Ameliorating Suicidality

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I was once given a referral for a patient who called me stating that he was not coping well at work, and that he was upset over a relationship with a woman that he recently terminated. He was particularly vague on the phone, emotionally removed, and seemed somewhat ambivalent in the first place. We set an appointment for the following day yet he failed to show. I simply thought he changed his mind due to his ambivalence until I received a call two days later from a psychiatric nurse at a nearby hospital stating that the patient had taken an overdose on the same day he was scheduled to see me. I spoke with the patient and we rescheduled an appointment for the day of his discharge from the hospital.

Clive was a stock broker in his early thirties. When we first met, he was clearly mentally confused, tangential in his thoughts and associations, unable to articulate his inner experience with coherence or congruency, panicky, and deeply ashamed of his suicide attempt. He explained how he was increasingly unable to concentrate or complete his responsibilities at work because he was too distraught over his former girlfriend. At first he spoke of her and their relationship in very ambiguous terms, only stating that he was very uncomfortable and overly self-conscious being with her, which was so disconcerting that he had to end the union. During the initial meeting he was in a frenzied state because he felt so lost about his life. One overarching theme was his obsessional preoccupation and rumination that he was not happy in comparison to others, and only if he could find certain answers to his confusion, he would be "back to normal." As he put it: "Why can't I just be like others? I see people laughing at their jobs. Why can't I just be like them. It's like my whole life has just stopped. I just want to be happy. I have to be happy now." Litman (1970) alerts us to four ominous signs of suicidal potential: (1) an impatient, agitated expectation that something must be done immediately; (2) a feasible, detailed lethal suicide plan; (3) narcissistic pride, suspicion, and

hyper-independence; and (4) tendencies toward isolation and withdrawal, living alone, or living with someone emotionally removed or estranged. Clive fit these criterion to a T, but what was overwhelming present was the urgency that he had to feel better about his entire life right then and there—at that very moment.

If suicidal trends are severe, patients should optimally be seen daily until the acute crisis is stabilized. The outlook is favorable if they feel more relieved after the initial interview, with decreased agitation and a slight lift in mood, and quickly form a dependent attachment to the therapist (Litman, 1970). At the end of our first session, Clive reportedly felt calmer and stated how comfortable he felt with me. We made an appointment two days after our initial meeting, but he called the next day feeling suicidal. We did some grounding techniques over the phone and he came to see me later that afternoon.

When Clive arrived, he was visibly shaking and paranoid, stating that he was not capable of controlling his impulses which felt alien yet compulsory to him. I was concerned that his suicidality had by now acquired an autonomous organization in his ego which was dissociated from the rest of his self and experienced as ego-syntonic. Under these circumstances, the only way to put a floor under a patient is have him talk about what is most important to him at that time (Semrad, 1980). Rather than focus directly on the suicidality, or even worse, prematurely conclude that he needed to be hospitalized, I insisted that he tell me exactly what he was experiencing in that moment without holding anything back. He began to disclose that he found himself unable to stop thinking about Ginger, his former girlfriend, and that the constant thought of her was bringing on the urge to kill himself. He was obsessed with rehashing various aspects of their relationship, her facial expressions, their conversations—her specific disclosures of past sexual exploits with other men. He recalled how over the past four months since he had been dating her, he had become more preoccupied and self-conscious about his desirability, which made him question his confidence, capabilities, and self-esteem. Unable to concentrate or complete his work, he found himself fantasizing about her all day, wondering what she was wearing, how she was acting when he was not around, who she was talking to, etc.—to the point that his whole reality as he knew it became encased in impending dread. He could not eat

or sleep or carry on with his daily activities he once enjoyed, such as going to the gym or visiting his friends, because he was constantly worrying about Ginger and her perception of him.

Clive confessed that there was something wrong from the very start with this woman, but he just couldn't seem to let go: she had an animal magnetism and he was mesmerized. They were sexual with one another within hours of meeting at a bar, and their entire relationship from then on focused around sex. Despite the pleasure of sexual passion, he reported a fundamental discomfort in the way she made him feel: there was no emotional warmth or intimacy—just sex. He started having intrusive and disturbing fantasies at work, the gym, and wherever he went—that every man must lust after her sexually, to the point that he about instigated fights with strangers who he perceived were eyeing his girl. Ginger had such a toxic influence on his psychic cohesion, that he eventually had to end the relationship because he simply wasn't functioning. As Clive put it: "It was like I was constantly walking on egg shells. I had to watch every little thing I thought or said: I couldn't be me." She did not take his rejection lightly and began to harass him at home and at work, threatening to show up and make a scene if he did not continue to see her. In the end, she had convinced him that he was "really fucked up in the head." He rapidly decompensated after the break-up, and this is when his suicidal fantasies and impulses started to take command over his psychic reality.

During this session I was more concerned with establishing a climate of understanding, stability, and safety rather than pursuing the etiology and psychodynamics of his suicidality. Bellak and Faithorn (1981) tell us that "one must demonstrate clearly to the patient a continuity between the immediate *panic*, the *precipitating factors*, and *life history*. This gives the patient at least some feeling of control over what seems frighteningly ego-alien" (p. 90). Clive was somewhat mollified and reassured that his panic and urgency was only a temporary reaction to unformulated and unarticulated conflictual inner experiences that we would later figure out more fully together, but for time being he needed to focus on his recovery. He had agreed to take a leave of absence from work, which relieved some of the immediate pressures he was shouldering. Given that he had never reported feeling suicidal before, nor did he ever have a relationship like this one that made

him feel so disjointed and out of control, he was comforted by the conviction that he would eventually reconstitute and be able to put this behind him.

Later that evening when I was sleeping, I was awaken by a dream (if not a nightmare) that I was suicidal, that my mind was fracturing, that my life and all I knew was being compromised by the sensation that I was no longer in control of my own thoughts or impulses. Relieved to wake but emotionally shaken, I immediately felt discombobulated. What did I identify with in my patient? Did I become a container for his self-destruction; was this merely my assimilation of his projective identifications; or was there a communicative aspect—a command hallucination—that resonated within my own dark interior? What archaic piece from my past was roused from its somnolent slumber; what uncanny death wish did this excavate in me? I instantly feared for Clive, and felt the need to check my phone messages. When I went downstairs to my office, I saw the red light flashing on the answering machine and knew it was him. I played back the message only to hear his languid voice in desperation and disquieted panic. I called him, but he did not answer, so I left a phone message on his machine explaining how worried I was about him and that I wanted him to give me a call immediately. Although I was on the verge of panicking myself, I decided to wait rather than jump the gun and run the risk of making a clinical blunder.

When he called the next day, he was acutely suicidal. He told me he was sitting in his bathtub for an hour and a half with a razor to his wrist. I insisted that he come to my office, but he preferred to talk on the phone instead. "Suicidal patients suffer from 'tunnel vision' and only see one particular solution. It is therefore important to show them that there are other options" (Bellak & Faithorn, 1981, p. 173). Clive told me that he did not see a way out of this nor could he envisage a future: his entire universe was colored by lack, chaos, and upheaval. In moments like this, we are reminded that if the therapist honestly reports feelings of helplessness in himself and of entertaining thoughts of breaking off communication with the patient, then an emergency situation has developed and it is time for some sort of active intervention (Litman & Farberow, 1970). How do you attempt to convince a person in this state of panic, dissociation, and irrationality that their

solution is based in impulsive, desperate actions rather than more competent ones? How do you appeal to the autonomous portion of the ego that still has the capacity for rational engagement? How do you instill hope? This was the moment of crisis: Do I insist he come? Do I go to his house? Do I call the police? Do I have him hospitalized? "We are going to get through this together" I said. "Now talk to me."

I got him grounded, he calmed down, we made a contingency plan, he reconstituted, and was more hopeful. "The prognosis is most favorable if the patient, although depressed and contemplating suicide, thinks of those who would suffer from his deed" (Blanck & Blank, 1974, p. 266). This mobilizes attachment and empathic motivations that cling to the value of life. I asked him to think of his family and the impact his actions would have on them. He contracted for safety, promised to go to his mother's house or the hospital if he felt unable to fight his impulses, and told me he would take a sedative prescribed by the psychiatrist to help him sleep.

The next day, he was better but disheveled. He told me that the one thing that gave him hope was my comment: "The feelings are only temporary: they will pass." We reinforced our contingency plan: he was going to seek out support from his family, go to dinner with a friend, make himself do some exercise, and spend the night with his mother rather than be alone.

The intensity of Clive's suicidality began to abate and we were able to look more closely at the insidious dynamics fueling his impulsivity and internal turmoil. Kernberg (1984) tells us that every suicide attempt or completion implies the mobilization of intense aggression not only in the patient, but within the interpersonal field, and this why so many suicides are intersubjectively informed. Malan (1979) further urges us to consider suicidality "as a fusion of intense destructive anger expressed self-destructively on the one hand, and love, protectiveness, concern and guilt on the other—the patient would rather kill himself than harm the other person—and it is usually the anger that needs to be brought into the open" (p. 204). Intuiting that Clive was not telling me the whole story, I urged him to tell me what he had *really* been bothered by but could not seem to tell me directly. With intense discomfort and shame, Clive confessed that what had really

disturbed him was Ginger's unsolicited and provocative sexual disclosures about her past. Over the course of their brief relationship, she had managed not to spare him a single detail about her sexual appetites. She admitted to "fucking hundreds of men," including enjoying "anal sex," and frequently cruised men "simply to fuck" and disregard after she had her fill. Clive was particularly troubled by observing semen-stained sheets on her bed that she did not even bother to wash from her previous lover; but what was even more unsettling to him was her flamboyant need to explain how it was from a "big black buck" she picked up at a bar. Clive's ego was assailed: he was unable to shelter himself from the pain of his own feelings of inadequacy. This threatened his integrity as a man based on the simple economy that his "dick" was the measure of his self-worth. To make matters worse, he was a premature ejaculator, which was a source of grave embarrassment and sexual ineptitude. At one point, in a state of dissatisfaction with his performance, Ginger referred to him as "Quick-draw McGraw," thus rendering him humiliated and vilified.

Clive felt that something was wrong with him because he could not shake off the deep humiliation and significance of her disclosures. He wanted truth and honesty, but he didn't want to know such brute facticity: "That's reality Clive, you're just goin' have to deal with it," she told him. Clive was drowning in his fundamental ambivalence between loving this woman—this "slut"—and hating her for how she made him feel so impotent and ineffectual. He was turning his aggression on himself, protecting her from his wrath and narcissistic rage that imperiled his psyche. He started to feel guilty for judging her so negatively, and feelings of betrayal were lacerating him with the need for self-punishment. At the same time he could not admit to himself that he hated her for feeling so inadequate and flawed. But the injury to his ego was a nefarious, festering wound that unearthed primordial deprivations and pain associated with his relationships with his primary attachment figures. He recalled that as a boy he was very clingy and dependent on his mother, experienced prolonged separation anxiety well into his elementary school years, and that he still relies on her emotionally as his primary source of support and comfort. His father, on the other hand, was a volatile and physically abuse man who used to beat him with a belt and shame him indiscriminately. As a result, Clive

became a childhood bully, was always getting into trouble, and picked on and beat up other kids as a way of expressing and reenacting his own traumas with his father. When he was older, Clive attempted to channel his aggression in more sublimated ways through sports and excelled in hockey. But his volatile temper and bad sportmanship led to multiple fights on the rink to the point that his mother was too embarrassed to attend his games, which hurt him deeply. His folks eventually divorced when Clive was a teenager because of his father's multiple affairs, yet his father blamed him for the break-up due to his bad behavior and for being a "mommy's boy." Ginger was a trigger for excavating deep feelings of deprivation and inadequacy related to his childhood past where he questioned his lovability. Unconsciously identifying with his father's rage and aggressivity, as well as his appetite for sexual pleasure, Ginger became the "sluts" his father was "screwing" which clashed with his desire to have a loving, nurturing woman like his mother. What intensified this identification was the fact that his father had become a depressive drunk since the divorce who was hospitalized on two occasions for suicide attempts.

Clive came to recognize many anaclitic depressive features within himself. When he was in the hospital, he described how a nurse had touched his face when he was sobbing, attempting to comfort him. He described this event as a painful ecstacy: "It felt so good," yet it *cut*. He further described a similar sensation when his mother held him in her arms, stroking his hair just shortly after leaving the hospital while staying with her and her new husband. There was a regressive yearning in Clive to return to a quiescent state of maternal blissfulness, and his suicidality was partially informed by these infantile longings that were not fulfilled with Ginger. Sex with her was not the warmth and love he truly craved, but she became a toxic introject he could not purge.

Over the weeks of his recovery, Clive's ego boundaries strengthened and he went back to work without further crisis. He began to understand more fully how he had lost his sense of self in this woman's worldview of eroticism = love and could see her pathology for what it was. He began to focus on seeking out substance and intimacy in a woman rather than appearance and beauty, vowing not to repeat the same

pattern; and gradually he started dating again. He soon met a woman, and cautiously, over-time, they fell in love. During the termination of our work together, he reported feeling the happiest he had ever been in his life. The blackness that had engulfed him just a few months before was now a distant world, while his future with his new partner was bright and full of promise. He thanked me for my help, while I in turn thanked him for his gift of recognition, and the therapy ended with a mutual hug.

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