move in the direction of the desired goals to some substitute goals that approximate those which have been lost. Remember that life—and remind the patient of this fact (in a kindly but oracular way)—is often the choice among lousy alternatives. The key to functioning, to wisdom and to life itself is often to choose the least lousy alternative that is practicably attainable.

Taken down to its bare roots, the principle is: To decrease lethality one puts a hook on perturbation and, doing what needs to be done, pulls the level of perturbation down—and with that action brings down the active level of lethality. Then, when the person is no longer highly suicidal—then the usual methods of psychotherapy (which are not the subject for this chapter) can be usefully employed.

As to how to help a suicidal individual, it is best to look upon any suicidal act, whatever its lethality, as an effort by an individual to stop unbearable anguish or intolerable pain by "doing something." Knowing this usually guides us as to what the treatment should be. In the same sense, the way to save a person's life is also to "do something." Those "somethings" include putting that information (that the person is in trouble with himself) into the stream of communication, letting others know about it, breaking what could be a fatal secret, talking to the person, talking to others, preferring help, getting loved ones interested and responsive, creating action around the person, showing response, indicating concern, and, if possible, offering love.

I conclude with an example—actually a composite of several actual highly suicidal persons I have known.

Case Study

A young woman in her 20s, a nurse at the hospital where I worked, asked me pleadingly if I would see her teenage sister whom she considered to be highly suicidal. The attractive, younger woman—agitated and tearful but coherent—told me (in the privacy of my office) that she was single, pregnant and determined to kill herself. She showed me a small automatic pistol she had in her purse. Her being pregnant was such a mortal shame to her, combined with strong feelings of rage and guilt, that she simply could not "bear to live" (or live to bear?). Suicide was the *only* alternative, and shooting herself was the *only* way to do it. Either she had to be unpregnant (the way she was before she conceived) or she had to be dead.

I did several things. For one, I took out a sheet of paper and—to begin to "widen her blinders"—said something like, "Now, let's see: You could have an abortion here locally." ("I couldn't do that.") It is precisely the "can'ts" and the "won'ts" and "have tos" and "nevers" and "always" and "onlys" that are to be negotiated in psychotherapy. "You could go away and have an abortion." ("I couldn't do that.") "You could bring the baby to term and keep the baby." ("I couldn't do that.") "You could have the baby and adopt it out." ("I couldn't do that.") "We could get in touch with the young man involved." ("I couldn't do that.") "We could involve the help of your parents." ("I couldn't do that.") and "You can always commit suicide, but there is obviously no need to do that today." (No response.) "Now first, let me take that gun, and then let's look at this *list* and rank them in order and see what their advantages, disadvantages and implications are, remembering that none of them may be perfect."

The very making of this list, my fairly calm and nonhortatory and nonjudgmental approach already had a calming influence on her. Within 15

minutes her lethality had begun to deescalate. She actually rank-ordered the list, commenting negatively on each item, but what was of critical importance was that suicide, which I included in the total realistic list, was now ranked third—no longer first or second.

She decided that she would, reluctantly, want to talk to the father of her child. Not only had they never discussed the "issue," but he did not even know about it. But there was a formidable obstacle: He lived in another city, almost across the country and that involved (what seemed to be a big item in the patient's mind) a long distance call. It was a matter of literally seconds to ascertain the area code from the long distance operator, to obtain his telephone number from information, and then—obviously with some trepidation and keen ambivalence for her—to dial his number (at university expense), with the support of my presence to speak to him directly.

The point is not how the issue was practically resolved, without an excessive number of deep or shallow interpretations as to why she permitted herself to become pregnant and other aspects of her relationships with men, etc. What is important is that it was possible to achieve the assignment of that day: to lower her lethality.

In general, any suicidal state is characterized by its transient quality, its pervasive ambivalence, and its dyadic nature. Psychiatrists and other health professionals are well advised to minimize, if not totally to disregard, those probably well-intentioned but shrill writings in this field which naively speak of an individual's "right to commit suicide"—a right which, in actuality, cannot be denied—as though the suicidal person were a chronic univalently self-destructive hermit.

A number of special features in the management of a highly lethal patient can be mentioned. Some of these special therapeutic stratagems or orientations with a highly lethal patient attend to or reflect the *transient, ambivalent* and

dyadic aspects of almost all suicidal acts.

1. A continuous, preferably daily, monitoring of the patient's lethality rating.

2. An active out-reach; being willing to deal with some of the reality problems of the patient openly, where advisable; giving direction (sans exhortation) to the patient; actively taking the side of life. It relates to befriending and caring.

3. Use of community resources including employment, Veterans Administration (when applicable), social agencies, and psychiatric social work assistance.

4. Consultation. There is almost no instance in a psychiatrist's professional life when consultation with a peer is as important as when he is dealing with a highly suicidal patient. The items to be discussed might include the therapist's treatment of the case; his own feelings of frustration, helplessness or even anger; his countertransference reactions generally; the advisability of hospitalization for the patient, etc.

5. Hospitalization. Hospitalization is always a complicating event in the treatment of a suicidal patient but it should not, on those grounds, be eschewed. Obviously, the quality of care—from doctors, nurses and attendants—is crucial. Stoller (1), discussing one of his complex long-range cases, says: ". . . there were several other factors without which the therapy might not have succeeded. First, the hospital. The patient's life could not have been saved if a hospital had not been immediately available *and a few of the personnel familiar with me and the patient.* (Italics added).

6. Transference. As in almost no other situation and at almost no other time, the successful treatment of a highly suicidal person depends heavily on the transference. The therapist can be active, show his personal concern, increase the frequency of the sessions, invoke the "magic" of the unique therapist-patient relationship, be less of a *tabula rasa,* give "transfusions" of (realistic) hope and succorance. In a figurative sense, I believe that Eros can work wonders against Thanatos.

7. The involvement of significant others. Suicide is most often a highly charged dyadic crisis. It follows from this that the therapist, unlike his usual practice of dealing almost exclusively with his patient (and

even fending off the spouse, the lover, parents, grown children), should consider the advisability of working directly with the significant other. For example, if the individual is male and married, it is important to meet his wife. The therapist must assess whether, in fact, she is suicidogenic; whether they ought to be separated; whether there are misunderstandings which the therapist can help resolve; or whether she is insightful and concerned and can be used by the therapist as his ally and co-therapist. The same is true for homosexual lovers, for patient and parent, etc. It is not suggested that the significant other be seen as often as the patient is seen, but that other real people in the suicidal patient's life be directly involved and, at the minimum, their role as hinderer or helper in the treatment process be assessed.

8. Careful modification of the usual canons of confidentiality. Admittedly, this is a touchy and complicated point, but the therapist should not ally himself with death. Statements given during the therapy session relating to the patient's overt suicidal (or homicidal) plans obviously cannot be treated as a "secret" between two collusive partners. In the previous example of the patient who opened her purse and showed me a small automatic pistol with which she said she was going, that day, to kill herself, two obvious interpretations would be that she obviously wanted me to take the weapon from her, or that she was threatening me In any event, I told her that she could not leave my office with the gun and insisted that she hand her purse to me. She countered by saying that I had abrogated the basic rule of therapy, namely that she could tell me anything. I pointed out that "anything" did not mean committing suicide and that she must know that I could not be a partner in that kind of enterprise. For a moment she seemed angered and then relieved; she gave me the gun. The rule is to "defuse" the potentially lethal situation. To have left her with a loaded gun would also leave her with a latent message.

9. Limitation of one's own practice to a very few highly lethal patients. It is possible to see a fairly large number of moderate and low-rated lethal patients in one's patient load, but one or two *highly* lethal patients seem to be the superhuman limit for most therapists at any given time. Such patients demand a great deal of investment of psychic energy and one must beware of spreading oneself loo thin in his or her own professional life.

Working with highly suicidal persons borrows from the goals of crisis intervention: not to take on and ameliorate the individual's entire personality structure and to cure all the neuroses, but simply to keep him or her alive. That is the *sine qua non* without which all the other expert psychotherapists represented in this volume could not function.

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