'I Can't Go On; I'll Go On':

Treating the Self-destructive Patient

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Estragon: I can't go on like this.
Vladimir: That's what you think.
Samuel Beckett, Waiting for Godot

Although no therapist likes to think that there are categories of patients who are "undesirable," most will admit to a reluctance to treat chronically suicidal patients. Particularly when there is a serious suicide attempt in the recent past.

I discovered the common perception of these patients as undesirable while working on an in-patient unit. There appears to be an inclination to decathect with patients when one believes that their death is a serious possibility. Many times this unexamined decathexis is the only clue to a growing suicidal crisis, which if not brought into awareness and used therapeutically potentiates the crisis. It is not surprising to discover the eagerness with which clinicians pass these patients on to the hospital team for care, and the readiness of the patient to connect with a hospital clinician. Underlying both of these otherwise unusual circumstances is the unspoken, often unconscious, knowledge in both patient and clinician that the patient has become undesirable.

Many clinicians assert that they don't treat these patients because of the demanding nature of the work and the intensity of the contact required, others, because of the potential for litigation. But ultimately, I believe that what makes us resist these patients is the palpable threat of failure which shadows such a treatment; the constant reminder of the analyst's limitations.[1] How is Greenson remembered, after all? As the author of an excellent book on technique, or as the analyst that failed to keep Marilyn Monroe from suicide?

[1] NOTE: include somewhere that the countertransference fear with suicidal patients is an envy of their permitting the death drive freedom. In fact, we are afraid of being traumatized by the very things our death drive desires: drugs to deaden into a narcissistic bliss, the freedom to murder and permission to kill ourselves.

In the end, it is this reluctance to take on the riskiest of cases that leads in our field to the tragic reality that the most complex and demanding treatment cases are rarely treated by our most experienced analysts. Many clinicians consider chronically suicidal patients inappropriate for analytic treatment altogether. Colt, in his otherwise useful book, The Enigma of Suicide, writes that these patients "may be treated with antidepressant drugs, shock treatment, cognitive therapy, Yoga, or any of more than 200 types of psychotherapy practiced today. Of them, only psychoanalysis is agreed to be inappropriate for suicidal patients" (p. 312-313). Hendin, a suicidologist and an analyst, agrees, "Most are either too anxious, too depressed, or just not well enough put together to stand it" (cited in Colt, p. 313).

This view has a long history within the psychoanalytic tradition, dating to Freud's (1904) early statement that such suicidality indicates a "toxic depression" (p. 264) and that this neurobiological toxicity rendered such illnesses beyond the scope of psychoanalysis.

Although Freud eventually changed his views on suicidal impulses, his earliest view is not out of line with most contemporary literature, which suggests that suicidal depression is a neuro-vegetative state requiring hospitalization, anti-depressant medications, and, if these fail, electro-convulsive therapy. For chronically suicidal patients, supportive therapy is added to the mix, along with long term use of anti-depressants and, most recently, out-patient ECT at regular intervals.

In my work with suicidal patients, both in hospital settings and in my private practice, I have taken an opposing stance. I believe that these life-prolonging measures are useful only insofar as they buy time for the establishment of a therapeutic alliance. And, further, that the focus of treatment, especially in the early stages should not be a waiting game of encouragement and support, but rather the forging of an intense alliance built on the mutual acknowledgement of the seriousness of the death wish.

Two brief examples: A 48 year old woman was hospitalized following a nearly lethal suicide attempt. She had swallowed over 200 pills from a stash of medications built up over years. Her analyst was on vacation. His diagnosis was of intractable bipolar depression that was

primarily hormonal. He told her that it was his task to be supportive and help her to survive until menopause relieved her of her depressive symptoms.

In our first session the patient was quite matter of fact about her upcoming death. She had last attempted suicide exactly twenty years earlier and had survived. She determined to give herself twenty years of the best treatment she could find. Her list was impressive, including a year on a psychiatric in-patient unit for professionals. Her current analyst was well known and highly regarded. But the treatment was an obvious failure. In twenty years she had experienced only two minutes of pleasure and now it was time to end it. We spoke of her various plans and she said that in the end there were two. The pills that she'd been hoarding, or using scarfs she'd collected to hang herself from the antique IV pole she used as a reading lamp. I asked about the scarfs. How had she chosen them? Aesthetically? Or for their strength? She said originally they had some emotional value, later she added particularly nice ones to her wardrobe, all the while aware they were part of a potential noose...

Another patient had been prevented from repeating a suicide attempt she had made four years earlier. She was going to reopen the scars on her forearms from her first serious suicide attempt. She had been in treatment with a psychiatrist for four years, twice weekly, focussing on medication management and support to keep her functioning at her demanding design job. In our early sessions, we spoke about her scars. She's had plastic surgery on one arm but not on the other. "Aren't they ugly?" she said, almost coyly, showing them to me. I looked at them, unflinchingly. "Tell me about them."

In each case, the patient tested my willingness to follow her into the terrain of death. As I did so the conversations became animated; the patients came in touch with their emotions: a kind of morbid playfulness in the first, a mixture of existential agony and curiosity in the second.

These early sessions brought about palpable relief in these patients; but not because a sensitive ear and adjusted medication had helped them over an anomalous suicidal crisis. As they told me months later, they had felt understood, joined in what had been an alienated internal

world where suicidal wishes were the only imagined relief from tormenting self-hate, relentless unhappiness, and despair.

My presence and attention served to reclaim a portion of the life force, if you will, which had been put into the service of energizing the death wish.

I will be discussing the following aspects of work with chronically suicidal patients: Diagnosis and treatment, transference and countertransference issues, external support systems, and finally some thoughts on the concept of undesirability. I will begin, however, with an attempt to locate the discussion in theoretical terms.

A decade after Freud formulated his toxic theory of anxiety and self-destructiveness, he transformed his perspective on suicide from the biochemical to the object relational. In "Mourning and Melancholia," (1917) Freud made the then radical claim that suicide was in fact a homicide directed at the object internalized through identification. A number of object relational views have followed, particularly in the literature on masochism. From these perspectives the suicidal impulse represents not the murder of the internalized object, but rather the attempt to maintain a relationship with the internalized, murderous parent (Berliner, 1958).

Chronic suicidality requires a somewhat more complex formulation than either of these, which I will offer in the section on transference. I would add, at this point, that in understanding these patients, I find useful what is perhaps the least accepted of Freud's metapsychological notions: the ineluctable inner urges embodied in the life and death drives.

Working with the chronically suicidal, one cannot avoid the notion that in these people an innate urge has been magnified to relentless proportions. I believe that the suicidal urge, when it exists, is a reflection of such an extraordinary rending of the normal requirements of child-rearing, that the psyche is in a kind of apocalyptic battle with itself. Warring relations among internalized object representations and fragments are fueled with a primal self-destructive energy run amok.

As a result, there is no one diagnosis associated with chronic suicidality. These patients present as borderline personality disorders, addicts and alcoholics, manic-depressives,

schizoaffectives, atypical psychotics, obsessive compulsive disorder, dissociative disorders including multiple personality disorder. In fact, I work with a number of patients who have been assigned nearly all of these diagnoses over the years, and accurately. The mind will go to great lengths to survive an internal murderer.

I invoke the death drive, not just because of its descriptive power, but because this concept, particularly as developed by Ferenczi, points the way for the treatment of these patients.

Ferenczi (1929) believed that chronically morbid, suicidal or melancholic patients were originally "unwelcome children," born into families where they weren't wanted. Since these children are "still much closer to individual non-being...slipping back into this non-being might therefore come much more easily to [them]. The 'life-force' which rears itself against the difficulties of life has not therefore any great innate strength. (p. 105)"

Ferenczi believed that it was the parents' responsibility to induce their children to live "by means of an immense expenditure of love, tenderness, and care...otherwise the death drives begin to stir immediately" (1929, p. 105). And indeed, in his treatment experiments, Ferenczi saw himself as the surrogate parent who would, by the sheer force of his love, reignite the life force in his suffering patients.

In his last paper, Ferenczi (1933) expanded his formulations to account not only for the effects of parental neglect, but parental abuse, as well. He described the traumatic interaction induced by the sexually and aggressively overstimulating parent, who destroys the child's reality testing by denying the seduction/aggression and simultaneously punishing what the seduction/aggression evokes. Although Ferenczi did not expand on the effects upon the child's life and death drives, we can interpolate that where neglect exacerbates the fundamentally passive urge toward non-being, abuse brings in its wake a more active destructive impulse: the urge to kill oneself (Lowental, 1986).

Technical issues with chronically suicidal patients

In the tradition of Ferenczi, I have found that when working with patients who are prone to such intense anxiety and self-loathing, prompting at times psychotic decompensation, or suicidal or homicidal enactments, a certain "elasticity of treatment" (Ferenczi, 1928) is required. In conceptualizing treatment parameters, one must hold two ideas very dear; on the one hand, we must understand profoundly the theory which underlies our treatment choices, on the other, we must know when to challenge that theory and learn from the patient just what it is that he or she needs.

I will begin with the concept of analytic neutrality. Traditionally, the analyst takes a position equidistant between id, ego and super-ego, is responsive to the patient's productions, follows and clarifies without leading or imposing his own values or expectations on the procedure. With the chronically suicidal patient a non-neutral stance is taken. The analyst is unabashedly in favor of the patient's survival. When the patient asks, in utter despair, "Why shouldn't I kill myself?" the answer I give is, "I can't convince you one way or another, but I can tell you that I want you to live."

He sits at times supporting the ego and tempering the super-ego's onslaught or the id's impulsivity, at times embracing the entirety of the patient, and at times just distant enough for the patient to make productive use of transference, but not so distant that the patient feels abandoned.

Where traditionally the analyst makes few interventions in sessions, with these patients, the analyst's voice is quite active, clarifying, interpreting, educating, soothing. Always reminding the patient of his presence with questions, helping to form the amorphous affect and fragmented memories into psychic images and representations.

I work with a woman, a lawyer, who is mostly silent in sessions, yet she cannot bear silence. "Please talk," she'll say. "I was wondering what is on your mind." ""You talk." "I remember in our last session..." "No, I don't want you to talk about me or about anything therapeutic. Can't you just talk?"

Most important is the ongoing management of the patient's anxiety. Often the patient communicates some action that must be taken to reduce anxiety, an action which invariably challenges the analyst's dearest held assumptions. I have been asked for photographs, a blanket, my jacket, my sock, a handshake, hand-holding, money, my clock.

While with most patients, careful analysis of the unconscious meanings of the request obviates the need to act upon it, these patients often require the concrete representation of the analyst's continuity and love, even after the request has been analyzed.

One patient, for example, asked to touch my books. The analysis brought out associations of being fed by what feeds me, as well as flashes of touching my penis. Following the analysis of the impulse, she still could not tolerate being denied permission to do so, and I allowed it. In deciding whether to permit an enactment, I ask myself the following questions: Is this necessary to prevent a psychotic or self-destructive decompensation? On the other hand, will the action itself be harmful to the patient or to me? After carefully considering these two questions, I make my decision. A book, after all, is not a penis.

When working with the chronically suicidal patient, there must be structure to one's availability. Often frequent outside contact is necessary. A paper could be written on the meanings of carrying a beeper, but this is certainly one way to place the relationship with the therapist between the patient and the suicidal impulse. Some patients ask for daily phone contact, brief reminders that the therapist still exists and that the relationship continues. At the very least, the therapist must check messages at regular intervals, letting the patient know when these times are.

One more technical detail: in working with chronically self-destructive patients, it is important to address in detail the potential for self-destructive enactment, and to monitor the rising and falling of these impulses. Often the regular contact and availability serves to lower the intensity of the suicidal urges, but these invariably return with these patients as the transference intensifies. Here, a word about contracts. At times, self-destructive patients feel relieved when

they have signed a contract prohibiting them from acting on such an impulse until they have had contact with the therapist. It reminds them of the therapist's presence when they need it most.

There are times, however, when the patient is motivated by death wishes against both the self and the love object, and any act of understanding from the therapist only serves to eroticize the death impulse. This subset of chronically suicidal patients suffer from a negative therapeutic reaction that can rapidly become lethal. I have found that at those times the only thing that has helped is to tell the patient that therapy seems to be energizing the death wish rather than preventing it and that therefore I can only continue treatment if the patient agrees altogether to give up self-destructive activity.

Transference and countertransference issues

What makes work with these patients so difficult are the complexities and toxicity of the internalized object-representations, and the fluidity with which these are transferred onto the analyst.

Invariably, there are at least two deadly transferences which may be called into operation at any given moment. These typically reveal a childhood with two or more abusive parents or family members. In the transference, as in such a childhood, when one representation is demonized, the other is experienced as the potential saviour. The difficulty is that lurking beneath every saviour are the ramifications of repressed betrayal and torture.

The patient described earlier, with the collection of scarfs, was raised by a sadistic, paranoid mother, and a passive, sexually abusive father. Each parental transference scenario contains a double self-destructive element, passive and active. There are moments when her rage toward me as the maternal sadistic torturer is turned straightforwardly against a part of herself. For example, she once asked me for Oreo cookies to feed the child part of herself. Identifying herself with the transference aggressor, she then bought herself the cookies and shoved them into her mouth, nearly choking herself in the process. On other occasions, her self-destructive

impulses were understood to be attempts at evoking a feeling of everlasting guilt in me so that even though I am a torturer, it is the basis for a continuous connection.

Alternatively, her paternal transference has shown itself to be the more dangerous one. This was particularly true before she recovered any memories of the sexual abuse. During this period, her experience of dependance on me invariably led to an inexplicable upsurge in her suicidality.

This patient had frequent wishes to climb on my lap and be rocked, a scenario which had actually been enacted with her previous therapist. That treatment ended with the patient's long-term psychiatric hospitalization. In our work, my not granting this wish but inviting the patient to imagine it brought with it the beginnings of the recovery of her memories of his abusiveness. It became apparent that the only way this patient could accept paternal love, was as a kind of suicide pact, a simultaneous love and punishment for its incestuous implications. (It is worth noting that, although this patient's father died of a heart attack, she believed that he had willed himself dead to escape his marriage, a kind of passive suicide.)

Thus, with this patient, the transference alternates between guilty torturer and saviour abuser, each one with potentially lethal implications.

Doubly treacherous transferences are often found in patients who have experienced physical and/or sexual abuse, although these are by no means the only circumstances in which the child experiences the parents as homicidal.

I have a patient whose mother only expresses love toward her child as a kind of pity for real or imagined physical and mental defects. Her father, in a paranoid psychotic rage actually attempted to murder her mother in the patient's presence. This patient vacillates between self-mutilation on the one hand, and the attempt to evoke murderous rage-as-love on the part others. The anxiety inherent in each of these strategies, however, is so unrelenting that it is not surprising to find substance abuse in this patient's history. It's important to note that 'Recovery' (in addiction terminology) for these patients often consists of replacing the death-like state of intoxication with the death actualizing suicidal impulse.

Naturally, such powerful transferences evoke powerful countertransferences. I have mentioned the counter-transferential decathexis in the face of an upsurge in suicidal ideation. As well as fears of failure, litigation, ruined reputation. As with all counter-transference these can provide useful information if they are acknowledged and examined and they can be extremely dangerous if they lead to unexamined reactive behavior. Many therapists get into trouble with these patients, for example, if they accept the transferential role of saviour uncritically. The therapist who rocked my patient, is an example of this.

With such creatively sado-masochistic patients, one must be continuous observant of potential sadistic or masochistic countertransference reactions. Masochism shows itself in responding to the patients needs in ways that are later resented (giving out one's home phone number, would be an example. Sadistic countertransference may show itself in a variety of ways, from the ostensibly ego-based impulse to make these patients face reality, on the one hand, to the mild urge to tease on the other. (I remember working with one patient whose memory was impaired due to ECT treatments. All kinds of teasing fantasies emerged when I was faced with the certainty that she would forget our sessions the next day.)

More insidious is the countertransferential death wish. One patient reported that her mother had told her to drop dead, which resulted in her cutting her arms and showing the scars to her mother, as if to say, see what you did to me. This episode took place during my vacation, and there was a clear, if unacknowledged, transferential element in the act. Interpretations to this effect were to no avail, and the self-destructive activity increased: The patient fractured her hand against a wall in my waiting room. Afterwards, the patient threatened to leave treatment. At that point I had the thought: well, if she's going to kill herself, it would be better if it were after she left treatment.

A bit of reflective analysis helped me to interrupt the patient's self-destructive spiral. I understood that the patient was evoking a murderous response in me to preserve her belief in her mother as a loving, rather than a sadistic object. If everyone, after all, wished the patient dead, then the patient must indeed be bad and deserving of the ill treatment that she's thus far received.

Implied in this scenario is the idea that the mother's actions are not sadistic, but punitive, and that when punishment is sufficient, the mother's love will be available. Too often, as mentioned earlier, the counter-transferential death wish remains unacknowledged and is expressed via a decathexis which validates the patient's masochistic defensive structure.

A final transference-countertransference dilemma that needs to be negotiated with these patients is the wish for physical contact. Patients who have experienced nothing but aggression and seduction often seek these from the analyst as demonstrations of love. This is easy to avoid. More difficult is the request of the patient, following the analysis of such wishes, for a concrete demonstration that love need not be aggressive or seductive. For example, one patient recently told me a dream where she was about to jump off a building. She told me that the only thing that would stop her is if I held her, which, in the dream, I did. I interpreted the dream as her fear that she might succeed in blackmailing me into seducing her. She explained that she needed to be held in a non-sexual manner, like a baby in the womb.

At these times I explain to the patient that the treatment is a kind of holding, even if it is not a physical one. This was not enough for this patient. She said, she can't feel that kind of holding. She described herself as a note and me as the bottle. She needed my holding so that the message can survive until it reaches shore. At times like this I am reminded of Brecht's comment that in the arena of world politics he prefers when nations are negotiating peace to times of war, certainly, and even to times of actual peace. Because during peace you never know when a war will take you by surprise; this is unlikely during negotiations.

Concluding Thoughts

> And you have to be made to live the death instinct, which is held in such abomination there, if you are to catch the true tone of Freud's biology. For to ignore the death instinct in his doctrine is to misunderstand that doctrine entirely. (Lacan 1960, 301)

In 1897, Freud turned away from his study of the impact of trauma and the resultant dissociations and focused his energies on patients, like himself, who had been raised in an environment where libido was primary. The parent-child relationship described, for example, in the early letters to Fliess: "What have they done to you, you poor child?" (1897, 289), is radically different from that exemplified in the Three Essays: "She strokes him, kisses him, rocks him and quite clearly treats him as a substitute for a complete sexual object...fulfilling her task in teaching the child to love" (1905,223). In other words, in seeking to divine a normal psychology, Freud shifted his attention from patients raised in a culture of the death drive, to those for whom the life drive was prominent.

The psychoanalysis that ensued emphasized the developmental effects of self-preservation and libido. Only when faced with the widespread destructiveness of World War I, did Freud restore the impact of trauma and destructiveness to his theory. Thus began a reconceptualization of the formative human motivations, such that death took its equal place alongside the life drives in psychoanalytic metapsychology.

Many psychoanalysts continue to emphasize Eros as the norm, rejecting Freud's final dual drive theory, or distorting it such that the death drive becomes unrecognizable. Even Lacan, who ostensibly advocated a return to Freud's death drive concept, presented the death drive, not as one of two immutable drives, but as drive itself, erupting from the underside of signification, undermining the ego's imaginary cohesiveness.[2]

[2] Lacan's formulation addresses one aspect of ego trauma over another; his emphasis is on the trauma to the meaning-making capacity that arises when the fledgling ego is confronted with a unifying reflection beyond its own capacity to hold structure. This trauma of meaning, in its extreme form, reflects the dilemma of patients with issues in the realm of psychosis; whereas the traumas of these patients are derived more from the realm of the trustworthiness of the relationship with the other. Whereas the one who cannot hold meaning tries to make sense out of the others' reflection but fails and turns then to suspicious rage or religious fervor in order to congeal meaning, the one who seeks a trustworthy relationship attempts to become what the other presents, i.e., the hateful object, in the hopes of achieving relationship.

I have chosen to focus on those patients for whom the death drive has always had the upper hand, both in their environments and in their psyches. These patients can be identified by the rigid, primitively aggressive character of the super-ego, the relative absence of a coherent ego-structure, and by the predominance of dissociative and destructive psychic processes over synthetic and integrative ones. Many of them have attempted suicide; some have attempted murder.

I have chosen this foray into the pure culture of the death drive to reinstate an understanding of the visceral power of this force, and to caution against either a neutral or romanticized stance toward life and death. With patients who garnered enough life force in their early environment, we prod death to its deconstructive advantage. Within such an optimal environment, death takes the form of that which is outside the ego organization; our task is to invite the patient to welcome it in.

But to view death solely from the vantage point of Eros is to fall victim to a romance; a romance which elides the reality of death, not as the facilitation of Eros, but the silencer of Eros; not as the catalyst for signification, but as that which puts an end to signification. For the patients I am describing, the death forces need no prodding; they are ubiquitous. Their energies are not silent but omnipresent.

The dissociated traumatized patient already lives the experience of a deconstructed ego, with the concomitant availability of the affective "real," in Lacanian terms. It is a world of terror. As Bromberg (1991) has described it, "The patient is, in one respect, an island of tortured affect, and this experience, along with its felt hopelessness of verbal expression, becomes the patient's essential 'truth,' while words and ideas become empty 'lies'" (47).

In contemporary society, at least in North America, there is an upsurge in reports of dissociation, an "epidemic of multiple personality disorder" (Shamdasani 1994, xvii). Certain theorists see in this a postmodern sensibility at work, and welcome the passing of the subjective ego as unifier of experience. I see, in the ascent of subject-destroying symptoms, an energized death drive which may reflect a cultural disintegration. Perhaps the "multiplicity" of the dissociative patient points the way for a complexity of subjectivity, necessary in our age of technological explosion, capital concentration, and role diffusion, but the suffering and violence of the dissociative's experience demonstrate the damaging effects of death drive culture.

This raises direct questions as to the stance of the psychoanalyst. When Winnicott wrote, he was able to assert a clear psychic boundary line between the effects of "good-enough mothering" and mothering that was not good-enough. "If maternal care is not good enough then the infant does not really come into existence, since there is no continuity of being; instead the personality becomes built on the basis of reactions to environmental impingement" (Winnicott, 1960a, p. 54). He argued for a fundamental adjustment in psychoanalytic technique once the boundary line had been crossed (1960b).

I do not always find the boundary line quite so clear. I find it an ongoing struggle to ascertain when aggression and sexuality are serving the interests of destruction and when they serve the life interests. At times the boundary may shift within a single session; at times within a single moment. Though often obscure, the distinction is essential, particularly in our work with destructive patients. It is, in my view, the boundary line between a psychoanalysis that strives toward deconstructing ego structures (in Lacanian terms, toward "a twilight, an imaginary decline of the world and even an experience at the limit of depersonalization" [Lacan, 1953-54, 232, cited in Boothby 1991]) and one that strives to bring the patient back from that experience;

it is the difference between lying down and sitting up; between an alliance with forces outside the ego's rigidities or an alliance with forces which strive toward a cohesion of ego; it is the difference between a psychoanalysis allied with the 'death' drive or with the life drive.

Treatment in the shadow of the death drive can be seen as a therapeutic counterpart to Ferenczi's description of the process of parenting; it requires an environment saturated, as it were, with Eros: "the child has to be induced by an immense expenditure of love, tenderness, and care, to forgive his parents for having brought him into the world without any intention on his part" (105). I try to point the way out of despair by showing these patients that I value their capacity to love more than their destructiveness and that I am willing to tolerate and contain their Thanatos (and my own) for the sake of their Eros (and my own).

> you must go on, I can't go on, you must go on, I"ll go on, you must say words, as long as there are any, until they find me, until they say me, strange pain, strange sin, you must go on, perhaps its done already, perhaps they have said me already, perhaps they have carried me to the threshold of my story, before the door that opens on my story, that would surprise me, if it opens, it will be I, it will be the silence, where I am, I don't know, I'll never know, in the silence you don't know, you must go on, I can't go on, I'll go on. (p. 414)
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> Samuel Beckett The Unnamable (1955)

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