THE THEORY AND PRACTICE OF PSYCHOTHERAPY WITH SPECIFIC DISORDERS

PSYCHOTHERAPY WITH SUICIDAL PATIENTS

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Psychotherapy with Suicidal Patients

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Table of Contents

Psychotherapy with Suicidal Patients

PSYCHODYNAMICS

Although suicide is frequently a reaction to a feeling of intolerance to one of the depressive reactions discussed in the previous chapter, this is not always the case. It is important to recognize that not all suicides manifest depressive symptoms and that the psychodynamics of depression are not always sufficient to account for all suicide attempts. Some of the most typical psychodynamics involved in suicide will be discussed. It is important to recognize that several of these psychodynamic factors may be operative at one time, in any one suicidal reaction.

Suicide as Appeal and Threat

It is clear that not all apparent suicide attempts are genuine. That is to say, the urge to destroy oneself is not always present in some "suicidal attempts" but rather represents an attempt on the part of the patient to coerce some person(s) in the environment to provide narcissistic supplies.

As an example, Mrs. Black, after twenty years of marriage, was feeling that her husband was beginning to lose interest in her. He was spending more and more time at his job and less and less time with her. When he was home he sat in front of the television and almost completely ignored her. The more

he ignored her, the more demanding she became and the more demanding she became, the more he ignored her as a way of showing her that he was not going to submit to her demands for fear that if he did give in to her demands that this would reward her into becoming even more demanding. Her children had grown older and did not seem to need her any more. It seemed to her that no one even knew that she existed or cared if she lived or died.

I have come to recognize that many dependent persons require acknowledgment and recognition by some significant other, not only as a source of narcissistic supplies for their self-esteem, but even more importantly they begin to doubt their own existence if persons no longer need them or react to them in a meaningful way.

In order to find out if she had any value to anyone and to force a reaction of loving concern toward her, one night after feeling particularly hurt and rejected by her husband, she ran to the medicine cabinet shouting and insisting that she was going to commit suicide because no one cared about her anyway. Fortunately, her husband ran after her and when she put a large handful of aspirin in her mouth, he smacked her across the face and knocked the aspirins out of her mouth. She later confided to me that she really had no intention of killing herself and did not intend to swallow the aspirins and even if she had accidentally done so she knew how to quickly prepare an antidote or even better yet have her husband do it for her. In her fantasy she

could visualize her husband pleading for her to live and begging her forgiveness for not having treated her properly. She felt that her husband's knocking the pills out of her mouth was sufficient indication to her that she was valuable to him, a feeling which restored her self-esteem; but most of all she felt that she had now conditioned her husband into being more attentive to her for fear that she might attempt suicide again. Thus, her narcissistic supplies would keep coming and she would never again have to feel the panic related to the unconscious doubting of her own existence because her husband was now constantly on guard to react to her and acknowledge her.

On the one hand the suicidal attempt is an appeal to other people for love, protection, esteem and so forth, but at the same time it is also a *threat.* It says, in effect, "Love me or else. . ." It is a kind of blackmail. It is meant to subtly communicate to the other, something to the effect, "I will punish you and embarrass you to the entire community. I will kill myself and everyone will know you drove me to it. You will never again have a moment's peace of mind. You have always wanted to be free of me, now I will always be in your thoughts and you will never be free of me."

There are, however, some of these patients who truly intend to go through with an actual suicide. Some of these patients feel, "I'll give him the chance to let me die if he wants me to. If he wants me to die there is no sense to living anyway. I'm too frightened to live without a close tie to someone. I

just can't live with this uncertainty of not knowing whether he wants me dead or alive and with this insecurity of not feeling protected and loved. I am committed to die unless he loves me enough to save me." These persons then will never attempt suicide unless the love object is present or nearby and is in a position to save them should the desire to do so be there. This will be discussed in more detail in the section dealing with the rescue fantasy.

It should be clear that for the kind of narcissistic person discussed here, the goal of the suicide *attempt* is different from the *act* of suicide in which death is truly sought. The suicide attempt represents, as indicated above, both an appeal and a threat. But the suicide itself in some way is seen by the patient as a way of achieving a final victory over some object(s) or aspect of the patient's world. In life, the patient felt constantly defeated by an inability to totally control his world, but unconsciously the patient feels that in death a final victory will be achieved over the rejecting object. The victory lies, in part, in hurting the other without giving the other a chance to hurt back, but also involved, ironically, is the feeling on the part of the patient that via the trauma of the suicide, his "life" will endure, for his memory will always be indelibly impressed upon the mind of his love object for the duration of her life, thereby insuring for him the non-separative and enduring union with her for which he has always yearned.

Suicide and the Rescue Fantasy

Those who have worked closely with patients who have attempted suicide have come to recognize a phenomenon termed by Jensen and Petty the "rescue fantasy." It is now well recognized that most persons before attempting suicide will, either consciously or unconsciously, alert someone, whom they have chosen to be their rescuer, as to their intentions. In the preparations for and in the execution of the suicidal act are expressed not only the wish to die but also the wish to live and to be saved by this rescuer. A savior is chosen and an opportunity for rescue is provided. If the behavior of the one chosen for the rescue is not what the suicidal person hopes or needs it to be, death is probable or inevitable. When they choose a rescuer it is usually someone who has a strong ego, strong enough to serve the both of them, and also someone who is loving enough to supply him with his needs for affection and protection. It is for these reasons that the therapist is frequently chosen as the rescuer.

The prototype for the relationship that the suicidal person seeks with the rescuer is probably that relationship early in infancy when the infant and mother shared a common ego and each responded directly to the unconscious of the other as though it were his own; apparently this state is temporarily reinstated by regression in the patient contemplating suicide. In attempting to affirm the existence of this state, which to the suicidal person suggests the ultimate in protection and security, the suicidal person drops subtle clues to the person chosen as rescuer; and if the rescuer picks these up and comes to

the rescue, then the patient achieves a sense of security, again through the belief that it could only have been via the union of unconsciouses that the other came to the rescue. It is only the conviction that such union exists that enables the fearfully regressed patient to continue to face life without being overwhelmed with fears of vulnerability and helplessness. If, however, the person chosen as the rescuer does not read the signs adequately enough to come in time to rescue the patient, then the suicidal person permits himself to die because to him, the failure to rescue is proof of abandonment which is so terrifying to him that death is seen as preferable to continuing to live in such terror.

Jensen and Petty indicate that it often happens that a potential rescuer recognizes the role assigned to him yet refuses that role or attempts to transfer it to someone else. Interference in communication between the suicidal person and the potential rescuer frequently seems to result from the latter's unconscious wish to be rid of the patient. The rescuer's own unconscious hostility may have been so aroused by the demands, the unpleasantness, the attempt to exercise extreme control and the antagonism of the suicidal person that his predominant unconscious attitude is, "Do it and be done with it. Good riddance."

Sterba elaborated upon the aggression expressed in the fantasy of rescue. The fantasy to be rescued in suicide expresses the passive wish to be

saved by someone upon whom the suicidal person has projected a share of his own aggression and whom he unconsciously holds responsible for his impending death. The aggression against the potential rescuer is expressed passively through the threat of making a murderer of the potential rescuer if the fantasy to be rescued is not fulfilled in reality.

While the fantasy expresses the passive wish to be rescued, the role of the rescuer is an active one and he *cannot equivocate* if he is to function in his designated capacity; equivocation will change his function from rescuer to "murderer." This fact has special importance for psychotherapists and others who by reason of transference are likely to be chosen as rescuers. Resorting to therapeutic anonymity or passivity by the therapist to avoid the responsibilities of the rescuer is a rationalization at best and will probably end disastrously for the suicidal person and sometimes for the potential rescuer as well.

I should also point out another potential problem at the other extreme. The therapist must be clear in regard to his own need for omnipotence in that he needs to recognize that he cannot be responsible for the life of another human being. If he were to feel responsible for the life of his patients, he would suffer terribly if they should commit suicide. He then places himself in a position very vulnerable to being "blackmailed" by the patients into giving narcissistic supplies and taking the responsibility for their life. Many patients

are seeking a kind of parasitic existence with another as their way of feeling safe and secure, and they will surely take advantage of the therapist in this way, to the detriment not only of the therapist but of the progress of the therapy as well. If the therapist is controllable in this way, he is not always free to act in a way which might be most therapeutic for the patient.

The following case illustrates the rescue fantasy of a 17-year-old girl, Nina. Nina was born out of wedlock and lived with her real mother, sister and stepfather, who never formally adopted Nina. She had never met her real father, but only knew that he lived in a far off city in the same state in which she lived. Her mother had told her that she had heard that he was married and had a family of his own. Nina was referred to me because she was having great difficulty in getting along with her peers and parents. Also she suffered from various phobias; the most serious and disturbing to her was one of lights hanging from a ceiling. She indicated that they reminded her of eyes that were peering at her and coming to get her. On her last visit to me prior to her suicidal attempt she brought me a poem which she asked me to read only after our session was over and she was gone. It was called “The Tree” and read as follows:

A tree in the distance

Is all that I can see

But you can't convince me

It's only a tree

It stands very tall

Very straight, very high

Its branches reach out

Touching clouds going by

It stands in the rain

And the sleet, and the snow

It keeps right on standing

When icy winds blow

It reminds me of man

Who is much like a tree

He suffers through hardships

And waits to be free

Way off in the distance

You ask what I see

But I'll never tell you

It's only a tree

On numerous occasions she had told me of a special tree that she could see from her bench in a small mall-type park, and when she felt hurt or particularly upset she would spend time in the presence of that tree. She had apparently made some kind of identification with it. The next day a letter arrived from her which read:

> Right now, Dr. Hammer, I wouldn't care if the whole world exploded. I feel very sad and confused. I don't feel as if I am a part of society or anything else for that matter. Why it is that I can't seem to grasp that true self of mine which is floating in the air so close by me? Why are there so many lonely sensitive feelings blocking out the better, happier ones? Who am I? Why did God create such a thing? What was it that happened to me as a child that makes me feel this way? Where are the answers to my ever-haunting questions? I honestly feel like a dead-being roaming the earth. I have no cares for anyone. Do you think it phases me to read about someone dying? Of course not. There are no feelings whatsoever in my soul for anyone. I'm a self-centered person. I guess I could say that I feel sorry for myself. I don't know why I should but I do. Why are there times when I would think of committing suicide? I really don't know but there are. I can't sleep nights, I'm irritable, I don't want people watching me, I like to be alone, I worry a lot. I hate those who ask questions concerning my personal affairs and I hate those who nag. I honestly believe I'll always have these feelings. I'll never rid myself of them. I can't go on living in a

world such as this being the person that I am. I put in a terrible night last night. I told God I wanted to die and I really do. I thought of how wonderful it would be to lie there with no more loneliness, heartache, sadness, tears or anything anymore. It would be like a long sleep and for once in my life I could be left alone. Death to me is far better than this so-called life. I think it's torture to live here where people do nothing but fight and hate each other. I went to a dance the other night and no one asked me to dance. Don't ask me why. I looked as good as anyone else did. Well, maybe I didn't to those boys. I guess no one likes a sentimental person like myself when everyone else is so fun-loving. I can't understand why I feel like this and why I'm here. I dread the nights. The days aren't too bad, but at night I cry until my face is all swollen. I'm making myself sick. I don't know what to do. I don't see how I've lasted this long. The other night I suddenly became a little girl again. I wasn't even talking sensible. I found myself crying to my father. Then I could see him sitting beside my bed and he took a hold of my hand and told me he loved me and that I didn't have to be afraid any more. Then another night I was lying there and suddenly I couldn't feel anything. I couldn't do anything at all. It was like I was mentally retarded, too. Then I could see Mom in the kitchen. She was yelling at me. I wanted to cook something and she told me I didn't know how. I felt ignorant. Everything I touched I dropped. Then I cried real hard. Dr. Hammer, please help me. You're the only person I can turn to. You're the only one that understands me. Nobody knows just how terrible these feelings are. If it lasts much longer, I don't know what I'll do.

Nina

The next evening I received a long-distance telephone call from the mother who was frantic. Nina had not returned from school yet, and now it was several hours past her suppertime. The mother had called the few friends that Nina had, but none had seen her. It was an extremely cold winter's night. The mother could not imagine where the girl could be and hoped that perhaps I might have some idea. I told her to call the police immediately and

have them start looking for her. Then I remembered her poem and letter and our past conversations regarding her going to visit the tree at times when she felt most unhappy. I suggested that the mother herself go to the park and search for her there near one of the large trees. I felt that it was very important that the mother be the one to find her. The mother called me back later to tell me that they had found her there and had taken her to the hospital. They found her lying nude in some bushes near the tree. She was suffering from shock and overexposure to the cold but the doctor felt that she would recover. He indicated that greater delay could possibly have been fatal. As I learned afterward, it was her goal to freeze to death, which she had learned was a very painless way to die. "You just fall asleep and it's all over." It also was apparent that in some way she was trying to achieve a kind of mystical union with the tree by dying in its presence.

She had apparently arranged the "suicide" to use both me and her mother as the rescuer because, as she had unconsciously arranged it, it would have been impossible for either one of us alone to have known enough about her at the time to save her. It was also clear that she was committed to die if we both did not come to the rescue. She apparently placed me in the role of the long lost father whom she had never met, fantasizing two loving parents expressing their love for her by coming to her rescue.

This case typically reflects many of the ingredients that one so often

finds in suicide attempts: the feelings of loneliness and isolation, the confusion and uncertainty, the extreme hostility toward self and others, the feelings of numbness as though one were already dead, the equating of death with peaceful sleep and rest and escape from pain, the uncontrollable obsessive, negative thoughts which make one feel helpless and worthless, the feeling of avoiding all people because they are seen as being too hurting and the recognition that the fear of life is greater than the fear of death (which will be discussed in more detail in a later section). However, most importantly, one sees in suicidal reactions despair rather than just depression. Those extreme feelings of hopelessness suggest to the patient that not only is life painful and miserable now, but they see no possible way it can ever change in the future. Despair involves depression plus pessimism. The prospect of having to endure endless pain and feelings of vulnerability and panic is intolerable to them. At this point, suicide is considered as a serious solution to what they feel are their otherwise insoluble problems. Without the element of hopelessness, depression would very seldom lead to real suicide intent.

In the case of Nina cited above, the clues to her suicidal intent were relatively open and direct, but they are not always so apparent. In some instances, patients will reveal their suicidal intent with subtle questioning such as “Do you know how many stories the Empire State Building has?” or “I wonder what it would feel like to jump from an airplane without a parachute?” or “What would happen if a person swallowed a whole bottle of

aspirins?" or even more subtly given as in the underlying theme of a poem where, for example, as one patient wrote, one hears a call from the depths of the sea with a yearning to heed the call.

Suicide as Inverted Homicide

It is true for many who kill themselves that they really did not wish to die but rather wished to kill someone else. At times this someone else is a real person such as a parent, husband or child, but the impulse to destroy is turned inward instead of outward because of intense superego development or because for years they have been conditioned by the parents never to express negative feelings. For their own security they have built up such an intense defense against the expression of negative feelings that when the rage becomes too great to bear they are forced to turn it inward against the self. At other times the someone else may not be a real person but rather a representative within the self of a particular person. Thus they may attempt to kill the voice of conscience which will not permit them a moment's rest or the goal may be to destroy the hated parent who has been introjected and operates within as superego or ego.

Sometimes they may turn their rage against the persistent and uncontrollably morbid obsessive thoughts which run through their mind and blow out their brains, which they hold responsible for their mental suffering.

At other times the patient takes his stand as his idealized image and seeks to destroy what he feels to be his inadequate actual self, as Horney has described. In other instances the destructiveness turned inward serves as supreme masochistic gratification or masochistic defense against the more frightened expression of sadistic impulses.

It is helpful if a patient who has repressed his rage against a parent has an opportunity to express his negative feelings toward that person before the parent dies. Once the parent has died, then the rage gets directed against the introjected parent now operating as superego or ego. When the patient considers committing suicide by killing the hated parent within himself, at the same time he preserves the magical feeling that he will somehow keep on living. If thwarted in his suicide attempt, such a person will typically remark afterward that it never occurred to him that he too would also cease to exist once the rage was discharged against the introjected parent serving now as conscience or as specific attitudes or traits within the self. He had identified himself only with the initiator of the rage but not its recipient.

Most suicidal persons do not want to die, they only want to indulge the rage to destroy. It is quite common to hear from those who attempt suicide that soon after they indulged the impulse they were sorry that they had done so and had changed their mind about wanting to die. The therapist needs to recognize that the patient has a wish to five in addition to the impulse to

destroy himself, although there are times when the latter impulse grossly overshadows the former. Once the rage has been expressed they are quite satisfied and now are ready to live although at times this change of heart is too late, such as when one comes to this recognition after having mortally wounded himself.

I point this out especially for those who take the philosophical stand that the therapist has no right to interfere with a patient's decision to take his own life if the patient is not psychotic. This argument fails to recognize the ambivalent nature of the suicidal impulse. I also point out this ambivalence to the suicidal patient and try to help him recognize that he also has a great wish to live, in addition to having a strong wish to die, but he cannot feel it because his wish to destroy himself is so intense and overshadowing. Helping the patient to recognize that he does not really want to die but only wishes to indulge his rage to destroy opens the way to suggestions for sublimating this rage and may improve the patient's receptivity to these suggestions and thus to be in a position to help himself should the impulse to self-destruction return again in the future.

Suicide and Loss of Self

Typically the college student has come to identify himself with his intellect. His entire self is built around his intellect. If the intellect gains

victories he is euphoric, but if the intellect meets defeats he is distraught. However, if the defeat is too severe it may lead to a feeling of loss of self. In one instance a student confided to me his fantasy of committing suicide. Fortunately he came in to talk to me about it before acting on his impulse. Since early childhood he had come to feel that the only valuable thing about him was his intellect. He did quite well until he came to graduate school where he failed an important examination which made it impossible for him to continue his graduate career. "If I am not my intelligence who am I then? Now I'm a nobody and a nothing. There is no need to continue living because there is no self left to do the living," he felt. He continued, "I'll make that professor suffer who made me a nobody. He killed me. He took away my ability to ever enjoy life. I'll do the same to him. I will write a note and leave it in my pocket. It will be addressed to my professor and I will tell him that it was his unfairness that drove me to kill myself. I will make it clear to him that he killed me. All of his friends and colleagues will also know about it. My death will be so indelibly impressed upon his conscience that he will never again be able to enjoy life. Oh, that will be sweet revenge."

Suicide as Atonement

Some persons attempt suicide in an attempt to atone for guilt, real or imagined. Especially for deeply religious persons there is sometimes the conviction that the only relief from guilt associated with a taboo act is to

make the supreme sacrifice of self. They become convinced, in their logic, that God demands it. They have become identified with their religious convictions and rather than lose these, which have given their life meaning, they prefer at least to salvage something by placing themselves in the good graces of God by making the supreme sacrifice. They feel that their only hope is to make it appear as though they were giving up their life as a sacrifice in order to please God so that they might gain His forgiveness and thereby still gain entrance into Heaven.

Suicide as Martyrdom

Somewhat related to the self-sacrificing individual discussed above is the person who dies in the service of her ultimate ideal of martyrdom. Typical of this kind of suicide is the wife who discovers that her husband is in love with another woman, usually a younger or much more attractive woman whose competition seems more than the patient can deal with. In the background of such a patient is an Oedipal situation in which she felt extremely humiliated and angry in having lost out in competition with her mother for father. As a result, she vows never to compete and lose again to another woman over a man that she loves and wants.

She commits suicide and leaves a note to the husband to the effect that it is because she loves him and wants him to be happy that she is removing

herself from the picture. She really commits suicide because she feels that it is inevitable that she will lose out in the competition with this woman, which will leave her so lonely and humiliated in the community that she would not be able to face anyone again. She feels that her life is over anyway. What she wants to achieve via the suicide is some victory over the other woman and some punishment of her husband. By behaving as a martyr, she tries to make her husband feel guilty for having wronged her and to make it impossible for him to ever let himself love the other woman. In this way she feels that she will be converting a defeat into a victory.

When the wife commits suicide, the husband, feeling very guilty, tends to project his guilt on to the other woman and blames her for the entire affair. In this way the suicidal wife has in a way "killed" the other woman and gained a final victory over her. In addition, the wife's image in the community, which she feels will five on and in this way give her life some enduring quality, becomes elevated because everyone feels that the patient's "unselfish" deed is a sign of her extraordinary character. Thus she feels that by her suicide she will have reversed a humiliating defeat and turned it into a total victory.

Suicide as Retaliatory Abandonment

Similar in many ways to the previous example but psycho-dynamically quite different is the suicide as retaliatory abandonment. Hendin discusses

this type of suicide in which the patient feels that she is about to be abandoned and says in essence, “If there is to be any rejecting or abandoning to be done, I’m the one who will do it.” I find that these persons equate being abandoned with being treated as though they are worthless and do not exist. They still have the child’s conception of death. For children death is understood basically as a separation or abandonment. It is not unusual for these persons to have dreams which portray death in this way such as taking a long sea voyage or saying goodbye at the train station or an airplane taking them higher and higher into the clouds, and the like.

Suicide, in these persons, seems to provide an illusory feeling of mastery over a situation through the control that one has over whether one lives or dies. It alleviates the feeling of helplessness by restoring the fantasy that one’s omnipotence is still intact. The feeling is “If I have control over life and death then I truly am omnipotent.”

Typical of this type of suicide is the young man who stands on a ledge of a tall building threatening to jump because his girlfriend left him for another man or just does not love him anymore. He is determined to maintain his control over her or die. He usually does not jump until he is assured that his girlfriend has come and he tries to threaten her into returning to him by his threat to jump. If she does not return to him then he jumps with the satisfaction that because she is there begging for his life he is really

abandoning her by taking his own life and in addition punishing her with the guilt of having to witness his suicide and his condemnation of her as he jumps.

This need to control and to maintain a sense of omnipotence or the inability to live without such assurance, I feel is one of the most basic dynamics underlying all suicides. Most of those who want to commit suicide, due to extreme insecurity, have regressed to that stage of infancy in which one feels totally helpless and needs to affirm one's omnipotence in order to feel a sense of security. The loss of control over their environment gives them no assurance that they will be protected should they require it, and so they attempt every means of manipulation to restore that sense of control over significant others and they are willing to die in the attempt should they fail to achieve it.

Suicide as Reunion

This type of suicide operates in those who are in mourning over the loss of a loved one with whom they have been extremely close over the years. They cannot tolerate the separation from their loved one usually because their dependency upon them has been so great over the years that the mate remaining feels totally helpless to care for herself. One such woman said to me, "It's like trying to live without your heart. Can a person live without a

heart?" The existence of such people over the years has been affirmed only by the presence and recognition on the part of the mate and without the mate they feel lost, as though they did not exist. They cannot tolerate the separation from the loved one and they fantasize an eternal fusion with him in death. This fulfills the childlike fantasy of having love forever after. Most frequently the emphasis is not put on the dying but on the gratification to follow. Prior to the suicide attempt they frequently will report dreams to the therapist in which their mate is calling them to come and join them and they feel blissfully happy at the prospect of being reunited with the mate.

The search for an eternal fusion in death is frequently the motivating factor when young lovers commit dual suicide in what is frequently referred to as a death-pact for lovers. The Norwegian movie "Elvira Madigan," which gained great popularity in this country, also reflects the basic theme that some lovers feel that their existence is only one-half of a total whole and that once the union of the two parts is achieved, the whole cannot be destroyed without both parts also being destroyed. They equate life with love and union. Thus when this love or union is lost then life is also felt to be lost and so they consequently attempt to reestablish this union in death.

The Masochist

Masochistic tendencies are involved in various kinds of suicidal

attempts, some of which have already been discussed in earlier sections. In this section, suicide as a direct result of masochism will be discussed.

Essentially, the masochist is one who turns the full vent of his destructive impulses upon himself. The masochistic person is basically one who struggles to drain an enormous amount of tension within himself only to meet with repeated failure and frustration. Much of his tension is the result of the bound-up energy of repressed sexuality. He is unable to achieve a release of this energy due to what may be called orgasm anxiety. He is fully capable of becoming sexually aroused but at the peak of his sexual excitement and just prior to orgiastic release he develops an anxiety reaction which serves to inhibit the release function. The letting-go or loss of control involved in orgasm is very threatening to him for one reason or another. Frequently it is unconsciously equated with a state of helpless vulnerability or with loss of self and death. As a result of this unconscious interpretation, an anxiety reaction occurs just at the point of discharge and release.

His inability to release his blocked energy through sexual orgasm results in the attempt to channelize and discharge it through other avenues such as destructive aggression. The masochist's continuous frustration and failure to reduce his own tension usually leads to a fantasy in which he sees himself as totally bursting inside and thereby achieving a total release from tension. In essence, the tension within him is perceived as the cause of his

enormous frustration and so it becomes the object of his destructive impulses. When this fantasy is acted out, it can result in suicide. To the masochist, death is the unconscious equivalent of the '"big orgasm" or release of tension for which he has always sought but been denied, and the little hurts which he imposes upon himself represent the prefatory exciting foreplay. Thus, he is always burdened by the conflict of both desiring and fearing his own death and is in a constant struggle to resist yielding to the temptation to completely give up his controls and destroy himself. At some point in his life he may yield to that temptation.

Suicide as a Demonstration of Courage

On the college campus I have noticed a few cases in which some young boys are teased for their lack of masculine appearance or for their general submissiveness and they feel compelled to demonstrate to their peers that they are a man by demonstrating a lack of fear where others tend to be most fearful—that is, in regard to death. One such young man revealed to me, after his stomach was pumped for having taken a large amount of aspirins, that since the event took place, his standing with his peers has risen astronomically. One of his peers, after having heard of the young man's suicide attempt said to him, "Gee, I never knew you had that much courage in you." As he had anticipated, his suicide attempt had gained him a new respect from his peers.

Suicide and Rebirth

Many of us are tempted to go to sleep early whenever we have had a particularly bad day. The goal is not only to put an end to a day that has been bad but the belief is that the new day will bring a new beginning. “Tomorrow will bring a better day” is a phrase that is often heard. What is true for one day can also be generalized for a lifetime. For some persons, life itself is seen as a bad day or a bad dream from which one has to awaken. They also feel like going to sleep and “waking up tomorrow” to a new beginning. Waking up to a new day is unconsciously equated with a rebirth, and of course going to sleep is equated with death. This attitude of rebirth is frequently taught by parents who have difficulty getting their children to go to sleep. In essence they will tell their children that sleep will undo all the hurts of the day, and at times they tell the child that if he goes to sleep now that when he wakes up in the morning he will find a nice surprise gift near his bed. This tends to overly reward going to sleep and looking forward to tomorrow and also overly encourages the tendency to avoid the hurts of the day by going to sleep. When this kind of child grows up and experiences life as a hard day, then the unconscious yearning for a better tomorrow through a death and a rebirth becomes very attractive.

Suicide and the Patient Who Sees Himself As Already Dead

I have found this kind of suicide attempt particularly in young girls in my work at a woman's reformatory. As a result of feeling badly hint in love relationships with their parents they make a vow never to love again because to love again and not to have that love returned is an extremely painful and humiliating experience. In order to guarantee for themselves that they will not be hurt again they have to repress all of their tender, loving feelings. In addition, they will usually repress their capacity to cry because tears permit them to feel their hurt feelings. As a result of feeling unable to love or cry they come to see themselves as an empty shell, devoid of feelings. Because we tend to equate feelings with life, these girls believe that in a sense, they are already dead. Many tell me that they feel as though they were numb. They may report dreams in which they see themselves with their eyes open, lying in a coffin, unable to move. The dream clearly reflects their unconscious attitude toward themselves.

Other persons equate sexual desire or sexual potency with life force and if they feel that they have lost their sexual desire or ability, then they may also feel that they are already dead and there is no reason in life to keep on living.

Generally, the feeling of being already dead goes along with strong feelings of detachment, repressed aggression and a fear of loving for fear of getting hurt. The case of Nina discussed earlier in this chapter is a good example of this type of person. Many of these persons see suicide as a release

from the constant torture of needing to repress and avoid feelings and the people who might trigger such feelings. They feel that the actual death is merely a carrying out of an event that has already taken place. As one girl said, "I'm already dead, I just don't know enough to fall down."

THERAPEUTIC CONSIDERATIONS

The Interview

A comprehensive interview, especially with the patient under severe stress, is essential for the determination of possible suicidal intentions which may be either conscious or unconscious. To determine the likelihood of possible suicidal acting-out in a patient, the therapist needs to clearly assess the patient's capacity for tolerating psychological pain and discomfort. The patient who habitually and immediately runs from pain and tension without ever given himself an opportunity to directly experience it or effectively master it is much more likely, under intense and unusual stress, to follow the same pattern and seek an immediate and final escape and is therefore much more likely to impulsively attempt suicide than is the patient who demonstrates in his life clear indications of the capacity to tolerate and endure pain without the immediately impulsive need to escape from it. Thus, such indices in the patient as the compulsive use of alcohol, drugs, sexuality, sleep, manicky activity, etcetera for the purpose of immediate tension

reduction are indicators of greater suicide potential; whereas evidence to the effect that the patient has been able in the past to endure and resolve psychological pain such as that which stems from anxiety, depression, long and intense frustrations, deprivations, disappointments and so forth, would, in most cases, be less suggestive of the likelihood of true suicidal acting-out.

If there have been past suicide attempts, the therapist needs to establish what the pattern or triggering events have been in order to recognize what basic needs or fantasies the suicide attempts are seeking to fulfill. If the patient has considered suicide in thought only, the therapist needs to obtain information as to the circumstances under which these thoughts arose and the details of how and when the patient might act out the suicidal intent. The details of his suicide fantasy need to be thoroughly explored. The device the patient would use to end his life and the persons he would require present during the act are especially crucial in providing clues as to the meaning of suicide to the particular patient. Thus, for example, patients who reveal that they would prefer to attempt suicide by bringing pain upon themselves such as by cutting a wrist or walking in front of a speeding car are probably reflecting the existence of intense masochistic tension within themselves, whereas those that would prefer to attempt suicide by means such as taking an overdose of sleeping pills or drowning are probably reflecting more of a passive-dependent personality for whom achieving a sense of merging or fusion is essential.

The therapist also needs to try to ascertain what clues the patient is likely to use for the rescue fantasy so that he and the patient's family may be alert to these clues when and if they should become apparent. The therapist also needs to determine what kinds of people the patient is likely to choose to play the role of the rescuer by determining from the patient the kinds of persons that provide him with the most security and feelings of worth. It is also important to ask the patient as well as his family how he tends to handle destructive impulses or how he reacts when he has been badly emotionally hurt or frustrated. It is important to try to establish whether the patient's pattern of handling destructive impulses is to turn them in, out, or to totally repress and deny the existence of such feelings.

Sometimes projective personality tests and inspection of recent dreams may be essential in establishing the likelihood of suicidal acting-out. It is also of value to explore for possible phobias which may reflect a defense against possible unconscious suicidal intent, such as fear of high places or of driving a car, and the like.

Still another important consideration is to ask the patient about his philosophy of life and death and whether he has a concept of an afterlife. This information can be vital for determining the likelihood of potential suicide and the circumstances around which it may most likely occur. Other vital questions that need to be asked in the interview should deal with helping the

therapist decide whether or not the patient is treatable on an outpatient basis or whether hospitalization may be required.

Consideration of Hospitalization

Hospitalization needs to be considered if the therapist feels that the patient is in poor contact with reality or if the patient feels helpless in regard to defending himself against his own destructive impulses. Some patients make it very clear that they are begging for protection and no longer feel safe with themselves. Sometimes this is reflected in the fact that the patient becomes panicked whenever he has to be alone, for this is the time when he fears that he may act out his destructive impulses against himself. As long as other persons are with him he feels fairly comfortable. It becomes readily clear that this kind of patient is not considering suicide as an attempt to force narcissistic supplies from his environment but rather is struggling to contain a destructive impulse that is basically ego-dystonic.

Not infrequently the patient will externalize his self-destructive feelings and report a need to break something in order to drain the tension of his destructive impulse. Others may report having a destructive impulse to hurt or kill one of their children even though this kind of patient knows that he really loves the child dearly. The tendency to produce sadistic ideation clearly reflects its use as a defense against the more frightening masochistic or self-

destructive impulses. If the patient should report a sudden increase in loss of control such as increased physical beatings of his wife or children, then this may be an indication that hospitalization is required.

If the suicidal intent is unconscious rather than conscious, then this may be another indicator that hospitalization may be required. For if the suicidal impulse is under the influence of conscious ego functioning then there is likely to be much more control over it. If the patient is to resist the destructive impulse by himself, he must have a "reality peg on which to hang his big unconscious load" and so the therapist should always attempt to make the impulse, and all its attendant aspects, conscious as soon as possible.

If the patient is struggling with suicidal preoccupations then it is obvious that once-a-week therapy will usually not be sufficient. If it becomes obvious that the patient cannot handle the problem on a once-a-week basis and the therapist does not feel that he has the time or the inclination to provide more time to the patient, then this would be another circumstance in which he would be better off considering hospitalization for his patient. I believe that the most important ingredient in this decision is how frightened the therapist is in dealing with such a problem. If the therapist is very frightened, then it is likely that he will not be able to provide the patient with the protection and help that the patient needs when the time comes, and on this basis he should consider hospitalization for the patient. Another

important factor is whether there are others in the patient's family or community that are available to assist the therapist in helping the patient feel a sense of protection. If the patient manifesting suicidal intentions lives all alone and is not really close to anyone in his community, then he should be considered for hospital treatment.

I am not one of those therapists, although I do recognize that there are many who insist that hospitalization is called for under all circumstances when suicidal intent becomes apparent. The therapist also needs to recognize that although there are some patients who would welcome hospitalization as a source of protection, there are other patients to whom hospitalization would be experienced as an extreme trauma and could actually precipitate a suicidal acting-out. I am especially referring to the kind of patient whose greatest fears are of separation and abandonment. To remove them from their families or from the secure relationship with the therapist could be an overwhelming trauma. Some of the patients in trusting the therapist have come to trust someone for the first time in their lives and if the therapist recommends that they be hospitalized, these patients may find it impossible ever to trust anyone again, especially another therapist. This would make it extremely difficult, if not impossible, for them to ever work out their problems.

It is clear that no hard-and-fast rule can be applied for all patients in

regard to hospitalization. However, as a general rule, I would suggest that if in doubt do the safer thing and have the patient hospitalized. It is much better to err in the direction of over-caution than under-caution.

Some General Therapeutic Considerations

The therapist needs to be cautious in assuming that because a patient's depression has lifted that therefore the threat of suicide is eliminated. On the contrary, suicide attempts in severely depressed patients often occur as the patient is emerging from the depths of psychomotor retardation. This cannot be easily explained unless perhaps one views psychomotor retardation as a depressive equivalent of catatonia which, in the depressed patient, serves as a defense against the carrying out of the suicidal impulse. Thus the therapist needs to be extremely alert to a possible suicidal reaction at those times when the patient seems to be making a spontaneous recovery from his depression.

Stone and Shein provide a number of suggestions in working therapeutically with the suicidal patient. Essentially they suggest that if the therapist is convinced that suicide is in the picture, it is important that he not avoid this area but rather express his concerns frankly and discuss them explicitly with the patient. The therapist should then make it clear to the patient that suicide is a maladaptive action and basically contrary to the patient's best interests, regardless of the patient's rationalizations for why

suicide might be the best alternative to his current life situation. If the patient is unwilling or unable to discuss his suicidal thoughts, then the therapist must assume that the basic therapeutic relationship necessary to treat a suicidal condition is lacking and that perhaps hospitalization needs to be discussed as possibly the best alternative.

It is important that both the therapist and patient together communicate to the closest relatives the patient's concerns regarding suicide in order to have them participate in the total monitoring and protective process that is necessary for the patient. The therapist must not permit the patient to manipulate him by insisting on therapeutic confidentiality. Suicide is one area in which such confidentialities cannot be abided by. This must be explained thoroughly to the patient and why this is in his best interest. It is also important to obtain the cooperation of the family physician and clergyman and other such persons who are close to the family so that they may be aware of the problem and be available to the patient and his family should a crisis arise and the therapist not be immediately available. The enlistment of other professionals in the crisis protects the therapist as well as the patient since it dilutes the transference elements involved in the rescue fantasy as well as lightens the burden of responsibility, while at the same time providing the patient with others who can be available to him at the time of crisis.

It is crucial that the therapist identify what the patient's conclusions concerning his reality situation are that are driving him to consider suicide and take an *active* approach in altering these conclusions. The therapist must be active and even directive if necessary, for he cannot take the chance that the patient might interpret a neutral or non-active approach as a sign of the therapist's lack of involvement in or concern for the patient. Without the patient clearly feeling the therapist's involvement with him, the suicidal reaction remains basically untreatable. The *relationship* between the therapist and the patient is the most crucial ingredient in any therapeutic approach with suicidals.

It is also important that the initial stages of therapy focus not on the past object relationships but on current human relationships and essentially what it is about these current relationships that is making life intolerable for the patient. More intensive psychotherapeutic goals in terms of personality change ought not to be considered until both the therapist and patient feel that the patient's original convictions concerning the hopelessness and helplessness of his life situation have been significantly altered and that the suicidal impulse is no longer an imminent menace. It is only after this initial therapeutic goal has been clearly achieved that the therapist should consider eliminating the focus on current life circumstances and concentrate more on the goal of bringing about some more basic personality changes.

This can be achieved best by helping the patient come to recognize the inappropriate ways in which he deals with his own angry feelings and by encouraging the externalization of such angry feelings. The therapist must make it clear to the patient that the expression of angry feelings is a human necessity and that such expression is important not only for the reduction of tension but also to enable honesty and trust to exist in a relationship. The patient must come to recognize what his conclusions have been that have made it so difficult for him to externalize his angry feelings, and here for the first time, the therapy can begin to focus on the past and the patient can be helped to recognize that, for example, it has always been his great need to be loved and his fear of losing such love that has made it impossible for him to express any negative feelings. At this point the therapy can then proceed in the orthodox manner.

Some Specific Approaches When Suicide Seems Imminent

Upon occasion the therapist is confronted with a situation in which the patient has made it abundantly clear that as soon as he leaves the therapist's office he intends to commit suicide. He has already decided to commit suicide and essentially is coming to your office one more time to see if you can give him some reason for living. You have only this one crack at him and you must reach him in this one session in some way so as to provide some obstacle to the impulse toward self-destruction.

I have found it helpful under these circumstances to keep in mind the simple ratio:

$$\text{Tendency toward suicide} = \frac{\text{fear of life}}{\text{fear of death}}$$

It is clear that for most of us the fear of death is greater than the fear of life and so the ratio is low and there is little tendency toward suicide. However, for the suicidal person the fear of life has become greater than the fear of death, either because life has become extremely painful or because their conception or philosophy of death is such as to make it appear extremely comforting and attractive as an alternative. Thus the therapist has two avenues of approach open to him in his attempt in this one session to keep his foot in the door of life, thereby keeping it from closing. He can first attempt to lighten the patient's fear of life by attempting to lessen the reality of the fear or by contributing toward the greater gratification and enjoyment that life can offer. I find these approaches in this kind of circumstance usually less effective than the other alternative which is to contribute toward the increase of his fear of death. I feel that this is an approach which has been very little considered by therapists. I will offer some examples.

For the narcissistic patient who is pleasure principle oriented and frightened of pain, I attempt to convince him that the act of dying itself is

extremely painful in contrast to what they may have heard or believed. I tell him most directly that if he cannot endure the pain of life that he will certainly find the pain of dying much more excruciating. I go into detail in regard to how each organ involved in the death process contributes toward the total pain. I point out to him that if he has the courage to face the terrible pain of dying he can certainly endure the pain of living. I tell him that he has demonstrated great courage in enduring all the pain he has had to so far, for he needs to know that his suffering has been appreciated by another. The patient has too comfortable and unrealistic an approach to death and I want him to reality-test his notions in the face of the information that I am providing. My goal is not necessarily to convince him that I am correct. All I want to do is to raise some doubt in his mind which is usually sufficient to prevent the destructive impulse from expressing itself immediately. Once it subsides I can then concentrate on decreasing the fear-of-life side of the ratio.

If the patient is relatively intelligent I attempt to demonstrate to him that his concept of death as a peaceful and restful sleep is not correct and is challenged by as eminent an authority as William Shakespeare. I find most suicidal persons to be basically romantics at heart and they feel an affinity with poets and poetry. I read to him the soliloquy from *Hamlet* (Act III, scene i) (which I always keep close at hand because if I first have to look for it the mood is shattered), and I read it slowly and particularly emphasize the words I have underlined when I come to them:

To be, or not to be: that is the question:

Whether 'tis nobler in the mind to suffer

The slings and arrows of outrageous fortune,

Or to take arms against a sea of troubles,

And by opposing end them? To die: to sleep:

No more; and by a sleep to say we end

The heartache and the thousand natural shocks

That flesh is heir to, 'tis a consummation

Devoutly to be wish'd. To die, to sleep;

To sleep: perchance to dream: ay, there's the rub:

For in that sleep of death *what dreams may come,*

When we have shuffled off this mortal coil,

Must give us pause. There's the respect

That makes calamity of so long life;

For who could bear the whips and scorns of time,

. . . . . .
. .

When he himself might his quietus make

. . . . . .

. .

But that the *dread of something after death,*

The undiscover'd country from whose bourn

No traveler returns, puzzles the will

And makes us rather *bear those ills* we have

Than fly to others that *we know not of?*

I then interpret the soliloquy to him in the following manner: Shakespeare seems to be telling us that at one time or another everyone has asked himself the question of whether we ought to endure all the hurts and sufferings that life must inevitably offer us or perhaps end our life by committing suicide. We usually decide to keep on living, not so much because life is always so beautiful but rather because we do not know for certain what lies on the other shore. We cannot be sure that death is truly a peaceful sleep. As Shakespeare tells us, it is quite likely that death is not a finality but that perhaps the nightmare of mental anguish persists after death. In fact, it may be a worse torture than we have ever anticipated. This is another example of how the fear-of-death side of the ratio can be increased which lowers the likelihood of immediate suicidal acting-out.

On rare occasions I have even subtly encouraged some of these patients in whom I felt that suicide was imminent and who I felt were basically

masochistic persons to use me as the object for their need to hurt. I may even needle them into some kind of angry discharge in the hope of draining the tension level associated with the destructive impulse. They try to hurt me and I show them that I feel hurt. Then, for the moment at least, their tension level is diminished and they do not need to hurt themselves. I do not advocate this approach because it is fraught with all kinds of therapeutic problems, but under what I feel to be dire circumstances I have resorted to this approach and have found it successful in the goal of preventing the imminent death of the patient.

After I am convinced that some kind of wedge against suicidal acting-out has been built or the destructive impulse has been drained, I then revert back to the other side of the ratio and attempt to decrease the fear of life and increase its gratifications. Invariably I find that in all suicides what is missing is love. Even more than their not being loved I find existing their lack of ability to love. I try to point out to them that beauty exists in the world only when one is loving, for when we are loving we are the recipient of the beauty of these feelings, but when others are loving us then only they are the happy beneficiaries of the beauty of these feelings.

I try to have these patients recognize that they have destroyed the beauty in their own lives because they have inhibited their capacity for loving due to their fear of getting hurt. Because they are committed to the fact that

they will never let themselves love again, of course it is then natural to think in terms of suicide because life without love is bereft of beauty and joy. I try to explain to them why love cannot have any guarantees in terms of it being returned by the other but that when one truly loves, it is its own reward. I point out to them that it is not their loving that has hurt them but their need for a sense of possessiveness of the other and that when one truly loves the other, the fact of possession of the other adds relatively little to the beauty of the experience within. This can be made a reality to the patient only through the therapist's warm feelings toward him. It is essentially through the caring relationship between therapist and patient that the patient gains the feelings of protection and worth which are the essential ingredients in his coming to fear life less. This is usually sufficient to eliminate the suicidal intent. When this has been achieved, then the therapist can focus more on helping the patient gain greater insight into himself thereby solidifying the patient's sense of security. I feel that for one who works regularly with depressed individuals who are potentially suicidal, it is essential that the therapist have for himself a clear and meaningful philosophy of life and death, for without this the patient will surely catch him unaware with his usually well-thought-out logic of why it is necessary that he die. It is usually not sufficient for the therapist to just assert that the patient's attitudes are irrational, for the patient needs something more than just this negative approach but rather craves something positive by which he can consider a new reorientation

toward life. This something positive can only come from a therapist who has first deeply explored himself and has discovered real beauty in man and in life.

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